The relationship between racial trauma and mental health outcomes in young adulthood: A UK context

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Abstract

In recent years, the concept of racial trauma has gained recognition as an important framework for understanding the psychological and emotional consequences of negative race-based experiences (Bryant-Davis & Ocampo, 2006; Carter, 2007). Given the intersectional nature of identity formation during young adulthood (Arnett, 2000; Erikson, 1968), and therefore the critical impact that racial trauma can have on the developmental trajectories of young adults, it is important to understand the enduring effects of racial adversity within this life stage. As an emerging field of study, research on racial trauma outside of the United States (US), where socio-cultural and historical contexts differ, remains limited. Grounded in a developmental psychology perspective, this study aims to examine the prevalence of racial trauma, and its relationship with other mental health outcomes in young adults within the United Kingdom (UK), whilst investigating the intersectionality of demographic and socio-cultural factors that shape these relationships. Participants (18-30 years old) completed an online survey, including socio-demographic questions and standardised scales which measured frequency of racial adversity, and symptoms of depression, anxiety, post-traumatic stress disorder (PTSD) and racial trauma. Correlation coefficient and regression analyses revealed a positive association between racial adversity and racial trauma symptoms. Higher levels of racial trauma were significantly linked to poorer mental well-being, highlighting the cumulative effect of racial adversity on mental health. Moreover, individuals in regions with higher racial diversity exhibited lower levels of racial trauma and better mental health outcomes, emphasising the need for comprehensive reform to address racial adversity across various social ecological levels.

CHAPTER ONE: INTRODUCTION

1.1 Trauma in Young Adulthood

1.1.1 A Developmental Psychology Perspective on Young Adulthood

As young adults navigate critical life and attachment transitions, they are often susceptible to the enduring effects of trauma. Trauma, whether arising from interpersonal experiences or external factors like armed conflicts or disasters, can significantly impact the cognitive, emotional, and behavioural well-being of individuals during this life phase (Kessler et al., 2007; Steel et al., 2009). The developmental psychology perspective acknowledges that young adulthood is a diverse and multifaceted period influenced by cultural, societal, and individual variations. It recognises the dynamic interplay between biological, cognitive, and psychosocial factors that shape this life stage (Schulenberg et al., 2004).

Early adulthood is marked by a unique intersection of factors that make young adults more susceptible to traumatic experiences. During this developmental stage, young adults are often exposed to a multitude of new and challenging life circumstances, such as pursuing higher education, entering the workforce, establishing intimate relationships, and assuming financial responsibilities (Arnett, 2000). These transitions inherently involve greater exposure to potential risks, whether that be interpersonal conflicts, workplace stressors, or financial uncertainties (Schulenberg & Maggs, 2002). Despite these increased risks, many young adults may still lack the full psychosocial maturity necessary to effectively navigate and cope with traumatic events (Cauffman et al., 2015). Cognitive and emotional development in early adulthood may not have yet reached a point where young adults possess robust coping mechanisms or problem-solving skills to help them manage adversity effectively (Sroufe & Collins, 1999). This lack of maturity can hinder their ability to engage in self-protective strategies, leaving them more vulnerable to the negative effects of trauma.

1.1.2 Defining Young Adulthood

Young adulthood is commonly recognised as the transition period between adolescence and middle adulthood, marked by notable physical, cognitive, emotional, and social changes (Berk, 2018). It represents a pivotal period characterised by significant personal growth, identity formation, and developing a sense of well-being (Erikson, 1968). It is also known to be a time of exploration, self-discovery, and increased independence as individuals navigate the challenges and responsibilities associated with the transition into later adulthood.

Erik Erikson proposed a theory of psychosocial development. His psychosocial development model is a theory that outlines eight stages of human development, each widely associated with a specific age range and unique psychosocial crises or challenges that individuals must navigate successfully to achieve healthy psychosocial development. Erikson's (1950) seminal work, "Childhood and Society," is a primary source that introduces his psychosocial development theory. During young adulthood, individuals confront the psychosocial crisis of identity vs. isolation (Erikson, 1968). This stage is a critical period in a person's life when they grapple with the psychosocial crisis of developing a strong sense of identity versus experiencing feelings of isolation and confusion about their identity. Central to this stage is the process of exploration and commitment to certain beliefs, values and life choices. Young adults in this stage are faced with the task of establishing a clear and stable sense of self (Erikson, 1968). They explore various roles, values, beliefs, and life paths, aiming to answer fundamental questions about who they are, what they stand for, and what they want to achieve in life (Côté, 2009; Erikson, 1968; Marcia, 1966; Schwartz et al., 2009; Waterman, 1999).

Our understanding of the various development stages and their associated challenges has been influenced by Erikson's theory of psychosocial development. However, like any theoretical framework, it is not without its critiques. Although Erikson (1968) has acknowledged the role of

cultural context in psychosocial development, a key notable criticism of Erikson's theory has been its lack of cultural specificity. Over the years, critics (Bishop, 2013; McLean et al., 2018; Ochse & Plug, 1986; Wheeler et al., 2002) have argued that the stages and crises, outlined by Erikson, may not be universally applicable across diverse cultural contexts. Different cultures may experience certain developmental aspects differently, challenging the universality of Erikson's stages (Brittian, 2011; Wheeler et al., 2002). This criticism aligns with the broader debate in psychology about the ethnocentric nature of many developmental theories. Lene Jensen has contributed to the discourse on the cultural limitations of developmental theories (Jensen, 2012, 2022; Jensen & Chen, 2013). She, along with other psychologists, has emphasised the importance of considering cultural contexts and societal structures in the shaping of individuals' experiences and challenges during various life stages (Arnett, 1998; Jensen, 2012; Phinney & Baldelomar, 2011). When mapping Erikson's theory onto cross-cultural models of human development, one must be cautious about assuming a one-size-fits-all approach. Different cultures have unique expectations, norms, and values that influence the way individuals navigate identity development and other psychosocial crises (Arnett, 2016). Incorporating cross-cultural perspectives, as suggested by critics, necessitates a more nuanced understanding of how cultural factors intersect with developmental processes. It requires acknowledging the diversity of human experiences and considering alternative frameworks that may better capture the intricacies of identity development within different cultural contexts.

Further criticisms of Erikson's psychosocial development theory (Erikson, 1968) have highlighted its limitations in capturing the complexities of contemporary life experiences. While Erikson's theory underscores the importance of identity formation during young adulthood, critics argue that it may not fully account for the diverse pathways that individuals take in today's rapidly changing societal landscape. Havighurst (1972), suggests that young (early) adulthood

describes the period when individuals are expected to complete various developmental tasks that mark important life transitions. These transitions encompass various domains including education, work, relationships, and identity formation. Pursuing higher education is a common task pursued during this phase where young adults are expected to adapt to new academic environments, increase autonomy, and explore personal interests and career aspirations (Arnett, 2000). Entering the workforce is another developmental task learned by a number of young adults, which involves finding suitable employment, establishing financial independence, and assuming 'adult' responsibilities (Schulenberg et al., 2004). Forming intimate relationships and committing to long-term partnerships is another hallmark of young adulthood, as they strive to understand themselves, their values, and their roles within society (Erikson, 1968; Schulenberg et al., 2004). This can include the development of romantic relationships, marriage, cohabitation, and starting a family (Berk, 2018). Relationship transitions during this stage involve the navigation of intimacy, fostering emotional bonds, and negotiating shared goals and values (Arnett, 2000). These relationships play a significant role in shaping one's identity and overall well-being.

Young adults actively explore these different life paths, careers, relationships, and belief systems. This exploration is essential for identity development as it allows individuals to gather experiences and information that contribute to the formation of a consistent and meaningful identity (Kroger, 2006; Schwartz et al., 2005). Once they have explored their options, they commit to certain values, roles, and life choices that align with their developing sense of self. Young adults who successfully navigate this crisis are more likely to have a strong self-concept, a clear understanding of their values, and a sense of purpose (Erikson, 1968; Schwartz et al., 2005; Waterman, 1999). On the other hand, failure to resolve the identity crisis can result in feelings of identity confusion or diffusion (Erikson, 1968). In the contemporary social context,

the transition from education to working life poses significant challenges for young adults (Blundell et al., 2020). This disparity exacerbates the already challenging task of identity formation and achieving autonomy. Young adults from racialised backgrounds often encounter systemic obstacles to accessing higher education (Rana et al., 2022) and securing stable employment (Bowyer & Henderson, 2020), perpetuating cycles of poverty and limiting social mobility (Major & Machin, 2020; Saunders, 2002). In the wake of the COVID-19 pandemic, entering or staying within the workforce as a marginalised young adult has been particularly challenging (Moen et al., 2020; Platt, 2021). Consequently, the transition to adulthood for racialised individuals has been marked by heightened financial strain, increased uncertainty, and a greater likelihood of experiencing prolonged periods of underemployment or unemployment (Burgess et al., 2022; Plenty et al., 2021; Villatoro et al., 2022). These challenges not only impede traditional markers of adult success but also contribute to heightened levels of stress, anxiety, and feelings of inadequacy among young adults from racialised backgrounds (Sanchez-Hucles, 1999). This means that these young adults may struggle with uncertainty about their goals, values, and roles, feeling lost or disconnected from themselves, leading to a sense of isolation and a lack of direction. This stage can be significantly influenced by traumatic experiences.

1.1.3 Trauma in Young Adulthood

Trauma can disrupt the normal course of identity development and lead to challenges and complexities in a person's efforts to form a stable and coherent sense of self. This can occur through fragmented self-concept, as feelings of powerlessness, shame, guilt, or self-blame can make it difficult to form a cohesive and positive identity (Erikson, 1968; Herman, 1992). Similarly, trauma symptoms, such as recurrent memories, can interfere with the process of exploration and commitment necessary for identity development (van der Kolk, 2014).

Individuals may become preoccupied with their traumatic past, making it challenging to focus on their future and personal growth. Trauma can also erode trust in one's own judgment or the intentions of others (Briere et al., 2015; Herman, 1997). This mistrust can hinder the formation of close and meaningful relationships, which are essential for identity development during this stage. Socially, traumatic experiences can disrupt the formation and maintenance of meaningful relationships, hindering the crucial task of establishing intimate connections with others, as posited by Erikson's psychosocial development theory (Erikson, 1968). Difficulties in trust-building may impede the establishment of secure attachments, influencing not only interpersonal relationships but also broader social engagement and community integration.

Trauma can manifest in somatic symptoms and health outcomes, with psychosomatic impacts including changes in sleep patterns, appetite disturbances, and increased vulnerability to both acute and chronic physical health conditions (Felitti et al., 1998). Conversely, the burden of managing a chronic illness or dealing with physical symptoms can also contribute to the development or exacerbation of trauma-related conditions, such as post-traumatic stress disorder (PTSD; Katon et al., 2007). The challenge of managing both the physical and psychological aspects of trauma can significantly impact young adults' overall well-being and quality of life. Furthermore, trauma in young adulthood extends to physiological consequences. For example, chronic exposure to trauma can activate the body's stress response system, leading to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the autonomic nervous system (McEwen, 2007). Prolonged activation of these physiological pathways can contribute to systemic inflammation, immune system suppression, and alterations in cardiovascular function (Danese & McEwen, 2012; McEwen, 2007), and this, in turn, can impact academic and occupational achievements, hindering the pursuit of educational and career goals during this formative life stage. Neurobiological research also highlights the impact of trauma on cognitive

processes, including attention, memory, and executive functions. Brain structures implicated in these cognitive functions also potentially affect academic and occupational achievements during young adulthood (Teicher et al., 2012), as cognitive impairments contribute to challenges in decision-making, goal-setting, and overall cognitive functioning.

Affectively, trauma in young adulthood can have lasting effects on emotional regulation and resilience. Exposure to trauma may contribute to heightened emotional reactivity, rendering individuals more susceptible to stressors (McLaughlin et al., 2010). Traumatic experiences shape the cognitive and perceptual frameworks of young adults, altering cognitive schemas and affecting information processing and interpretation of events (Beck, 1967; Ehlers & Clark, 2000). Distorted cognitive patterns can lead to negative self-perceptions, difficulties in problem-solving, and altered beliefs about the world. Additionally, the emotional consequences of trauma, such as symptoms of anxiety, depression, and PTSD, significantly impact the overall emotional well-being of young adults (Kessler et al., 2010).

Despite this framework providing a comprehensive understanding of the multifaceted impacts of trauma on young adults, there are some critiques. The focus on the individualised experience of trauma risks to overlook the broader socio-political contexts that underpin the occurrence and perpetuation of traumatic events. By solely attributing trauma to individual pathology or maladaptation, there is a risk of neglecting the socio-political factors that shape experiences of violence and victimisation. As argued by Fassin & Rechtman (2009), trauma often intersects with systemic inequalities, political violence, and historical injustices. This critique aligns with broader discussions within critical trauma literature, which emphasise the importance of examining the social, cultural, and historical aspects of trauma. Scholars, such as Summerfield (1999), have advocated for a socio-political approach to trauma that considers how structural factors shape experiences of violence and victimisation. Additionally, the de-

politicisation of trauma within this framework overlooks the ways in which power and structural violence intersect with experiences of trauma. Fassin & Rechtman (2009) caution against separating trauma from its socio-political context, as victimhood can be co-opted by political agendas or used to justify interventions that prioritise individual healing over broader social transformation. Similarly, Laub and Auerhahn (1989) highlight the importance of recognising the political nature of trauma and how this understanding affects therapy and communication about trauma.

1.1.4 Trauma Link to Global Mental Health Issues

Expanding on the discussion about trauma's impact during young adulthood, the global perspective on mental health among this demographic reveals widespread psychological distress across various cultural, social, and economic settings. Global mental health statistics highlight a disquieting prevalence of mental health issues among young adults aged 18 to 30, cutting across diverse cultural, social, and economic contexts (Kessler et al., 2007). According to the World Health Organisation (WHO), almost 20% of young adults experience a mental health disorder each year, highlighting their heightened vulnerability (World Health Organization, 2023). Mental health conditions significantly contribute to the global disease burden, with depression emerging as the single largest contributor to years lived with a disability within this demographic. Young adulthood, marked by pivotal transitions like pursuing higher education, entering the workforce, and forging personal and professional relationships (Arnett, 2000; Schulenberg et al., 2004), is fraught with challenges. Exploring the prevalence and impact of mental health issues among young adults highlights the need to consider a more nuanced exploration of the social determinants and structural factors that contribute to mental health disparities within this demographic.

Research suggests that social determinants, including socioeconomic status, discrimination, and access to resources, play a significant role in shaping mental health outcomes among young adults (Lund et al., 2011; Patel et al., 2007), as echoed by Speed and Taggart (2019) in their critical examination of stigma campaigns in mental health. Speed and Taggart (2019) highlight two models—one focusing on the stigma of mental illness and the other on stigma in mental health. The former, rooted in an individual aetiology model, medicalises mental health issues, with a focus of normalising them as just other forms of illness. This approach could de-stigmatise individuals by emphasising the medical aspects of their condition, and potentially overlooking broader social determinants of mental health issues such as poverty, trauma, and inequality (Speed & Taggart, 2019). The "stigma in mental health" model adopts a social aetiology perspective, recognising the inter-relationship between various social, economic, and cultural factors in shaping mental health outcomes. This model highlights the need to address not only individual diagnoses but also the societal conditions that contribute to stigma and discrimination against those with mental health difficulties (Speed & Taggart, 2019). These models recognise the consequences of stigma and discrimination on individuals living with mental health difficulties and highlight the importance of addressing these issues through inclusive ethical frameworks.

For instance, Speed and Taggart's (2019) emphasis on broader social determinants, reinforces the idea that socio-economic factors, such as income inequality, are linked to mental health disparities among young adults (Pickett & Wilkinson, 2015). Additionally, as discussed within the context of the stigma models (Speed & Taggart, 2019), experiences of discrimination based on race, ethnicity, or gender have been shown to heighten psychological distress in this demographic (Williams, 2019). Structural barriers can hinder access to essential services, exacerbating the global mental health crisis among young adults (Thornicroft, 2008), a

perspective also emphasised by Speed and Taggart (2019) when referencing the need to address discrimination and stigma through societal and structural reforms. Alegria and colleagues (2018) further acknowledge the importance of addressing social determinants and advocating for mental health equity through a socioecological lens, a sentiment again echoed by Speed and Taggart (2019) in their examination of different stigma models and their broader societal implications. As societal structures and individual experiences intertwine to shape mental health outcomes among young adults, trauma and its enduring impact on psychological well-being emerges as a critical focal point.

Trauma is a pervasive and multifaceted experience that can significantly influence an individual's cognitive, emotional, and behavioural well-being (van der Kolk, 2014). Individuals residing in regions affected by armed conflicts, natural disasters, or humanitarian crises contend with heightened trauma levels, fostering a surge in mental health adversities within these populations (Miller & Rasmussen, 2010; Steel et al., 2009; Tol et al., 2011). The confluence of trauma and other mental health outcomes assumes particular significance during critical life stages, including childhood, adolescence, and young adulthood (Arpawong et al., 2016; McKay et al., 2021; Schilling et al., 2008). During young adulthood, trauma's impact on mental health is considerable and enduring, often culminating in psychological disorders such as PTSD, anxiety, depression, and substance misuse (Kessler et al., 2005). Untreated or inadequately managed mental health difficulties can yield prolonged implications, hindering educational and occupational achievements, disrupting interpersonal relationships, and elevating the risk of self-harm or suicidal behaviours (Benjet et al., 2016; Felitti et al., 1998; Green et al., 2010; Kessler et al., 2010; McLaughlin et al., 2013).

The global implications of the trauma-mental health link are wide-reaching, affecting not only individual well-being but also social cohesion, economic productivity, and public health

systems (Patel et al., 2018). Mental health conditions stemming from trauma can hinder educational attainment, impair work performance, and strain interpersonal relationships (Copeland et al., 2007; Kessler et al., 2008). Additionally, the stigma surrounding mental health issues often discourages help-seeking, perpetuating a cycle of untreated trauma-related conditions (Clement et al., 2015). The multifaceted impact of trauma on young adulthood highlights an urgent need for research and clinical interventions that specifically address the diverse and interconnected ways that trauma shapes the lives of young adults.

Given the profound trauma-mental health link in young adulthood, it is important to recognise how this intersects with various aspects of an individual's life, especially race. Research suggests that racialised individuals navigate unique challenges influenced by societal perceptions and biases (Jones, 2000; Paradies, 2006). It is also suggests that individuals from racialised backgrounds are disproportionately affected by trauma and its mental health consequences (Herman, 1997). Understanding how race interacts with the trauma-mental health link can provide valuable insights into the complexities of individuals' experiences and the broader societal implications of addressing mental health disparities.

1.2 The Geography of Race

To delve deeper into understanding the intersection between race and the trauma-mental health link, it is important to first explore how different factors, such as geographical context, may influence this relationship.

Existing research suggests that individuals residing in regions of low racial diversity may encounter more negative racial experiences, with various factors contributing to this. Blumer‘s (1958) work on race prejudice as a sense of group position, highlights the increased visibility of minorities in less diverse settings, exposing them to heightened stereotyping and prejudice. This greater visibility amplifies the likelihood of negative racial experiences, as individuals may be

more readily subjected to biases and preconceptions. According to Allport's (1954) Social Contact Theory (SCT), positive interactions between individuals from different racial or ethnic groups can mitigate prejudice. However, in less diverse populations, limited opportunities for intergroup contact may contribute to the perpetuation of negative stereotypes and biases. This lack of contact becomes a contributing factor to the negative racial experiences encountered by individuals in such settings. Allport's (1954) seminal work on contact theory proposed that increased intergroup contact could lead to improved intergroup relations and reduced prejudice. However, the applicability of this theory in less diverse contexts requires careful examination. As Henriques (1984) discusses in "Changing the Subject," social regulation and subjectivity influence individuals' perceptions and interactions within their social environments. In contexts where intergroup contact is scarce, individuals may rely more heavily on pre-conceived notions and stereotypes, further entrenching prejudices. Dixon, Durrheim, and Tredoux (2005) argue that the mere presence of intergroup contact does not guarantee positive outcomes. Factors such as the quality and frequency of interactions, as well as the broader socio-political context, influence the impact of intergroup contact on prejudice reduction. Similarly, Dovidio and colleagues (2003) emphasise the importance of considering historical and situational factors when evaluating the effects of intergroup contact. Longitudinal studies, such as those conducted by Levin and colleagues (Levin et al., 2003; Pettigrew & Tropp, 2006), highlight the nuanced nature of intergroup friendships and their impact on attitudes towards racialised groups over time. This suggests the complexity of intergroup dynamics and proposes that sustained positive contact is necessary for meaningful attitude change. Pettigrew and Tropp's (2006) meta-analytic exploration of intergroup contact theory provides empirical support for its effectiveness in reducing prejudice, yet they also acknowledge the need for further research to explore the boundary conditions and moderators of this effect, particularly in less diverse settings.

The limitations of SCT, particularly its applicability in less diverse contexts, highlight the need to consider alternative frameworks such as Social Identity Theory (SIT; Tajfel et al., 1979; Turner et al., 1979). SIT suggests that individuals categorise themselves and others into social groups, fostering in-group favouritism and out-group discrimination. In less diverse populations, individuals may be more likely to perceive racial and ethnic differences as salient, contributing to negative intergroup dynamics. This heightened awareness of group distinctions can lead to more frequent and impactful negative racial experiences (Dixon et al., 2005). Additionally, perceptions of threat play a role in shaping racial experiences, as suggested by the integrated threat theory of prejudice (Stephan & Stephan, 2000). Less diverse populations may foster perceptions of racial and ethnic threat, contributing to negative racial experiences and discriminatory behaviours. The unfamiliarity with individuals from different backgrounds in such settings can lead to heightened perceptions of threat, exacerbating intergroup tensions.

While SIT provides valuable insights into intergroup dynamics, particularly in less diverse contexts, it also has its limitations when applied to the complexities of racial and ethnic relations. SIT's emphasis on in-group favouritism and out-group discrimination offers a framework for understanding how individuals categorise themselves and others, but it may oversimplify the nuances of racial experiences and interactions. One critique of SIT is its focus on the cognitive processes of categorisation, without sufficiently addressing the broader societal structures and power dynamics that shape intergroup relations. As Dixon and colleagues (2005) suggest, SIT's emphasis on individual perceptions overlooks the systemic factors that contribute to negative racial experiences, such as institutionalised racism and historical inequalities. Moreover, while SIT acknowledges the existence of social groups, it may not fully account for the intersectionality of identities and the ways in which multiple social categorisations (e.g., race, gender, class) intersect to shape individuals' experiences of discrimination and marginalisation

(Crenshaw, 1989). Integrated threat theory, as proposed by Stephan and Stephan (2000), offers a complementary perspective by highlighting the role of perceived threats in intergroup relations. However, applying this theory solely within the framework of SIT may overlook the broader societal contexts that influence perceptions of threat, such as media representations, political rhetoric, and economic disparities (Stephan & Stephan, 2000).

In less diverse populations where racial and ethnic differences are more salient, SIT's focus on group categorisation may fail to capture the complexities of intergroup dynamics and the ways in which power differentials contribute to discriminatory behaviours. Therefore, while SIT provides a useful framework for understanding some aspects of intergroup relations, it should be complemented with broader sociological perspectives that consider the structural factors shaping racial experiences and interactions.

In addressing these limitations of the SIT and its implications within less diverse settings, the Minority Stress Model MSM; (Meyer, 2003) highlights how a lack of a supportive community and understanding environment can intensify minority stress, leading to more negative racial experiences. In less diverse settings, the absence of a robust support system may contribute to the accumulation of stressors for individuals from minority groups. In-group and out-group dynamics also come into play in less diverse populations, where stronger in-group bonds may result in heightened distinctions between "us" and "them" (Hewstone et al., 2002). This division can lead to greater out-group discrimination and more frequent negative racial experiences for individuals perceived as different. The emphasis on in-group solidarity in less diverse populations may inadvertently contribute to the exclusion and mistreatment of those who are considered outsiders. The MSM provides a framework to understand the importance of considering the socio-cultural context when examining the experiences of racialised people.

The MSM does however, primarily focus on individual-level stressors experienced by minority individuals, such as discrimination and prejudice, without fully considering the broader socio-cultural and structural factors that contribute to these stressors (Hewstone et al., 2002). This narrow focus may overlook the systemic inequalities and power dynamics that perpetuate negative racial experiences in less diverse populations. Additionally, while the MSM acknowledges the role of in-group and out-group dynamics, it may not fully capture the complexities of these dynamics within more homogeneous settings. In these less diverse regions, where in-group bonds may be stronger, the division between "us" and "them" may be more pronounced, leading to heightened out-group discrimination and negative racial experiences (Hewstone et al., 2002). The MSM's focus on minority stress may also inadvertently reinforce a deficit-based perspective that places the burden of adaptation and resilience solely on racialised individuals, rather than addressing the broader structural inequalities and systemic barriers that perpetuate discrimination and exclusion (Meyer, 2003).

While the MSM provides a valuable framework for understanding the experiences of racialised individuals, particularly in terms of minority stress, it is essential to complement this model with a broader structural analysis that considers the socio-cultural context and systemic factors that shape intergroup dynamics and contribute to negative racial experiences in less diverse settings.

In summary, the exploration of various theoretical frameworks including the SCT, SIT, and the MSM offers a nuanced understanding of the complexities involved in racial experiences, particularly within less diverse settings. While each model offers valuable perspectives, they also exhibit limitations in fully capturing the multifaceted nature of racial dynamics, highlighting the importance of integrating multiple frameworks and considering broader structural factors. Integrating these perspectives emphasises the importance of considering both individual

experiences and systemic factors in understanding the experience of racial adversity. Expanding this analysis to the specific context of race in the United Kingdom (UK) provides an opportunity to apply these frameworks within a unique socio-political landscape, enriching our understanding of racial relations and experiences in this setting.

1.3 Race in the United Kingdom

The United States of America (USA), marked by a legacy of institutionally entrenched slavery and Jim Crow laws, maintains a deeply ingrained black-white racial binary. The USA's history of slavery is deeply rooted in its formation, and its historical struggles for civil rights and ongoing racial tensions, have cultivated a distinct American discourse on race (Williams & Mohammed, 2009). Although the UK also has a historical legacy of participating in slavery, this was primarily through its colonial empire, where the British were actively involved in the transatlantic slave trade. The USA's historical trajectory has led to a complex framework of racial categorisation that differs significantly from the nuanced emphasis on culture and ethnicity in the UK. This divergence in conceptualising race is critical for understanding the limitations of applying American frameworks to the British context, an important distinction for this study.

1.3.1 Critical Race Theory

Critical Race Theory (CRT), developed within the USA context, provides a crucial lens through which to examine racial trauma, particularly in contexts where systemic racism is deeply ingrained (Bell, 2023). Intersectionality, as defined by Crenshaw (1989), is a theoretical framework that emphasises the interconnected nature of various social identities, such as race, gender, class, and sexuality. It highlights how these identities intersect and interact to shape individuals' experiences of privilege and oppression (Crenshaw, 1989). This concept highlights the need to consider multiple dimensions of identity when examining inequalities and advocating for social justice. CRT highlights the intersectionality of race, power, and law, illuminating how

racial hierarchies are perpetuated through legal and societal structures (Crenshaw, 1988). When considering the application of CRT to the context of the UK, several challenges arise. Whilst the UK shares a history of colonialism and racial discrimination with the United states (US), the legal landscape and racial dynamics differ significantly between the two countries (Bell, 2023).

Immigration patterns, multicultural policies, and differing conceptions of race and ethnicity (Ladson-Billings & Tate, 1995) make it challenging to directly apply CRT principles to understand racial dynamics in the UK. Additionally, while CRT emphasises the role of law in perpetuating racial oppression, the legal systems in the UK diverge from those in the US, further complicating its application (Crenshaw, 1988).

Despite these challenges, by centring the experiences of marginalised racial groups and considering the intersections of race, class, gender, and other forms of oppression, CRT offers valuable insights into the mechanisms through which racial trauma manifests (Solórzano & Yosso, 2002). Its application to the UK context, however, would require a nuanced understanding of the unique historical, legal, and social factors at play (Bell, 2023).

1.3.2 Cultural and Historical Context of Race in the UK

In the UK, racial dynamics have largely been shaped by its colonial, exploitation and enslavement history. This has influenced immigration patterns and the establishment of a multicultural society in the post-World War II era (Gilroy, 2002; Shankley et al., 2020). The British Empire's imperialistic pursuits led to the subjugation of non-white populations and the establishment of racial hierarchies. This history not only fostered prejudiced attitudes but also ingrained systemic inequalities. As addressed by Fanon's (1963) 'The Wretched of the Earth', colonialism's psychological impact leaves a legacy of racial trauma, leading to a sense of inferiority among colonised populations.

While the UK did not experience state-sanctioned segregation akin to the Jim Crow laws in the USA, racialised groups in the UK have faced systemic discrimination and racial tensions (Solomos & Back, 1996). Post-World War II immigration, predominantly from former colonies, was intended to rebuild the nation (Shankley et al., 2020) and played a pivotal role in shaping the UK's racial landscape. The Windrush generation migrated to the UK from the Caribbean between 1948 and 1971 to address labour shortages, however, this influx of migrants, along with others who arrived from various parts of the Commonwealth during the same post-war period, brought people from diverse racial backgrounds to the UK. They faced hostility and discrimination, which revealed deeply entrenched racial biases and amplified the complexities of covert racism (Shankley & Byrne, 2020). As covert racism encompasses subtle and indirect forms of discrimination, the "Othering" of immigrant communities where individuals from racialised backgrounds are perceived as different or foreign (Essed, 1991), is a manifestation of covert racism that leads to exclusion and marginalisation. Covert racism often relies on coded language and symbolic gestures, creating an environment where discrimination can be masked (Alexander, 2019), and is difficult to discern and address (Coates, 2011). The subsequent multiculturalism paradoxically exposed the persistence of racial prejudices and marked a tension between the celebration of cultural diversity, and the persistence of racial inequality (Back & Solomos, 1996).

The complex relationship between the UK's cultural and historical context, and contemporary developments, like the 2016 European Union Referendum (known colloquially as 'Brexit'), anti-immigration policies, and 'hostile environment' policies, significantly shape the experiences of race for racialised communities:

'Brexit' and anti-immigration policies introduced a new dimension to racialised experiences and brought the issue of immigration to the forefront of national discourse. The

Brexit referendum exposed deep-seated anxieties about national identity, national sovereignty and immigration, with racial undertones permeating debates surrounding immigration controls (Ford & Goodwin, 2014). The resurgence of nativist sentiment underscored the further entrenchment of covert racism, as individuals from racialised backgrounds face hostility based on their perceived foreignness and cultural incompatibility (Small & Solomos, 2006). Statistics suggest that racially motivated hate crimes in the UK have consistently increased every year since 2013 (Allen & Zayed, 2022). This sentiment has been capitalised upon by political figures who advocate for stricter immigration policies, fostering a hostile environment for immigrants (Achiume, 2018). This hostile environment, as discussed by Redclift and Rajina (2021), has translated into discriminatory policies and practices, exacerbating the experiences of racial injustice for racialised communities. The UK Home Office's hostile environment policy was a group of administrative and legislative measures that aimed to reduce immigration to the UK. In 2012, then Home Secretary, Theresa May, introduced the term "hostile environment" when announcing plans to make it difficult for migrants without legal status to remain in the UK (Kirkup & Winnett, 2012). This was further enacted through the UK's Immigration Acts of 2014 and 2016 (Home Office 2014; Home Office, 2016). This policy eventually led to the Windrush scandal which unfolded in 2018. The scandal brought to light the wrongful detention, denial of legal rights, difficulties accessing benefits, pensions, healthcare and employment, and in some instances, unjust deportations of individuals, and their descendants, who were initially invited to the UK and granted indefinite right to reside in the country post World War II (Williams, 2020). The consideration of immigration generations therefore also becomes crucial in the understanding of racialised experiences within the UK. The Windrush scandal specifically highlights the struggles faced by post-war immigrants and their descendants, revealing systemic racial issues that necessitate examination within the UK context (Back & Solomos, 1996). The

historical and contemporary context of immigration underscores the need to explore how systemic issues impact different generations of immigrants, and their descendants, within the UK context, acknowledging its own historical struggles and patterns of discrimination separate from the racial dynamics in the USA (Back & Solomos, 1996; Williams & Mohammed, 2009).

The exploration of racial trauma in Britain necessitates a nuanced understanding, distinct from the extensive literature on this topic in the USA. Both nation's historical, social, and institutional contexts contribute to their unique manifestations of racial experiences. In the UK, the concept of race is intricately woven with notions of ethnicity, rooted in the country's colonial history. The emphasis on ethnic categories such as "Black British," "Pakistani British," and "White British" reflects a focus on cultural diversity, rather than the rigid black-white racial binary found in the USA, and aligns with the historical approach to multiculturalism in the UK, which has traditionally prioritised integration over assimilation into a singular racial category such as “Black” or “White” (Modood, 2007). Understanding these sociological differences is crucial for analysing contemporary racial issues in both contexts. The historical trajectories, legal frameworks, and societal responses to racial issues shape the experiences of racialised communities. While the US literature on racial trauma offers valuable insights, its direct application to Britain is limited by the unique historical and cultural factors that define the British experience of race. Thus, a dedicated exploration of racial trauma in the UK is essential to uncover the nuanced ways in which individuals navigate and experience racial issues within this distinct sociological landscape.

1.3.3 Prevalence of Racist Acts in the UK

Racial discrimination, particularly within employment and housing contexts, is a pervasive issue within the UK (Khan, 2018). The Equality and Human Rights Commission (EHRC) conducted extensive research, revealing widespread racial disparities. In the realm of

employment, racially minoritised individuals frequently encounter disadvantages concerning job opportunities, career progression, and remuneration (EHRC, 2019). Similarly, racial discrimination persists in the housing sector, with instances of racialised individuals facing housing denials or less favourable terms (EHRC, 2019).

Racial violence, notably in the form of hate crimes, represents a critical concern. The most recent data recorded for police-recorded hate crimes (Home Office, 2020), indicates that most hate crimes in England and Wales have been race-based and account for 72% of all hate crime offences, an increase from the previous year. These incidents include physical attacks, verbal abuse, and other forms of violence that target individuals based on their race or ethnicity. The digital era has ushered in a new dimension of racial violence, with a surge in online hate speech and cyberbullying. These online platforms have become arenas where racially motivated vitriol proliferates, with tangible emotional and psychological repercussions offline (Vidgen et al., 2019; Williams & Pearson, 2016). Xenophobia in the context of Brexit has emerged as a salient issue. The period following the 2016 Brexit referendum witnessed a notable surge in xenophobic incidents and anti-immigrant sentiment. Reports documented instances of verbal abuse, physical assaults, and discriminatory practices directed at immigrants and European Union nationals across the UK (Equality Commission for Northern Ireland, 2022; Nandi & Luthra, 2021; Weaver, 2016).

Systemic racism is a structural framework that inherently disadvantages racialised groups. This system is characterised by institutional practices, policies, and cultural norms that uphold racial hierarchies. It was not until Macpherson’s (1999) Stephen Lawrence inquiry that institutional racism within public bodies (e.g., the police) was publicly acknowledged (Shankley & Rhodes, 2020). The "rotten apple theory" is a metaphor often used to describe the idea that problems within an organisation, such as a police force, can be attributed to a few bad

individuals rather than to systemic issues within the institution itself (Sherman, 1978). This theory suggests that by removing or correcting the behaviour of these "bad apples," the organisation can be fixed without the need to address broader structural problems (Sherman, 1978). In the context of systemic racism, the "rotten apple theory" fails to capture the complexity and pervasiveness of racial biases and inequalities that are embedded within societal structures and institutions (Bonilla-Silva, 2006; Henriques, 1984). Instead of recognising racism as a systemic issue that requires comprehensive reform, the "rotten apple theory" simplifies the problem to individual misconduct. Henriques (1984) provides a critical analysis of psychology and its role in understanding and addressing issues like systemic racism. This body of work emphasises the need to move beyond individualistic explanations of behaviour and to consider the broader social and structural factors that shape individual and group experiences. This perspective aligns with the understanding that systemic racism is not just about individual acts of discrimination but about the collective impact of policies, practices, and cultural norms that perpetuate racial hierarchies and disadvantages for racialised groups. Incorporating Henriques' analysis into the discussion of systemic racism, highlights the inadequacy of the "rotten apple theory" and emphasises the importance of addressing the deep-rooted and institutionalised nature of racism that cannot be resolved by simply addressing individual behaviours. It calls for a more nuanced understanding of how subjectivity and social regulation are intertwined with societal power dynamics, including those related to race.

As highlighted by Bonilla-Silva (2006), systemic racism operates both overtly and covertly. A report by the Commission on Race and Ethnic Disparities (2021) illustrates that racial disparities manifest in various domains including education, housing, employment, and healthcare. As highlighted by existing literature, individuals of racialised backgrounds often encounter barriers in accessing quality education and face employment discrimination due to

racial biases driven by systemic racism (Bertrand & Mullainathan, 2004; Pager & Shepherd, 2008). Covert racism compounds these disparities by permeating interpersonal interactions and institutional practices. Rollock et al. (2014), suggest that racial microaggressions, a manifestation of covert racism, have psychological and emotional impacts, contributing to the racial trauma experienced by individuals from racialised communities. Microaggressions, for instance, are often subtle and unintentional, yet they perpetuate racial stereotypes and can profoundly affect the mental and emotional well-being of racialised individuals (Sue et al., 2008). Racial microaggressions, characterised by insensitive comments, stereotyping, and exclusionary behaviour, permeate different areas of life (Almond, 2019; Burdsey, 2011; Lufkin, 2018; Sue & Spanierman, 2020). Notably, educational settings are not immune, as racially minoritised students may contend with microaggressions that adversely affect their well-being and educational experiences (Joseph-Salisbury, 2019; Morrison et al., 2023). It is essential to acknowledge that the prevalence of these experiences is context-dependent, influenced by geographic locations, demographic factors, and evolving societal and political dynamics. Moreover, underreporting remains a persistent issue, as many victims may refrain from reporting race-based incidents due to fear, societal stigma, or a lack of confidence in institutional redress mechanisms. The cumulative effect of these disparities is a sense of marginalisation and racial trauma experienced by racialised groups. Previous literature (Braveman et al., 2011; Paradies et al., 2015; Sonderlund et al., 2022; Williams & Mohammed, 2009) underscores how the unequal distribution of resources and opportunities along racial lines contributes to a pervasive feeling of alienation and emotional distress within these communities.

The prevalence of overt and covert racist acts in the UK, encompassing racial discrimination, racial violence, xenophobia, and racial microaggressions, constitutes a multifaceted and pressing issue within the socio-political landscape. ‘Hostile environment’

policies within the UK (Home Office, 2014; Home Office, 2016) exemplify the intertwining of systemic racism and covert racism. Although presented as measures to regulate immigration, these policies disproportionately target individuals from racialised backgrounds, perpetuating discrimination under the guise of administrative necessity (Gentleman, 2019). These policies further perpetuate covert racism by not only reinforcing existing stereotypes but also creating a culture of suspicion and fear based on race and ethnicity (The Refugee and Migrant Forum of Essex and London, 2022; Williams, 2020), as predicted by Pete Wishart MP (Gower & Wilson, 2014).

Addressing the multifaceted issue of racism in the UK demands comprehensive and sustained efforts. Legal safeguards against discrimination, public awareness campaigns, and initiatives promoting diversity and inclusion are among the strategies employed. However, the complexity of the issue necessitates ongoing commitment from individuals, communities, institutions, and policymakers.

1.4 Understanding Racial Trauma

The definition of psychological trauma found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5): “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychological Association, 2013), has been critiqued for its limitations in encompassing culturally and racially related trauma. Nadal and colleagues (2019) challenge the conventional understanding of trauma and argue that current conceptualisations often overlook the nuanced and pervasive impact of racially and culturally related trauma. By neglecting to include these experiences, existing definitions may inadvertently marginalise the experiences of individuals facing racially-specific traumas. Subsequently, in recent years, the concept of racial trauma has emerged as a crucial framework for comprehending the profound psychological and

emotional consequences of experiences tied to discrimination, racism, and racialised violence faced by individuals from racialised backgrounds.

1.4.1 Defining Racial Trauma

Racial trauma, also referred to as 'race-based traumatic stress' in some literature (e.g. Bryant-Davis, 2007; Carter, 2007; Carter et al., 2004), can be precisely defined as the psychological, and physical emotional distress that ensues from exposure to racially discriminatory experiences, racism, and racialised violence (Bryant-Davis & Ocampo, 2006; Bryant-Davis, 2007). This trauma is not limited to isolated incidents but rather encompasses a broad spectrum of adverse events, ranging from overt acts of racism to more subtle and insidious forms of discrimination (Williams et al., 2003).

At its core, racial trauma encompasses the tangible and intangible manifestations of racism. It includes responses to the overt acts of racism, such as hate crimes and racial slurs, which are explicit and more identifiable forms of racial discrimination, and the more subtle and systemic forms of discrimination, including microaggressions, racial profiling, and structural or systemic inequalities. Moreover, racial trauma extends to the witnessing of acts of racism. Individuals from racialised backgrounds may experience distress not only from direct experiences of racism but also from observing racial injustices inflicted on others. Witnessing acts of racism can evoke feelings of anger, helplessness, and vicarious trauma (Bor et al., 2018; Nadal et al., 2017). Eichstaedt et al. (2021), examined the emotional and mental health impact of the murder of George Floyd on the US population. Rates of anxiety and depression were found to be significantly higher in Black populations compared to other racial groups. This suggests that witnessing racist acts can amplify the psychological and emotional toll of racial trauma, as individuals grapple with both their personal experiences and the collective trauma experienced by their racial or ethnic community.

One of the distinguishing features of racial trauma is its cumulative nature. Racialised individuals often face a lifetime of exposure to discriminatory experiences, whether as direct targets or as witnesses to racism. Each encounter with racism, whether overt or covert, contributes to a growing burden of psychological distress. Multiple exposures to acts of racism can intensify the trauma, leading to chronic and enduring mental health challenges (Mouzon et al., 2017). The cumulative impact of racial trauma is profound and can manifest in a range of mental health conditions, including anxiety, depression, PTSD, and psychological distress (Paradies et al., 2015; Williams & Mohammed, 2009). This cumulative aspect underscores the urgency of addressing racial trauma and dismantling systems of racism that perpetuate it. Moreover, it highlights the importance of comprehensive support systems and mental health interventions that consider the enduring and collective nature of racial trauma.

1.4.2 Models of Racial Trauma

Racial trauma is a complex and multifaceted phenomenon that has garnered increasing attention in the fields of psychology and mental health. Racial trauma models provide critical frameworks for understanding the complex relationship between racism, discrimination, and mental health outcomes among racialised groups.

Race-Based Traumatic Stress (RBTS) Theory

Carter's (2007) RBTS theory provides a framework for understanding the psychological impact of racial discrimination and stressors on individuals from racialised groups. This theory suggests that experiences of racism can trigger symptoms akin to those of PTSD, including heightened anxiety, depression, and hypervigilance (Carter, 2007). His theory emphasises the cumulative nature of racial trauma, whereby repeated exposure to discrimination and micro-aggressions over time can exacerbate psychological distress (Carter, 2007; Williams et al., 2003; Williams & Mohammed, 2009). This is particularly relevant in the context of the UK, where

studies have shown that experiences of racism and discrimination are prevalent among racialised young adults in the UK (Mirza & Warwick, 2022; Stoll et al., 2022). Carter's (2007) theory also highlights the intersectionality of racial trauma with other forms of oppression, such as gender, class, and sexuality, which further shapes individuals' experiences and mental health outcomes (Carter, 2007).

Carter's (2007) RBTS theory has significantly contributed to our understanding of the psychological impact of racial discrimination, however, it is essential to acknowledge the limitations inherent within the framework. The theory's emphasis on the cumulative nature of racial trauma is present, however, as some studies suggest that the effects of racism can vary in intensity and duration (Williams et al., 2019), a more nuanced consideration of racial trauma's cumulative nature would be beneficial.

Despite Carter's (2007) acknowledgement of the historical context of racism in the USA, there is a notable gap in addressing the trans-generational transmission of trauma (Bryant-Davis & Ocampo, 2006; Nash, 2008) in the context of contemporary mental health outcomes. Additionally, whilst the theory recognises the intersectionality of racial trauma with other forms of oppression, such as gender, class, and sexuality (Carter, 2007), a more comprehensive exploration of these interactions may be warranted. This would be particularly important when considering the distinctive socio-political landscape of different countries, such as the UK, which requires a more nuanced approach to capture the complex and intersecting nature of various social identities and the compounding effects stemming from multiple forms of discrimination, as suggested by existing research (Lewis et al., 2017). Incorporating additional models and frameworks alongside Carter's (2007) RBTS theory can enhance our understanding of the complex and multifaceted nature of racial trauma.

The Intersectionality framework. The Intersectionality framework (Crenshaw, 1989) recognises the complex relationship between multiple social identities and systems of oppression that shape individuals' experiences of racial trauma. While RBTS theory (Carter, 2007) focuses primarily on the psychological impact of racial discrimination, the Intersectionality framework acknowledges that individuals hold intersecting identities based on race, gender, sexuality, class, and other factors, which can influence their vulnerability to and experiences of racial trauma (Crenshaw, 1989). This model recognises that the experience of racial trauma is not uniform across racial and ethnic groups and that intersecting identities can compound or mitigate the effects of racial trauma (Bowleg, 2012). By considering the Intersectionality framework alongside the RBTS theory, research is better able to understand the nuanced ways in which demographic and sociocultural identities intersect to shape the relationship between racial trauma and other mental health outcomes, as well as the unique mental health needs of individuals with diverse and overlapping marginalised identities (Lewis et al., 2017). It is important to note that while the Intersectionality framework highlights the multiplicity of identities, its emphasis on identity categories may overshadow structural factors and systemic inequalities that contribute to racial trauma (Nash, 2008).

Cumulative Racial-Ethnic Trauma (CRET) Model. Although the RBTS theory (Carter, 2007) highlights the cumulative nature of racial stressors, the CRET Model (Awad et al., 2019) further acknowledges how racial trauma can accumulate over time, with repeated exposure to racism and discrimination having a cumulative impact on mental health outcomes. This model complements the RBTS theory (Carter, 2007) by providing a framework to understand how the systemic accumulation of racial adversity contributes to the manifestation and severity of racial trauma symptoms. It illustrates how racial trauma can persist and worsen over time as individuals continue to navigate racialised experiences across different stages of life (Awad et

al., 2019). If we consider how racial trauma accumulates during a critical period of identity formation and social navigation, like young adulthood (Arnett, 2000; Erikson, 1968), it would help to better understand racial adversity's enduring effects.

Moreover, the CRET Model (Awad et al., 2019) acknowledges the historical context and collective trauma shared by racialised communities, but its focus on people of Middle Eastern and North African (MENA) descent may limit its applicability to other racial and ethnic groups. For instance, African Americans experience racial trauma from centuries of systemic racism, including slavery, segregation, and ongoing police violence (Sue, 2016), whilst Indigenous people have historical trauma related to colonisation, forced assimilation, and ongoing marginalisation (Evans-Campbell, 2008).

The Historical and Intergenerational Trauma (HIT) Model. Although the CRET Model (Awad et al., 2019) does consider the historical context and collective trauma of racialised communities, its focus is primarily on the cumulative impact of racial trauma across the lifespan of racialised individuals. The HIT Model (Brave Heart, 2003) on the other hand, delves into the transmission of trauma across generations, and highlights the impact of historical traumas, such as slavery, colonisation, and forced migration, on contemporary mental health outcomes and race-based stress (Brave Heart, 2003). It contextualises individual experiences of racial trauma within broader historical and intergenerational contexts and suggests that the trauma experienced by previous generations can be transmitted to subsequent ones through cultural, social, and psychological mechanisms, enriching our understanding of racial trauma beyond individual-level factors (Brave Heart, 2003). The HIT Model (Brave Heart, 2003) acknowledges the transgenerational impact of racial trauma, and that traumatic experiences and their consequences can be passed down from one generation to the next, influencing the parenting styles, coping strategies, and mental health of subsequent generations. It emphasises that the effects of racial

trauma can extend across generations, affecting not only individuals but also families and communities (Hankerson et al., 2022; Scott-Jones et al., 2020; Williams & Williams-Morris, 2000).

Similar to the critique of the CRET Model (Awad et al., 2019), the HIT model (Brave Heart, 2003) focuses on one group, the Lakota Natives, which may limit the model's applicability to other racial and ethnic groups or socio-political contexts. Understanding historical and intergenerational trauma is crucial in comprehending the ongoing mental health challenges faced by racialised communities today, as historical injustices continue to echo through generations (Evans-Campbell, 2008). Considering the HIT model (Brave Heart, 2003) alongside the RBTS theory (Carter, 2007) and the CRET model (Awad et al., 2019) could provide a framework for exploring the broader socio-political-historical context in which racial trauma occurs. Doing so would acknowledge the ongoing impact of systemic racism and discrimination on individuals' mental well-being, as well as how historical and intergenerational factors may shape the experiences of racial trauma among individuals of different immigration generations, which is particularly important when considering the socio-political context of race within the UK.

Considering these models in the context of racial trauma has provided a nuanced understanding of the complex relationship between racism, discrimination, and mental health outcomes among racialised groups. As the highlighted models emerged from the context of racial experiences within the USA, their applicability to the UK warrant careful consideration. Cultural variations in the manifestation and perception of racial trauma may affect the generalisability of the theory to populations outside the original scope. Whilst these models contribute significantly to our understanding of racial trauma as a theoretical concept, it is crucial to acknowledge their limitations and the need for a more comprehensive exploration of the diverse and intersecting

identities within the socio-political landscape of the UK. Delving into the extent of racial trauma research in the UK can enhance our understanding of the current state of knowledge, research gaps, and the potential avenues for future research.

1.4.3 Extent of Racial Trauma Research in the UK

The study of racial trauma within the UK remains a relatively underexplored area in academic research, despite the increasing recognition of its significance in understanding the psychosocial impact of racialised experiences. Existing literature often draws heavily from research conducted in the USA, which has a distinct racial history and sociocultural context. This reliance on USA-centric literature may not fully capture the nuanced manifestations of racial trauma in the UK. Limited empirical studies within the UK context have investigated racial trauma, and those that do exist have employed a qualitative approach with a focus on specific racial groups or contexts. For instance, the work of Samuel (2023) explored the experiences of disclosing racial trauma in psychological therapy. Similarly, King (2021) looked at the experiences of NHS Psychologists who had worked with Black and Asian service users, both studies investigating how the experience of racial trauma is explored within psychological services. While these studies contribute valuable insights, a comprehensive exploration of racial trauma across diverse ethnicities and regions within the UK general population remains notably scarce. The scarcity of research dedicated to racial trauma within the UK underscores the urgent need for more nuanced investigations that consider the unique historical, cultural, and social factors shaping racial dynamics in this context. It is crucial for future research to bridge this gap and contribute to a more comprehensive understanding of the experiences and consequences of racial trauma within the UK's sociocultural landscape.

The theoretical discussion in this chapter highlights the complexity and diversity of trauma experiences during young adulthood, emphasising that this life stage is marked by significant psychological vulnerabilities as a result of ongoing developmental transitions. However, existing theoretical frameworks, such as Erikson's stages of psychosocial development, have been critiqued for their lack of cultural specificity, particularly in addressing how race-based experiences influence mental health outcomes. This gap in the theoretical understanding demands a systematic review of the literature, to explore the relationship between negative race-based experiences and mental health, thereby providing a more nuanced and inclusive understanding that accounts for the unique challenges faced by racialised individuals. The review is crucial for identifying how these negative experiences, often overlooked in traditional frameworks, directly impact mental health, thereby laying the groundwork for more culturally sensitive approaches to understanding trauma in young adulthood.

1.5 Systemic Review: The Relationship between Negative Race-Based Experiences and Mental Health Outcomes

1.5.1 Overview

The existing literature on racial trauma is not extensive or well-defined. While the initial aim of this literature review was to explore the relationship between racial trauma and other mental health outcomes, it became evident that terminology within the existing literature did not always align with the specific concept of racial trauma. Despite the inclusion of search terms such as "racial trauma", "race-based trauma" and "race-based traumatic stress", none of the included studies of this review directly investigated racial trauma; rather, they focused on negative race-based experiences such as discrimination, racism, and micro-aggressions. In

response to this observation, the focus of this review was re-framed to examine the relationship between negative race-based experiences and mental health outcomes.

It is essential to acknowledge the interconnected nature of negative race-based experiences and racial trauma. Negative race-based experiences, including but not limited to discrimination, racism, and micro-aggressions, often contribute to the development and perpetuation of racial trauma within racialised communities (Nadal et al., 2019). By expanding the scope of the literature review to encompass these experiences, this review aims to capture a broader array of factors that may influence mental wellbeing within the context of racial trauma. Secondly, the decision to focus on negative race-based experiences was guided by the recognised limitations of existing literature. While racial trauma represents a distinct construct with its own, unique psychological implications, the lack of available research specifically addressing racial trauma, highlights the need for a more inclusive approach. By examining the broader spectrum of negative race-based experiences, this literature review seeks to provide valuable insights into the contextual factors that contribute to the manifestation of racial trauma and its relationship with other mental health outcomes.

By adopting a more inclusive approach to conceptualising negative race-based experiences, this literature review can serve as a foundation for future research endeavours focused specifically on racial trauma. By synthesising existing knowledge on related constructs, such as negative race-based experiences, this review lays the groundwork for a more comprehensive understanding of racial trauma and its relationship with other mental health outcomes. This systematic literature review was therefore completed with the aim of clarifying the primary and direct link between negative race-based experiences and mental health outcomes, whilst also calling attention to gaps in the existing literature and directions for future research related to racial trauma.

1.5.2 Search Methodology

Design

This review uses the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and critically evaluates 19 research studies identified through EBSCO databases using specific inclusion and exclusion criteria. Risk of bias and methodological quality were assessed using the National Institute for Health and Care Excellence Quality Appraisal Checklist (NICE QAC) for quantitative studies reporting correlations and associations (National Institute for Health and Care Excellence, 2012).

Search Strategy

An electronic literature search was conducted as per the PRISMA statement (Page et al., 2021). Searches were conducted through EBSCOhost on the 31 June 2023, and published journal articles were sourced using the APA PsycArticles, APA PsycInfo, APA PsycTests, CINAHL Ultimate, eBook Collection (EBSCOhost), E-Journals and MEDLINE Ultimate databases. A publication time limit was not applied to the search.

A search of existing literature revealed that the use of 'racial trauma', 'race-based trauma', 'race-based traumatic stress' and 'racial discrimination' would adequately capture terms for negative race-based experiences. The search strategy therefore used abstract terms for negative race-based experiences ("racial trauma" OR "race-based trauma" OR "race-based traumatic stress" OR "racial discrimination"), AND mental health outcomes ("mental illness" OR "mental health outcomes" OR "mental health") AND relationship ("relationship" OR "correlation" OR "association" OR "connection").

Inclusion/Exclusion Criteria

The inclusion of only English-language records was a pragmatic choice due to limited resources. Notably, none of the records produced by the search were written in languages other

than English. No date range restrictions were applied to the search, allowing for the inclusion of all relevant studies regardless of their publication date. Based on quality assurance, all studies also had to be published as full-text in a peer-reviewed journal. Including peer-reviewed records ensured consistency in the quality and rigour of the sources included in the review. Including records available only in abstract or summary form would make it difficult to assess the quality of the research and determine their further suitability for inclusion. Screened records were also restricted to studies that generated quantitative data, as the review objectives specifically pertain to the quantitative features of associations/correlations. Records that did not report on a primary quantitative study were therefore excluded. The initial search returned 606 results; duplicates, non-full-text records, non-peer-reviewed records, and qualitative records were removed.

Records screening. The titles and abstracts of the remaining (n=113) records were screened for suitability per inclusion/exclusion criteria defined in Table 1. Of these, 75 were eliminated from the process.

Table 1

Inclusion and Exclusion Criteria

Include	Exclude
Studies involving racialised populations who have experienced negative race-based experiences (e.g., racial discrimination, racial bias, racial prejudice).	Studies that explore an association between negative race-based experiences and mental health outcomes within specific health or humanitarian crisis contexts (e.g., COVID-19 or HIV).
Studies that investigate the association between negative race-based experiences and clinical mental health outcomes.	Studies that measure general psychological distress or measure mental health without specifying clinical mental health outcomes.

	Studies that primarily report indirect associations between negative race-based experiences and mental health outcomes, without addressing the primary or direct relationship between these factors.
	Studies that have not used standardised measure(s) of mental health outcomes
	Studies not sufficiently relevant to the review question

Articles investigating the correlation between negative race-based experiences and mental health outcomes within the context of health and humanitarian crises (e.g., COVID-19 or HIV), were excluded from the review. This exclusion aimed to ensure the review's findings possess broad applicability, transcending particular situations. By excluding such papers, conclusions that are relevant to a wide range of contexts can be drawn. Studies that measure general psychological distress or measure mental health without specifying clinical mental health outcomes were also excluded from the review. This decision was motivated by the necessity for precision in the analysis, considering that general psychological distress encompasses a wide range of experiences and symptoms. Such breadth can make it difficult to draw meaningful conclusions about the relationship with race-based experiences. Additionally, articles addressing general psychological distress often have broader research objectives, potentially deviating from the specific insights we aim to extract in this review. By excluding these papers, the validity and overall robustness of the review and conclusions are considered. Studies that have not used standardised measure(s) of mental health outcomes were similarly excluded from the review. This is because the use of standardised measures promotes comparability across studies,

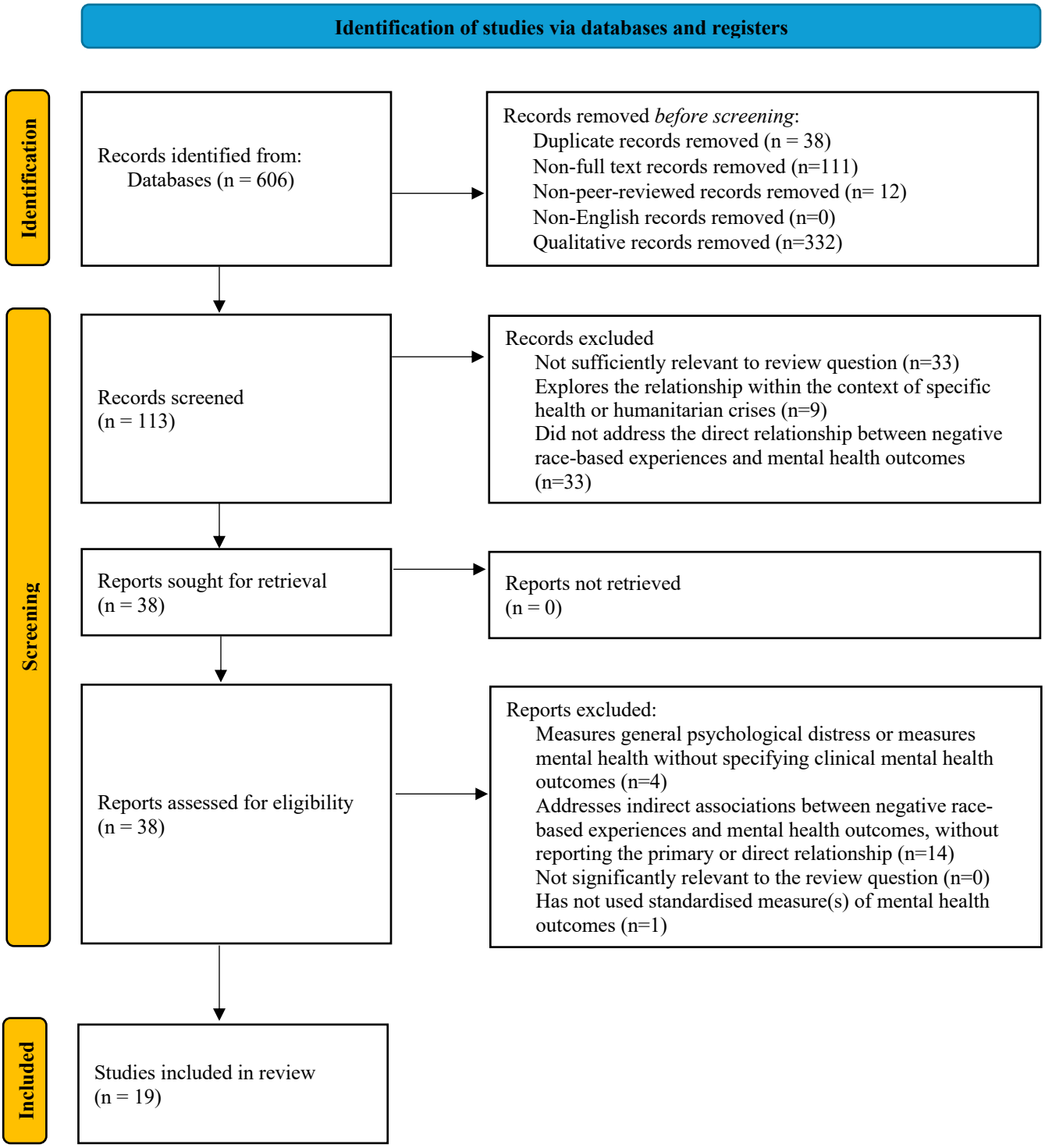
facilitating a more consistent and reliable analysis that can be generalised across diverse populations and methodologies.

Papers that primarily report indirect associations between negative race-based experiences and mental health outcomes, without addressing the primary or direct relationship between these factors, were also excluded from the review, to ensure that the findings align closely with the main research question of the review. Given the specific research objectives, which involve a focused examination of the direct relationship between negative race-based experiences and mental health outcomes, excluding papers that do not emphasise this primary association helps to maintain alignment between the review's inclusion criteria and the review aims. While there is an acknowledgement of the importance of secondary effects, moderators, and mediators, the current review intentionally concentrates on providing a clear and focused analysis of the primary association. By excluding papers that don't emphasise the main association, the review aims to enhance the internal validity of the review.

Reports assessed for eligibility. The full texts of the remaining articles (n=38) were assessed for eligibility. A total of 19 studies matched the inclusion/exclusion criteria for the review. Across the different stages of the study selection process, the primary basis for exclusion was: not reporting on the primary or direct relationship between adverse race-based experiences and mental-health outcomes. See Figure 1 for the PRISMA flow diagram (Page et al., 2021) of the study selection process.

Figure 1

PRISMA Flow Diagram



Data Extraction and Analysis

A quantitative narrative approach was used to reflect on the statistical findings, as opposed to meta-analysis, due to the heterogeneity of the cited articles. Summarising findings through narrative synthesis allowed for the contextualisation and interpretation of results, acknowledging the diversity in study designs, populations, and outcomes (Thompson, 2020). The studies included in the review were deemed appropriate for a quantitative narrative analysis. The main features and findings of the relationship between adverse race-based experiences and mental health outcomes were examined and can be found in Table 2.

The 19 studies were assessed for quality using the NICE QAC; (National Institute for Health and Care Excellence, 2012). The NICE QAC assesses methodological quality, for quantitative studies reporting correlations and associations, in five areas: population; method of selection; outcomes; analyses; and summary. An overall global NICE QAC study quality grading score was then assigned to each paper (see Table 2) in accordance with the guidelines (see Appendix A). Articles were not excluded from the review based on quality. This decision was driven by the review's aim to provide a comprehensive understanding of the relationship between negative race-based experiences and mental health outcomes, reduce bias, maintain transparency, identify research gaps, and gain insights into methodological trends. This inclusive approach acknowledged the potential value of lower-quality studies and encourages a more nuanced analysis of the available evidence.

Table 2

Study Variables And Findings: Relationship between Negative Race-based Experiences and Mental Health Outcomes

First author (year), country	Sample size (N)	Age		Ethnic/racial populations	Race-based experience measures	Mental health measures relevant to the review question	Methodology	Findings relevant to review question	Global Study Quality Grading
		Range	Mean						
Bernard (2022), USA	158	(8-15)	11.50	Black	Race-Related Events Scale (RES)	Children's Depression Inventory (CDI)	Longitudinal cohort	There was a significant total effect of racial discrimination on depressive symptoms ($b = 0.65$, $SE = 0.17$, 95% CI [0.31, 0.99], $p < 0.001$)	++
Bernard (2023), USA	158	(8-15)	11.56	Black	Race-Related Events Scale (RES)	Children's Depression Inventory (CDI) Multidimensional Anxiety Scale for Children–Second Edition (MASC-2)	Cross-sectional	There was a weak total effect of racial discrimination on depressive symptoms ($b = 0.28$, $SE = 0.17$, $p = 0.091$) There was a significant total effect of racial discrimination on anxiety symptoms ($b = 0.85$, $SE = 0.50$, $p = 0.086$)	+
Chen (2014), USA	118	(18-35)	21.74	Asian-American and Pacific Islander	Everyday Discrimination Scale (EDS)	Patient Health Questionnaire (PHQ)-9 Generalized Anxiety Disorder 7-item (GAD-7)	Cross-sectional	There was a weak total effect of perceived racial discrimination on depressive symptoms ($b = 0.22$, $SE = 0.08$, $p<.01$) There was a weak total effect of racial discrimination on anxiety	+

								symptoms (b = 0.18, SE = 0.07, p < .01)	
Cénat (2021), Canada	845	(15-40)	24.96	Black	Everyday Discrimination Scale (EDS)	Centre for Epidemiological Studies Depression Scale (CES-D-10)	Cross-sectional	The findings demonstrated that the score for everyday racial discrimination emerged as the most prominent predictor of depression symptoms (b = 0.30, p < .001).	+
Danyluck (2022), USA	303	(18-78)	43.62	American Indian and Alaska Native	Brief Perceived Ethnic Discrimination Questionnaire–Community Version (PEDQ-CVB)	Epidemiologic Studies Depression Scale–Revised (CESD-R)	Cross-sectional	In unadjusted models, there were significant associations between depressive symptoms and both lifetime and past-week racial discrimination (lifetime, b = 0.198, 95% CI [0.137, 0.259]; past-week, b = 0.162, 95% CI [0.111, 0.214]).	+
del Río-González (2021), USA	578	(18-45)	28.83	Black	Expanded Everyday Discrimination Scale (EDS)	Patient Health Questionnaire (PHQ-9)	Cross-sectional	As participants' reported experiences of discrimination increased (r = .34, p < .001), so did their scores for depressive symptoms.	++
Estrada-Martinez (2012), USA	604	(19-25)	-	African-American	Daily Life-Experiences (DLE) subscale	Brief Symptom Inventory (BSI)	Longitudinal multi-level approach	The effect of racial discrimination stressors on the risk for depressive symptoms over time (β = 0.08 , *SE = 0.02, p* < .001)	+

Gee (2007), USA	2047	-	41.23	Asian-American	Everyday Discrimination Scale (EDS)	World Health Organization Composite International Diagnostic Interview (WHM-CIDI)	Cross-sectional	Discrimination was associated with anxiety disorders (*OR* = 2.70, 95% CI [2.06, 3.54], $p \geqslant 0.001$). There was a stronger association of discrimination on depressive disorders (*OR* = 1.94, 95% CI [1.40, 2.70], $p \geqslant 0.001$).	+
Haft (2022), USA	198	(18-25)	20.01	Chinese-heritage	Everyday Discrimination Scale (EDS)	Beck Anxiety Inventory (BAI)	Cross-sectional	Perceived discrimination emerged as a substantial predictor of anxiety (β = 0.35, $p < .001$).	++
Lavner (2023), USA	889	(10-18)	10.56	Black	Schedule of Racist Events (SRE)	Diagnostic Interview Schedule for Children-Version 4 (DISC-IV)	Longitudinal cross-lagged panel model	The path from racial discrimination to depressive symptoms is significant (Wald $\chi 2$ [1] = 37.470, p = .000).	-
Liu (2022), USA	289	-	33.1	Asian-American	Stop AAPI Hate Reporting Center's incident report questionnaire	Center for Epidemiologic Studies Depression (CES-D) Scale	Cross-sectional	The frequency of discriminatory events showed a significant and positive association with depressive symptoms (B = 7.64, p < .001).	+
Lui (2022), USA	915	(18-36)	19.93	White, Black, Asian, Latino/a and other	Racial and Ethnic Microaggressions Scale (REMS) Experiences	Perceived Stress Scale Center for Epidemiologic Studies–	Cross-sectional	Findings suggested a statistically significant positive correlation between racial microaggressions and experiences of stress (r = .243, $p < .001$), anxiety (r =	++

					of discriminati on (EOD)	Depression (CES-D) Scale State-Trait Anxiety Inventory–Trait Form-Anxiety Subscale (STAI-trait)		.236, $p < .001$), and depression ($r = .307$, $p <$ .001). Findings suggested a statistically significant positive correlation between racial discrimination and experiences of stress ($r =$ .195, $p < .001$), anxiety ($r =$ .211, $p < .001$), and depression ($r = .263$, $p <$ .001).	
Marks (2020), USA	381	(18-25)	22.10	Self-identified multiracial	Schedule of Racist Events (SRE)	Depression, Anxiety, Stress Scales-42 (DASS-42)	Cross-sectional	Findings suggested a statistically significant positive correlation between racial discrimination and depression ($c' = .20$; $p < .01$)	-
Matthews (2013), USA	478	-	31.51	African-American	Daily Life Experiences Scale (DLE-R)	Center for Epidemiologic Studies Depression Scale (CES-D)	Cross-sectional	Racial discrimination was positively associated with depressive symptoms ($r =$ .40, $p < .001$).	++
Mouzon (2017), USA	773	55–93	66.65	African-American	Everyday Discriminati on Scale (EDS)	Center for Epidemiological Studies-Depression scale (CES-D)	Cross-sectional	Everyday racial discrimination was associated with depressive symptoms (IRR= 1.02, 95% CI [1.01–1.03])	++
Nadal (2014), USA	506	(18-66)	24.83	Asian, Latina/o, Black, White, and multiracial	Racial and Ethnic Microaggre ssions Scale (REMS)	Mental Health Inventory (MHI)	Cross-sectional	The impact of various racial and ethnic microaggressions were significantly and negatively correlated with depression ($r = –.12$, $p =$ .026).	-

Rodriguez-Seijas (2015), USA	5191	-	-	African-American and Afro-Caribbean	A perceived race-based discrimination experiences scale	World Mental Health Composite International Diagnostic Interview (WMH-CIDI)	Cross-sectional	Perceived racial discrimination was significantly associated with mental health disorders including: major depressive episode ($r = 0.17$, $p > .001$), generalized anxiety disorder ($r = 0.15$, $p > .001$), and post-traumatic stress disorder ($r = 0.17$, $p > .001$).	+
Tobin (2021), USA	618	(21-69)	43.52	Black	Perceived Discrimination Scale (PDS)	World Mental Health Composite International Diagnostic Interview (WMH-CIDI)	Cross-sectional	Major discrimination (*OR* = 1.17, 95% CI [.09, 1.54], $p = .257$) and everyday discrimination (*OR* = 1.08, 95% CI [.99, 1.18]1, $p = .055$) in adulthood were not significantly associated with MDD.	+
Williams (2021), USA	5191	(18-)	-	African-American and Afro-Caribbean	Everyday Discrimination Scale (EDS)	World Mental Health Composite International Diagnostic Interview (WMH-CIDI) Short Form	Cross-sectional	Racial discrimination was associated with OCD symptoms: e.g. contamination (*ORR* = 1.04, 95% CI [1.01–1.08], $p < .05$), unacceptable thoughts (*ORR* = 1.06, 95% CI [1.01–1.11], $p < .05$).	+

Note. Global study quality rating descriptions: "++" is classified as the majority, if not all, of the checklist criteria has been met, and in instances where criteria are unmet, the conclusions are highly improbable to change, "+" is classified as some checklist criteria has been satisfied,

however, in cases where they are unmet or inadequately described, the likelihood of alterations to the conclusions is low, "-" is classified as Few or none of the checklist criteria have been fulfilled, and there is a high probability that the conclusions will change, or very likely to change (National Institute for Health and Care Excellence, 2012).

1.5.3 Results

Overview of study characteristics

The review revealed 19 papers examining the relationship between race-based experiences and mental health outcomes (Bernard et al., 2022, 2023; Cénat et al., 2021; Chen et al., 2014; Danyluck et al., 2021; del Río-González et al., 2021; Estrada-Martínez et al., 2012; Gee et al., 2007; Haft et al., 2022; Lavner et al., 2022; Liu et al., 2022; Lui et al., 2022; Marks et al., 2020; Matthews et al., 2013; Mouzon et al., 2017; Nadal et al., 2014; Rodriguez-Seijas et al., 2015; Thomas Tobin & Moody, 2021; Williams et al., 2021), featuring diverse populations and employing varied methodologies. The combined participant count was 26,601, with all studies conducted in North America—18 in the USA and one in Canada (Cénat et al., 2021).

Ethnic/racial groups. The racial groups represented were Black (68%, *n*=13), Asian and Pacific Islander (32%, *n*=6), White (11%, *n*=2), and Other (32%, *n*=6). Among the Black population, two papers (Rodriguez-Seijas et al., 2015; Williams et al., 2021) included the Afro-Caribbean ethnic group and five (Estrada-Martínez et al., 2012; Matthews et al., 2013; Mouzon et al., 2017; Rodriguez-Seijas et al., 2015; Williams et al., 2021) included the African-American ethnic group. There were five papers in which Asian and Pacific Islander ethnic groups were represented: Asian American (Chen et al., 2014; Gee et al., 2007; Liu et al., 2022), Chinese-heritage (Haft et al., 2022), and Pacific Islander (Chen et al., 2014). American Indian and Alaska Native ethnic groups were represented in one paper (Danyluck et al., 2021).

Age. Age distribution varied, with 79% (*n*=15) concentrating on adults (e.g., Mekawi et al., 2021; Nadal et al., 2014; Thomas Tobin & Moody, 2021), 16% on children and adolescents (*n*=3; Bernard et al., 2022, 2023; Lavner et al., 2022), and 5% (*n*=1; Cénat et al., 2021) without a specific age focus. Within adult-focused studies, Mouzon et al. (2017)

specifically explored older adults, and five studies (Estrada-Martínez et al., 2012; Haft et al., 2022; Lui et al., 2022; Marks et al., 2020), investigated younger adults, providing a more diverse perspective on the impact of adverse race-based experiences across different life stages.

Quality Assessment

Critical appraisal of the cited studies was conducted using the NICE QAC (National Institute for Health and Care Excellence, 2012) tool, allowing for a thorough evaluation of study quality. Notably, six studies (Bernard et al., 2022; del Río-González et al., 2021; Haft et al., 2022; Lui et al., 2022; Matthews et al., 2013; Mouzon et al., 2017) yielded a '++' rating, indicating robust internal and external validity in areas such as study participants, outcome measurement, analytical rigour, and overall study summary. Four studies (Lavner et al., 2022; Marks et al., 2020; Nadal et al., 2014; Williams et al., 2021) received a '-' rating, and the remaining nine were given a '+' rating. Three studies (Lavner et al., 2022; Marks et al., 2020; Nadal et al., 2014) did not identify or control for confounding factors to minimise sources of bias, which in turn contributed to their '-' NICE QAC quality ratings.

Measures of Negative Race-Based Experiences

The studies included in this review employed a range of different measures to capture race-based experiences across various ethnic and racial populations. Six studies (Cénat et al., 2021; Chen et al., 2014; del Río-González et al., 2021; Gee et al., 2007; Haft et al., 2022; Mouzon et al., 2017; Williams et al., 2021) used a variation of the EDS (Williams et al., 1997), making it the most frequently used measure across the studies. The RES (Neblett, 2019) was employed in studies by Bernard et al. (2022; 2023), the REMS (Nadal, 2011) in Lui et al. (2022) and Nadal et al. (2014), the SRE (Landrine & Klonoff, 1996) employed by Lavner et al. (2022) and Marks et al. (2020) and variations of the DLE (Harrell et al., 1997) used by Estrada-Martínez et al. (2012) and Matthews et al. (2013). Many of the studies (e.g.

Lavner et al., 2022; Liu et al., 2022; Marks et al., 2020; Nadal et al., 2014) failed to report on the validity and/or reliability of the used measures, affecting their global NICE QAC quality rating. The remaining studies each used different measures to capture race-based experiences.

Measures of Mental Health Outcomes

The included studies employed a wide array of instruments to assess mental health outcomes. In total, 12 different standardised mental health measures were used across the 19 studies. The Children's Depression Inventory (CDI; Kovacs, 1992) was used to explore depressive symptoms among children and adolescents in studies conducted by Bernard et al. (2022, 2023), whilst the Diagnostic Interview Schedule for Children-Version 4 (DISC-IV; Shaffer et al., 2000) was used in the study conducted by Lavner and colleagues in 2022. The Multidimensional Anxiety Scale for Children–Second Edition (MASC-2; March et al., 1997) was utilised by Bernard et al. (2023) to illuminate the landscape of anxiety symptoms within the same demographic cohort.

For studies with an adult-focus, a range of instruments were employed to capture the relationship between negative race-based experiences and mental health outcomes. The Patient Health Questionnaire 9 (PHQ-9; Kroenke et al., 2001) and Generalized Anxiety Disorder 7-item (GAD-7; Spitzer et al., 2006) were notably used by Chen et al. (2014) and del Río-González et al. (2021). Variations of The Center for Epidemiological Studies Depression Scale (CES-D-10; Andresen et al., 1994) were used by six studies (Cénat et al., 2021; Danyluck et al., 2021; M. A. Liu et al., 2022; Lui et al., 2022; Matthews et al., 2013; Mouzon et al., 2017), and variations of the World Health Organization Composite International Diagnostic Interview (WHM-CIDI; Kessler & Üstün, 2004) were utilised by four studies (Gee et al., 2007; Rodriguez-Seijas et al., 2015; Tobin & Moody, 2021; Williams et al., 2021) to measure anxiety-, depression- and stress-related symptoms or disorders. Five other unique mental health outcome measures were used in the remaining studies. These

instruments collectively underscored the methodological diversity and depth employed in the synthesis of findings.

The Relationship between Negative Race-Based Experiences and Mental Health Outcomes

In examining the relationship between negative race-based experiences and mental health outcomes, 17 studies (89%) explored depressive symptoms. Bernard et al. (2022) identified a substantial total effect of racial discrimination on depressive symptoms, while Cénat et al. (2021) highlighted the notable predictive role of everyday racial discrimination in depression symptoms. Danyluck et al. (2021) demonstrated significant associations between depressive symptoms and both lifetime and past-week racial discrimination. Tobin and Moody (2021), however, found no significant association between major and everyday discrimination in adulthood and major depressive disorder (MDD). In contrast, Rodriguez-Seijas et al. (2015) reported significant associations between perceived racial discrimination and major depressive episodes. Lavner et al. (2022) identified a significant path from racial discrimination to depressive symptoms, and Liu et al. (2022) observed a positive association between the frequency of discriminatory events and depressive symptoms. Conversely, Bernard et al. (2023) and Chen et al. (2014) found weak total effects of perceived racial discrimination on depressive symptoms. Six studies (del Río-González et al., 2021; Estrada-Martínez et al., 2012; Gee et al., 2007; Marks et al., 2020; Matthews et al., 2013; Mouzon et al., 2017) reported statistically significant positive correlations between racial discrimination and depression, while Lui et al. (2022) found significant positive correlations between racial microaggressions and experiences of depression. In contrast, Nadal et al. (2014) reported a negative correlation between racial and ethnic microaggressions and depression.

For anxiety symptoms or disorders, seven studies (37%) reported on this relationship. Bernard et al. (2023) reported a significant total effect of racial discrimination on anxiety symptoms, and Haft et al., (2022) highlighted the substantial predictive role of perceived

discrimination in anxiety. Gee et al. (2007) reported a statistically significant positive correlation between racial discrimination and anxiety, and Rodriguez-Seijas et al. (2015) found a significant association between perceived racial discrimination and generalised anxiety disorder. Lui et al. (2022) identified significant positive correlations between racial microaggressions and experiences of anxiety. Williams et al. (2021) reported that racial discrimination was associated with obsessive-compulsive disorder (OCD) symptoms, while Chen et al. (2014) found weak total effects of perceived racial discrimination on anxiety symptoms.

Additionally, two studies (11%) delved into the relationship between negative race-based experiences and stress. Rodriguez-Seijas et al. (2015) found a significant association between perceived racial discrimination and post-traumatic stress disorder, and Lui et al. (2022) discovered significant positive correlations between racial microaggressions and experiences of stress.

1.5.4 Discussion

The Relationship between Negative Race-Based Experiences and Mental Health Outcomes

The systematic exploration of existing literature presented in this review reveals a nuanced but overarchingly positive relationship between negative race-based experiences and mental health outcomes. Most of the studies focused on depressive symptoms, indicating a substantial body of evidence linking racial discrimination to this particular aspect of mental health. The findings are consistent with the broader acknowledgement of the pervasive impact of race-based experiences on mental well-being. However, the heterogeneity in the methodologies and populations studied suggest that the relationship is multifaceted and influenced by various contextual factors. The robustness of the evidence is evident in studies reporting significant positive correlations between racial discrimination and depression, as well as those identifying substantial total effects of perceived racial discrimination on

depressive symptoms. The variation in the strength and nature of these associations was noticeable, with some studies reporting weak total effects. This variability suggests that individual, contextual, and cultural factors may modulate the impact of racial adversity on depressive symptoms. Additionally, while the negative correlation between racial/ethnic microaggressions and depression (Nadal et al., 2014) suggests that different types of race-based experiences may elicit diverse mental health responses, it is also possible that this finding is a statistical anomaly or that specific characteristics of the sample contributed to the outlying results. However, the lack of investigation into potential mediating factors limits the ability to draw definitive conclusions.

The overarchingly consistent findings of a positive relationship between racial discrimination and depressive symptoms underscore the profound impact of negative race-based experiences on mental health. These findings resonate with the concept of racial trauma, which suggests that exposure to discriminatory acts, racism, and microaggressions can lead to significant psychological distress. The observed relationship suggests a graded exposure or severity impact. This echoes findings from the broader trauma literature that suggest a dose-response effect—wherein the severity, frequency, or duration of negative experiences correlates with the intensity of mental health outcomes (Dohrenwend & Dohrenwend, 1974; Mollica et al., 1998). The work of (Carter, 2007) highlights the enduring effects of racial trauma on individuals' emotional well-being, suggesting that the chronic stress resulting from race-based experiences can contribute to the development and exacerbation of depressive disorders. The observed associations between racial discrimination and depressive symptoms within the reviewed literature, therefore, provides empirical support for the conceptualisation of racial trauma as a distinct form of psychological distress stemming from negative race-based experiences. The nuanced variations in the strength and nature of associations across studies also highlights the need to

consider individual, contextual, and cultural factors as potential modulators of the impact of racial adversity on depressive symptoms (Pascoe & Richman, 2009).

While the exploration of anxiety and stress symptoms/disorders was less prevalent in the reviewed studies, the findings highlight the need for a more comprehensive understanding of the mental health outcomes associated with negative race-based experiences. The studies reporting significant associations between racial discrimination and anxiety symptoms, as well as generalised anxiety disorder, suggest that adverse racial experiences may extend their impact beyond depressive symptoms. Furthermore, the association between racial microaggressions and experiences of anxiety highlights the importance of considering subtle, pervasive nature of racial adversity in understanding mental health outcomes.

While the exploration of anxiety symptoms and disorders, in the context of negative race-based experiences, is less prevalent in the reviewed studies, the identified associations highlight the need to consider anxiety as having a potential relationship with racial trauma. Existing literature proposes that exposure to racial discrimination and micro-aggressions can evoke fear, hypervigilance, and feelings of threat, contributing to the development of anxiety symptoms and disorders (Bryant-Davis & Ocampo, 2006). Moreover, the work of Williams and Mohammed (2009) highlights the role of racial stressors in perpetuating chronic anxiety among marginalised populations, further supporting the link between negative race-based experiences and anxiety outcomes. The significant associations reported between racial discrimination, micro-aggressions, and anxiety symptoms within this review provide further support for the conceptualisation of racial trauma as a multi-dimensional construct that encompasses both depressive and anxiety-related manifestations of psychological distress. It is essential to also consider the cumulative effect of repeated exposure to racial discrimination and micro-aggressions over time. Severity, frequency, and duration of these negative experiences may contribute to heightened levels of psychological distress,

reinforcing the graded exposure or severity impact model (Carter, 2007; Dohrenwend, 2006; Williams & Mohammed, 2009).

The consideration of different life stages, from childhood to older adulthood, enriches our understanding of the lifespan impact of negative race-based experiences. Recognising these nuances is vital for future research and clinical practice that considers the diverse needs of individuals at different stages of life. The unique challenges and vulnerabilities at each developmental stage may contribute to distinct mental health outcomes. For example, the studies focusing on children and adolescents shed light on the potential long-term consequences of racial adversity, emphasising the need for early interventions to mitigate its impact. Similarly, the exploration of negative race-based experiences in older adults provides insights into how cumulative experiences over a lifetime may shape mental health in later years. The consideration of different life stages in the reviewed literature provides valuable insights into how racial trauma may manifest across the lifespan. RBTS theory suggests that individuals may experience cumulative psychological harm as a result of repeated exposure to race-based stressors over time (Carter, 2007). The findings of studies focusing on children and adolescents highlight the potential long-term consequences of racial adversity, suggesting that early exposure to negative race-based experiences may contribute to the development of racial trauma symptoms later in life (Gibbons et al., 2010). Similarly, the exploration of racial trauma in older adults sheds light on how accumulated experiences of discrimination and racism may manifest as psychological distress in later years, highlighting the enduring impact of racial trauma across the lifespan (Jackson et al., 2011). Although five of the reviewed studies investigated younger adults, the definition of young adulthood varied across the studies, ranging from ages 18 to 25, and others extending up to 36 years. This disparity in defining young adulthood complicated the interpretation of results, making it challenging to discern consistent patterns or trends in how negative race-based experiences impacted mental

health outcomes during this life stage. Standardising the definition of young adulthood in future research would facilitate more accurate comparisons and a nuanced understanding of the relationship between race-based experiences and mental health within this life stage.

Review Limitations

Search strategy.

Precision in search terms. Acknowledging the limitation associated with the specificity of the chosen search strategy, it is essential to emphasise that the selected terms (including 'racial trauma,' 'race-based trauma,' 'race-based traumatic stress' and 'racial discrimination,') were deliberately chosen to ensure a focused and comprehensive retrieval of literature directly aligned with the research question. This specificity was deemed necessary to maintain precision and clarity (Bramer et al., 2018) in capturing studies explicitly investigating the primary research objectives. The decision to prioritise these terms was driven by the need to create a well-defined scope for the review, enhancing the likelihood of identifying studies directly pertinent to the primary research objectives (Thomas et al., 2019). Whilst alternative terminologies or conceptualisations may exist in the literature, the selected terms were considered widely recognised or used within the field, providing a robust foundation for a systematic exploration of the topic. The potential exclusion of studies using different terminology is a trade-off made to maintain the specificity necessary for a focused and in-depth analysis (Gough et al., 2017).

Precision in outcome measures. The decision to include only studies that investigated the association between negative race-based experiences and clinical mental health outcomes, excluding those measuring general psychological distress without specifying clinical outcomes, reflected a commitment to precision in the analysis. However, this choice introduced a limitation regarding the inclusivity of studies exploring broader psychological well-being. The exclusion of studies focusing on general psychological distress may omit

valuable insights into the broader impact of negative race-based experiences on mental health, beyond clinical manifestations. This limitation highlights the trade-off between specificity and comprehensiveness in defining the scope of the review (Gusenbauer & Haddaway, 2020; Thomas et al., 2019).

Search quality. The decision to include only peer-reviewed, full-text articles is a rigorous criterion for ensuring the quality of the included studies. However, this may have inadvertently introduced publication bias, as valuable insights from non-peer-reviewed or abstract-only sources might have been overlooked. While this criterion enhances the overall methodological robustness, it may limit the diversity of perspectives considered in the review. It is plausible that valuable insights from non-peer-reviewed sources might have been excluded, impacting the inclusivity of the analysis. However, this criterion was intentionally set to prioritise the reliability and rigour of the included studies, aligning with best practices for systematic reviews.

The use of the EBSCOhost platform for the literature search may introduce a degree of selection bias. While EBSCOhost is a comprehensive database, its coverage is not exhaustive, alternative databases or search engines might yield different results, and the exclusive reliance on EBSCOhost might limit the breadth of studies included in the review (Konno & Pullin, 2020). This could impact the comprehensiveness of the review, particularly if relevant studies are not adequately represented in the chosen databases. This potential bias is an inherent challenge in systematic reviews, and despite efforts to choose a widely recognised database, there is an acknowledgement of the possibility of missing relevant studies available on other platforms.

Gaps in the existing literature. A limitation of the reviewed studies is the absence of explicit exploration of the relationship between negative race-based experiences and racial trauma, despite the inclusion of "racial trauma", “race-based traumatic stress’ and “race-based

trauma" as search terms. Its absence as a specific focus in the included studies may imply a potential gap in the literature regarding the direct examination of the different mental health outcomes associated with the unique experiences of racial trauma. By not explicitly exploring the phenomenon of racial trauma, researchers may miss the opportunity to uncover distinct patterns, mechanisms, and coping strategies that individuals employ in response to these specific stressors.

Another notable gap in the existing research is the limited consideration of social-cultural factors that could interact with mental health outcomes. The intricacies of how race intersects with other dimensions of identity, such as ethnicity, gender, and socioeconomic status, remain understudied. These intersections, as highlighted by Crenshaw's (1989) Intersectionality framework, highlight the need for more comprehensive investigations into the multifaceted nature of mental health disparities. Future research should strive to disentangle these complexities, as the intersectionality of identities may contribute significantly to the variability in mental health outcomes among individuals exposed to negative race-based experiences.

While this review included studies conducted in North America, it is essential to acknowledge that the racial and ethnic landscape, as well as the socio-political context, varies globally (Christian, 2019; Harrison, 1995). The lack of studies from other regions hinders our ability to draw cross-cultural comparisons and understand the universal and context-specific aspects of the relationship between negative race-based experiences and mental health outcomes. Subsequently, the relatively scant exploration across multiple racial groups is another limitation of the included studies. Most papers predominantly focused on Black and Asian populations, potentially overlooking variations in the experiences and impact of racial trauma among other racial and ethnic groups. Only two of the included studies explored across two or more racial groups. A more comprehensive understanding requires research

that systematically examines the relationship across diverse racial and ethnic backgrounds, considering the unique historical and societal contexts that shape each group's experiences of negative race-based adversity and subsequent mental health outcomes.

Methodological challenges in the included studies. While conducting this systematic literature review, certain methodological challenges within the included studies merit consideration. Variations in study designs, measurement tools, and data collection methods, introduced complexities in synthesising findings. Despite only four of the studies being given a '-' global quality rating, with 10 different discrimination measures and 12 different mental health outcome measures being used across the studies, there seemed to be evidence of a lack of construct consistency. These methodological differences may impact the comparability of results and contribute to potential heterogeneity in the overall analysis (Deeks. et al., 2023). While acknowledging the methodological challenges present in the included studies, it is crucial to highlight that these variations also contribute to the richness and comprehensiveness of the systematic literature review (Gough et al., 2017; Petticrew & Roberts, 2008). The diversity in study designs, measurement tools, and data collection methods reflects the multifaceted nature of research exploring the relationship between negative race-based experiences and mental health outcomes. This diversity allows for a more nuanced understanding of the complex relationship between these variables, offering valuable insights that might be overlooked in a more homogenous body of literature (Gough et al., 2017). The variability in sample sizes, age ranges, and racial/ethnic classifications, rather than being perceived solely as challenges, can be regarded as a strength of the review. This diversity enhances the generalisability of the findings, allowing for a more inclusive representation of different demographic groups and contexts.

Generalisability and external validity. The generalisability of the findings from this systematic review may face limitations related to external validity. The included studies

exhibit diversity not only in their methodological approaches but also in the populations studied, encompassing different age groups, ethnicities, and geographic locations. While the review aims to contribute valuable insights, the external validity of its findings may be influenced by the heterogeneity present within the included studies (Deeks. et al., 2023). While it is essential to recognise the diversity within the included studies may cause limitations related to external validity, it is equally important to emphasise that this very diversity can also enhance the external validity of the review. The broad representation of various age groups, ethnicities, and geographic locations in the studies reflects a real-world complexity that adds richness to the generalisability of the findings and allows for a more comprehensive understanding of the relationship between negative race-based experiences and mental health outcomes. This nuanced approach ensures that the conclusions drawn from the review are sensitive to the diverse experiences and circumstances surrounding negative race-based experiences and mental health outcomes. Thus, while external validity considerations are important, the review's commitment to inclusivity and representation contributes to the robustness and relevance of its findings in real-world settings.

Conclusion. The review findings suggest that overall, there is a consistent and prevalent association between negative race-based experiences and mental health outcomes. While it identifies an association, direction of this relationship cannot be determined. The review acknowledges heterogeneity in methodologies, ethnic/racial groups, and age distribution. Consequently, it cannot conclusively assert uniformity in the impact of negative race-based experiences across all contexts, populations, or life stages. This identified variance leads to questions about concurrent validity across the reviewed papers. For a number of the included articles, weak study design has suggested poor conduct validity. This in turn, makes it difficult to synthesise an effective review of the research.

Considerations for Future Research

Future research should adopt a more comprehensive approach by exploring how social-cultural factors, such as ethnicity, gender, and socioeconomic status, interact with negative race-based experiences to influence mental health outcomes. This would provide a more nuanced understanding of the mechanisms through which racism affects mental well-being and informs targeted interventions. Expanding the geographical scope of research beyond North America is crucial for developing a global understanding of the relationship between negative race-based experiences and mental health outcomes. Doing so would enhance understanding of the contextual factors that contribute to the manifestation and impact of racial adversity in diverse cultural settings. Additionally, to address the limited exploration across diverse racial and ethnic groups, future studies should aim to include participants from various backgrounds.

While the review acknowledges the importance of exploring the relationship across different life stages, it does not provide a comprehensive understanding of how negative race-based experiences impact mental health outcomes uniquely at each developmental milestone, and age-specific nuances require further exploration — the complexities of intersectionality (Crenshaw, 1989) can make it challenging to generalise findings. Subsequently, there is a particular need for a dedicated exploration of racial trauma within the different age populations. A focus on young adulthood is particularly justified by the potential impact on developmental trajectories, and the intersectionality of identity development within this life stage.

This literature review identified a notable gap in the explicit exploration of the relationship between negative race-based experiences, and racial trauma as a mental health outcome, despite the inclusion of the term in the search strategy. As the existing research has highlighted a nuanced relationship between negative race-based experiences, and mental health outcomes such as depression, anxiety and stress disorders, it would be valuable to

explore whether a similar relationship exists with racial trauma. Cénat (2023) positions racial trauma as a major risk factor for the development of other mental health outcomes, which suggests that the exploration of the relationship between racial trauma and other mental health outcomes could also be beneficial. Given the unique psychological impact of racial trauma, further research is imperative to fill this gap and provide a nuanced understanding of how experiences of racialised distress interact with mental health outcomes.

In conclusion, despite the limitations inherent in the present literature review, it serves as a foundational resource for guiding future investigations into the dynamics between racial trauma and other mental health outcomes. This review underscores the significance of examining the relationship between negative race-based experiences and mental health outcomes, offering insights that can inform and complement forthcoming research endeavours. However, to advance our understanding further, future research should adopt rigorous methodologies, utilise validated measures, and provide clearer definitions of constructs.

1.6 Research Aims and Research Questions

1.6.2 Research Aims

- To examine the prevalence of racial trauma and its relationship with other mental health outcomes in young adults from diverse ethnicities and regions within the UK.
- To investigate the intersectionality of demographic and socio-cultural factors in shaping the experience of racial trauma and its relationship with other mental health outcomes.

1.6.3 Research Questions

- Does the experience of racial adversity relate to the experience of racial trauma, and to what extent does this relationship demonstrate a cumulative effect?

- Is there a relationship between racial trauma and with other mental health outcomes, such as anxiety, depression, and PTSD, among racialised young adults in the UK?
- Do racialised young adults, from regions of low racial diversity in the UK, experience more racial trauma and exhibit poorer mental health outcomes compared to those from more diverse areas?
- How do intersectional factors moderate the relationship between racial trauma and other mental health outcomes, and which groups experience greater vulnerability as a result?

These research aims and questions are grounded in the existing literature on racial adversity, racial trauma and other mental health outcomes, and they address the unique sociocultural and historical factors that shape the experience of racial trauma in the UK context.

CHAPTER TWO: METHODS

2.1 Epistemological Positioning and Justification of Methodology

When examining the relationship between racial trauma and other mental health outcomes in young adulthood, the choice of an epistemological position significantly shapes the research approach. While constructivism was deliberated as a potential stance, due to its emphasis on subjective interpretation and context (Charmaz, 2014; Creswell & Creswell, 2018), it was ultimately discarded in favour of a post-positivist perspective.

Constructivism, rooted in the recognition of individual subjectivity and cultural contexts (Hale-Haniff & Pasztor, 1999; Reagan, 1999), could provide valuable insights into the lived experiences of those affected by racial trauma (Smith, 2012). It could enable a deep exploration of personal narratives and the meaning-making process, shedding light on the complexities of mental health outcomes. However, given the focus of examining the relationship between racial trauma and other mental health outcomes across a larger population, constructivism's emphasis on unique subjectivities could limit the generalisability of findings. Moreover, constructivist methodologies, often qualitative in nature (Creswell & Creswell, 2018; Ritchie et al., 2013), might not fully capture the broader patterns and statistical associations that are crucial to understanding the overarching trends in a quantitative research design.

Instead, this study aligns itself with a post-positivist standpoint. By acknowledging the role of subjectivity while aiming for objectivity, this position allows for a nuanced exploration of the research question. Employing a correlational quantitative methodology, the study seeks to identify associations between racial trauma and other mental health outcomes within a diverse sample of young adults.

One of the key assumptions underlying post-positivism is that while objective reality exists, our understanding of it is influenced by our subjectivity and interpretation (Braun & Clarke, 2013; Guba & Lincoln, 1994; Panhwar et al., 2017; Tanlaka et al., 2019). The post-positivist approach enables an understanding of these associations while accounting for the potential influence of contextual factors, cultural nuances, and individual variations (Braun & Clarke, 2013; Panhwar et al., 2017; Tanlaka et al., 2019). Self-report measures acknowledge this assumption by recognising that participants' responses reflect their individual perspectives, influenced by their cultural backgrounds, experiences, and personal contexts (DeVellis, 2016). Researchers employing self-report measures within a post-positivist framework recognise the significance of understanding participants' subjective experiences as they contribute to the construction of knowledge. Furthermore, Karl Popper's falsification theory (2005), a cornerstone of post-positivism, emphasises the critical role of falsifiability in scientific inquiry. According to Popper, scientific theories should be formulated in a way that makes them potentially falsifiable through empirical testing (Popper, 2005). This perspective aligns with the post-positivist notion that while objective reality exists, our interpretations and understanding of it are subject to scrutiny and revision based on empirical evidence (Creswell & Poth, 2016). Popper's emphasis on falsifiability encourages researchers to approach their inquiries with scepticism, acknowledging the influence of subjective factors while striving for objectivity through rigorous testing and falsification of hypotheses derived from the research questions. Thus, within a post-positivist framework, researchers are not only attuned to the subjectivity inherent in knowledge construction but also committed to the continual refinement of understanding through empirical scrutiny and falsification.

The decision to adopt a post-positivist position was justified by the research's goal of establishing empirical relationships that can inform interventions and policies. This approach facilitates a balance between quantifiable data analysis and the recognition of the inherent

complexities in the experiences of racial trauma. By striking this balance, the study aims to contribute to both a broader understanding of the topic and the potential for targeted support strategies to mitigate the relationship that racial trauma has with other mental health outcomes in young adulthood.

2.1.1 Researcher Position

The boundaries, within which research questions and designs are produced, are shaped by the social context of the researchers' identities (Jafar, 2018). Without confronting this alongside the presence of other biases, the concept of validity should be questioned (Jafar, 2018; Jamieson et al., 2022).

As a 29-year-old Black woman living in the UK, my personal experiences and identity profoundly shape my approach to exploring racial trauma and its relationship with other mental health outcomes. In this study, I positioned myself as an insider, bringing a lived perspective that extends beyond statistical analyses and theoretical frameworks. Being a Black woman was not incidental to this research; it was intrinsic to understanding the layered dimensions of racial trauma. My insider perspective allowed me to appreciate the interaction between identity, culture, and societal expectations that define the lived experiences of racialised individuals in the UK. This intentional positioning aimed to bridge the gap between academic inquiry and the lived realities of the participants, grounding the study in the authentic narratives of those directly affected. However, I was acutely aware of the potential biases inherent in my position. Reflexivity became a constant companion in my research journey, demanding ongoing self-awareness and critical reflection on how my background influenced the study's design, data collection, and interpretation. Transparency in reporting my positionality became paramount, allowing readers to assess the impact of my personal perspective on the research.

My insider perspective guided the careful crafting of the research design. By choosing measures that have undergone cross-cultural validation, I aimed to enhance the study's methodological rigour, ensuring that the measures not only demonstrated reliability and validity across groups but were also capable of capturing the nuances of racial trauma experiences that may vary across different cultural and racial contexts. Additionally, recognising the potential influence of contextual factors, the research design incorporated variables that go beyond the immediate focus of racial trauma and other mental health outcomes. By doing so, the research captured the diversity of experiences across racialised groups, while still providing a framework for meaningful quantitative analysis.

Whilst analysing and interpreting the data, my personal perspective also informed the narrative around the data. To avoid reductionist interpretations, acknowledging the limitations of quantitative measures in capturing the full depth of participants' experiences was important for the comprehensive understanding of the implications of the results, not only for academic discourse but also for the development of targeted interventions and policies.

By embracing my insider viewpoint, my goal was to add depth and authenticity to the exploration of racial trauma and other mental health outcomes. I saw this not only as an academic choice but as a commitment to amplifying the voices of racialised individuals and communities, providing insights that contribute not just to scholarly discussions but also resonate with the lived experiences of the community being explored. The best way for me to do this, however, was by adopting a scientific paradigm whereby I could design a methodology that guarded against inherent biases and protected the integrity of the findings.

2.2 Design

This research adopted a quantitative cross-sectional correlational design, which allowed for the systematic examination of the associations between racial trauma and other

mental health outcomes, using statistical data at a single data point. This design was well-suited for investigating the strength and direction of relationships between these variables. It allowed for the study of naturally occurring relationships and facilitated the examination of such relationships within a larger population. Findings from the study possessed the potential for broader applicability to the wider population. By using a quantitative study design, the strength of the associations between racial trauma and different mental health outcomes were able to be compared, helping prioritise areas of focus for future research and clinical implications. The disadvantage of this design was that only correlation could be determined, not causation.

2.3 Ethical Considerations

Ethical approval was gained from the University of Essex Ethics Sub Committee 2 (Appendix B).

The principal investigator met with a Race and Ethnicity Advisory group for a consultation on how to conduct research in a manner that benefits the communities involved and does not exploit their experiences. The provided feedback was considered during the design of the study.

Participants came from a student/working population, and due to the study exploring trauma and other mental health outcomes, it was possible that participants could be from either a clinical or non-clinical population and present with complex needs, potential risks, mental health difficulties or vulnerability due to their experience of racial (or other) trauma. Despite this, it was expected for their participation to be straightforward. Before the collection of data, upon accessing the survey site Qualtrics, all participants were provided with an electronic study information sheet, clearly detailing what the study involved, details about confidentiality and their right to withdraw. This was to enable participants to make an informed decision and decide whether they felt able to participate in the study. As part of the

participant information sheet, participants were encouraged to stop participating in the study and take a break in the unlikely event that they experienced symptoms of anxiety or distress during the study, or experienced increasing PTSD symptoms or suicidal ideation whilst completing measures. Participants completed potentially distressing measures without clinical staff present and were advised that for some participants, the study could evoke distressing or traumatic memories. To address this, participants were given a list of services for (racial) trauma and mental health support. These details were provided as part of the study information sheet and the study debrief, ensuring that even those who chose to withdraw from the study would have access to the necessary support resources. Participants were advised that participation was voluntary and that they had the option to withdraw their consent at any point before finalising their responses. It was, however, explained that due to the anonymous nature of the study, once the final submission button was clicked, their responses could no longer be retracted or withdrawn. Participants were invited to provide their informed consent before being able to progress on to the experimental questions.

2.3.1 Confidentiality and Data Protection

All data collection, and most of the participant recruitment, took place online. All data was collected and stored in accordance with the (Data Protection Act, 2018). Participant responses were collected through the survey site Qualtrics. Survey responses did not contain any personal information as participants were not required to provide their names, emails, or any other identifying information. Participant data was not identifiable at any stage of the research. Qualtrics was used because responses could be collected using a secure and confidential network, with settings activated that enabled data to be collected without the recording of personal details or IP addresses. All data collected was anonymous and confidential.

To minimise the risk of accidental breach of confidentiality or threat to anonymity, General Data Protection Regulation (GDPR) guidelines were observed by research personnel. Participants were not able to view the responses of other participants, and only research personnel had access to any collected data. Once data collection had ended and the survey was closed, the principal investigator exported and downloaded raw data from Qualtrics as an SPSS data file, which was used for statistical analysis. All data was stored anonymously and securely and was only accessible by members of the research team. Raw data files were saved and stored in a University of Essex Box folder. The data controller was the University and its Data Protection Officer, who was contactable by participants through email.

2.4 Procedure

2.4.1 Demographics and Sample Size

To be eligible for this study, participants were required to be aged 18-30 years old, living in the UK, and self-identifying as a racialised person. To determine the appropriate sample size for the current study, an online multiple regression a-priori sample size calculator (Soper, 2023) was used. The calculation was based on an anticipated medium effect size of 0.2, a probability level of 0.05, and a desired statistical power level of 0.8. Based on the calculations, it was estimated that a minimum sample size of 98 participants was required. This effect size was selected based on previous research exploring the relationship between negative race-based experiences and psychological outcomes ***(Carter et al., 2017; Lee & Ahn, 2011; Taylor & Jay Turner, 2002)***.

2.4.2 Recruitment

Participants were recruited from across the UK through opportunity and snowball sampling. Recruitment for the study commenced on June 1st, 2023, and continued until October 7th, 2023. A temporary pause occurred between July 14th and August 1st, 2023, to accommodate necessary amendments to the wording of the inclusion criteria. Recruitment

resumed on August 2nd, 2023, following the approval of these amendments by the ethics committee.

To ensure a diverse and representative sample of young adults, a multi-pronged recruitment strategy was implemented, drawing upon various platforms and networks across the UK. This approach aligns with established research methodologies that advocate for a comprehensive and inclusive participant recruitment process (Carter et al., 2023; Garnett & Northwood, 2022; Manohar et al., 2019). A recruitment poster (Appendix C) outlining the research project was widely circulated through:

- X, formerly Twitter (Appendix D)
- LinkedIn (Appendix E)
- Instagram (Appendix F)
- At The Heart charity organisation mailing list
- Cultural Student Union societies
- Doctorate of Clinical Psychology mailing lists through course administrators

The recruitment poster included information about the study focus, what it involved, eligibility criteria, contact details of the researcher and a QR code to access the survey site. Interested participants were invited to scan the QR code or click on a link that directed them to the participant information sheet on Qualtrics. Utilising social media platforms such as X, LinkedIn, and Instagram leveraged the widespread reach and engagement of these platforms, allowing for the dissemination of information to a broad audience (Baltar & Brunet, 2012; Dosek, 2021; Leighton et al., 2021). Additionally, tapping into the mailing list of At The Heart, a UK-based charity organisation that supports young adults from racialised backgrounds (At The Heart, n.d.), provided access to the study's target population. Accessing students through Cultural Student Union societies and Doctorate of Clinical Psychology mailing lists not only facilitated the recruitment of participants with diverse cultural

backgrounds but also aligns with the recommendation to employ culturally sensitive approaches in participant selection (Awad et al., 2016; Hughson et al., 2016). Opting to recruit from the general population rather than a clinical one, the decision was made to refrain from advertising in National Health Service (NHS) locations. This multifaceted recruitment strategy aimed to enhance the generalisability and richness of the participant cohort and reflect the diverse perspectives and experiences of racialised young adults in the UK.

2.4.3 Study Protocol

Using the online survey platform Qualtrics, participants provided demographic and sociocultural information and completed all measures within a single session lasting approximately 30 minutes. When accessing the Qualtrics link, participants were presented with a screen displaying the study information sheet (Appendix G). The information sheet detailed the title of the study, research background, what the research involved, the confidentiality and data management plan, the dissemination plan, potential benefits of participating, possible risks, discomforts, and inconveniences and the procedure for concerns and complaints. The information sheet also included a list of resources for support and the contact details for the Principal Investigator, Research Supervisors, the Clinical Director for the Doctorate in Clinical Psychology, and the University of Essex Research Governance and Planning Manager. Participants were advised to read the presented information carefully and were informed of their right to withdraw at any time up, until submission of responses, so that they could make an informed decision before continuing to the next page, which displayed a consent form. When providing consent to participate in the study, participants were required to endorse checkboxes to confirm eligibility, understanding of what the study entails, and agreement to take part in the study (Appendix H). Consented participants were then invited to answer socio-demographic questions (Appendix I) pertaining to:

- Age

- Gender
- Sexual orientation
- Racial identity
- Ethnic identity
- Language
- Immigrant generation
- Geographical location
- Religious belief
- Social class
- Employment status, and;
- Disability status.

Following this, participants were invited to complete measures on Qualtrics (Appendices J - O). Upon completion of the measures, participants were presented with a screen displaying the study debrief sheet (Appendix P). The debrief sheet reminded participants that they were able to withdraw from the study up until the submission of their responses and that any incomplete survey responses were assumed to be withdrawn from the study and would therefore be removed from the data set. The debrief sheet also repeated some details found in the information sheet such as study information, contact details, and a list of resources and appropriate psychological services. Participants were then invited to submit their responses.

2.5 Measures

2.5.1 Mental Health Measures

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001a), the Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) the Impact of Events Scale-Revised

(IES-R; Weiss & Marmar, 1997), and the International Trauma Questionnaire (ITQ; Cloitre et al., 2018) were the scales used to measure symptoms of depression, anxiety and PTSD.

PHQ-9

The PHQ-9 (Kroenke et al., 2001a) is a widely used nine-item self-assessment tool designed to measure and evaluate the severity of depression symptoms. Consisting of nine questions based on the diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5; American Psychiatric Association, 2013), the PHQ-9 gauges the frequency and intensity of common depressive symptoms such as low mood, loss of interest, sleep disturbances, and appetite changes (e.g. "Feeling down, depressed, or hopeless") on a four-point scale ranging from 0 ("Not at all") to 3 ("Nearly every day"). Previous research suggests that the PHQ-9 possesses good internal reliability (Hansson et al., 2009), test-retest reliability (Cameron et al., 2008; Kroenke et al., 2001b), and construct validity (Beard et al., 2016; Gilbody et al., 2007; Levis et al., 2019; Martin et al., 2006). A study conducted by Huang et al. (2006) also suggests that the PHQ-9 demonstrates good internal consistency validity across a racially and ethnically diverse population, with Cronbach α values ranging between 0.79 and 0.86. In the current sample, the PHQ-9 had an α of .88.

GAD-7

The GAD-7 (Spitzer et al., 2006) is a frequently utilised self-report assessment measure designed to assess the severity of generalised anxiety disorder (GAD) symptoms reflected in the DSM-5-TR (American Psychiatric Association, 2022). The GAD-7 captures the frequency and intensity of common anxiety-related symptoms such as excessive worry, restlessness, and irritability (e.g. "worrying too much about different things") on a seven-item Likert scale ranging from 0 ("Not at all") to 3 ("Nearly every day"). Previous studies exploring the psychometric properties of the GAD-7 suggest robust internal reliability

(Plummer et al., 2016; Spitzer et al., 2006), as well as reliable test-retest consistency (Löwe et al., 2008; Spitzer et al., 2006). Research also suggests that the GAD-7 has good construct validity (Hinz et al., 2017; Kroenke et al., 2007). Existing literature also indicates the measure's strong internal consistency reliability across culturally diverse populations (Dhira et al., 2021; García-Campayo et al., 2010; Sousa et al., 2015) with Cronbach α values ranging from 0.85 to 0.94. In the current sample, the GAD-7 had an α of .92.

IES-R

The IES-R (Weiss & Marmar, 1997) is a self-assessment tool designed to evaluate the severity of symptoms related to PTSD. The tool comprises 22 items, each rated on a 5-point Likert scale ranging from 0 ("Not at all") to 4 ("Extremely"). The IES-R aims to assess the frequency and intensity of prevalent PTSD symptoms such as intrusive thoughts, avoidance behaviours, and heightened arousal (e.g. "my feelings about it were kind of numb"). Past research suggests that the IES-R exhibits good internal reliability, along with good test-retest reliability (Creamer et al., 2003; Weiss & Marmar, 1997) and construct validity (Creamer et al., 2003; Weiss & Marmar, 1997). Additionally, research suggests that the IES-R has good internal consistency reliability across the subscales (Cronbach α values ranging from 0.82 to 0.94) and can effectively be used across varied populations (Madhu et al., 2022; Park et al., 2021; Weiss, 2007). In the current sample, the IES-R had an α of .95.

ITQ

The ITQ is a self-assessment tool used for evaluating and diagnosing PTSD and complex PTSD. Comprising a structured set of 22 questions scored on a 5-point Likert scale ("Not at all" to "Extremely"), the ITQ is grounded in the diagnostic criteria of International Classification of Diseases, 11th Revision (ICD-11; (World Health Organization, n.d.), providing a comprehensive assessment of trauma-related symptoms such as intrusive experiences, avoidance behaviours, and negative alterations in mood and cognition (e.g. "I

feel numb or emotionally shut down"). Past research indicates that the ITQ has good internal reliability (Cloitre et al., 2018), which underscores its consistent measurement of trauma-related symptoms. Moreover, research by Karatzias et al. (2016) demonstrates favourable test-retest reliability over time. Additionally, studies suggest good construct validity of the ITQ, as it effectively assesses PTSD and complex PTSD symptoms (Hyland et al., 2017; Karatzias et al., 2016). Collectively, the ITQ exhibits sound psychometric properties, making it a valuable tool for assessing trauma-related psychopathology across various populations (Donat et al., 2019; Peraud et al., 2022; Valdovinos et al., 2023). In the current sample, the PTSD ITQ subscale had an α of .89.

The IES-R has been widely used in research and clinical settings to assess trauma symptoms, and despite the ITQ being newer, its reliability and validity is also well-established. Although both measures have been shown to have good construct validity and reliability on their own, both were utilised to further boost validity.

2.5.2 Racial Trauma Measure

Trauma Symptoms of Discrimination Scale (TSDS)

The Trauma Symptoms of Discrimination Scale (TSDS; Williams et al., 2018) is a 21-item, self-report measure designed to assess anxiety-related trauma symptoms associated with experiences of racial discrimination. Participants were invited to report the frequency of their race-based distress (e.g. "Due to past experiences of discrimination, I often feel afraid as if something awful might happen") on a four-point Likert scale ranging from 'Never' (1) to 'Often' (4). The TSDS was found to have high internal consistency (Cronbach's $\alpha = 0.94$ for total score). In its initial study, it was suggested that the TSDS has high concurrent validity, predictability validity, and reliability (Williams et al., 2018). Existing literature also indicates the measure's strong internal consistency (Ching et al., 2023; Cole et al., 2023; de la Salle et al., 2022; Maxie-Moreman & Tynes, 2022; Williams et al., 2018, 2020). The Racial Trauma

Scale (RTS; Williams et al., 2022) was also considered but was not included in the battery of measures due to a limited number of validation studies. In the current sample, the TSDS had an α of .96.

2.5.3 Racial Discrimination Measure

General Ethnic Discrimination Scale (GEDS)

The General Ethnic Discrimination Scale (GEDS; Landrine et al., 2006) is an 18-item self-report psychometric tool designed to assess perceived experiences of racial adversity. The GEDS asks respondents to rate the frequency and intensity of racism experiences across different sub-scales (e.g. Recent Discrimination, Lifetime Discrimination) on a 6-point Likert-type scale ranging from "Never" (1) to "Almost all the time" (6). Past research indicates that the GEDS demonstrates high internal reliability, with values of Cronbach's α ranging from 0.90 to 0.97 (Autin et al., 2022; Duffy et al., 2018; Hwang & Goto, 2008; Landrine et al., 2006), test-retest reliability and concurrent validity (Landrine et al., 2006). In the current sample, the GEDS Recent Discrimination sub-scale had an α of .93, and the GEDS Lifetime Discrimination sub-scale had an α of .93.

2.6 Analysis

The data collected for this study were subjected to statistical analysis using IBM SPSS Statistics version 27. Descriptive statistics were initially calculated to provide a comprehensive summary of the dataset. This included mean and standard deviation for continuous variables, and frequencies and percentages for categorical variables. Before proceeding with the analyses, it was necessary to assess whether the assumptions of the statistical tests were met; for example, the normality of continuous variables was assessed through Shapiro-Wilk tests, histograms, skewness and kurtosis indices to ensure the appropriateness of parametric analyses (Field, 2018). To explore the relationship between racial trauma, racial adversity and each of the other mental health outcomes (depression,

anxiety, PTSD), bivariate correlation analyses were conducted. Correlation coefficients were calculated between racial trauma and anxiety, depression, and PTSD, as well as between racial trauma and racial discrimination frequency. The significance level was set at $p < 0.05$. The use of bivariate correlation analyses aligns with conventional approaches for exploring associations between variables (Gravetter et al., 2021).

Multiple regression analyses were performed to further investigate the relationship between racial trauma (scores from TSDS), racial discrimination frequency (GEDS subscales), and each mental health outcome (scores from PHQ-9, GAD-7, and IES-R, ITQ combined). The IES-R and ITQ scales were combined into one PTSD measure, which is justified by their high correlation coefficient (.733). This indicates a strong and significant association between the two scales, suggesting that both scales are measuring similar constructs of PTSD and thus can be aggregated to provide a comprehensive measure for regression and correlation analyses. This approach enhances the robustness of the findings and improves the interpretability of the results by using a unified measure of PTSD symptomatology.

Regression analyses allowed for a nuanced understanding of the unique contribution of each predictor variable while controlling for potential confounding effects (Field, 2018). Racial discrimination frequency, and each mental health outcome variable (anxiety, depression, PTSD) were treated as dependent variables and racial trauma was the primary independent variable. Gender, immigration generation, and regional diversity levels were included as covariates to control for their potential confounding effects. Gender has been highlighted as a significant factor, with research indicating that racialised women may experience unique forms of race-based stress (Lewis & Neville, 2015). Research also suggests that there are differences in how racialised people from different immigration generations are affected by race-based distress (Liu & Suyemoto, 2016; Portillo et al., 2002). Similarly, Regional diversity levels are a factor of interest as it has been suggested that access

to more diverse groups can be associated with less racial prejudice (Dovidio et al., 2017; Pettigrew & Meertens, 1995). Controlling for potential confounding factors through the inclusion of covariates ensures the robustness of the findings (Tabachnick et al., 2019).

To investigate the differences in mental health outcomes among regions categorised by levels of racial diversity, Analysis of Variance (ANOVA) was chosen as the most appropriate statistical test. ANOVA is specifically designed to compare means across multiple groups (Field, 2018), making it well-suited for examining variations in mental health outcomes across regions with differing levels of racial diversity. Partial eta squared (η^2) values were examined to assess effect sizes.

Unlike other tests, such as t-tests, the ANOVA allowed for the simultaneous comparison of three or more groups, providing a comprehensive understanding of the relationship between racial diversity and mental health outcomes across a range of contexts (Pallant, 2020). Moreover, the ANOVA provided statistical evidence for whether there are significant differences in mean scores of mental health outcomes, such as depression, anxiety, and PTSD, among the regions. This made it particularly advantageous for exploring complex relationships involving multiple dependent variables and categorical independent variables (Howell, 2012), such as racial diversity levels. By employing ANOVA, the study aimed to capture the nuanced differences in mental health outcomes across diverse regions, thereby contributing to a more comprehensive understanding of the impact of racial diversity on mental well-being.

In opting for the ANOVA over the analysis of covariance (ANCOVA), several factors were considered. While ANCOVA allowed for the inclusion of covariates to control for potential confounding variables, the complexity of incorporating multiple covariates and the subsequent increase in model complexity were deemed potential hindrances (Tabachnick et al., 2019). To maintain clarity and focus on the research question being explored, a more

straightforward approach was preferred, aligning with the desire for direct interpretation of the results. This decision was also influenced by the need to ensure adequate statistical power (Cohen, 2013), a crucial consideration given the study's sample size.

In order to better understand the relationship between racial trauma and the other mental health outcomes, it was important to consider factors that could influence this connection. To identify moderating variables for this relationship, correlation and regression-based moderator analyses were conducted. Moderation analysis within a correlational framework allowed for the understanding of factors that could influence the strength or direction of the relationship between racial trauma and the other mental health outcomes (Baron & Kenny, 1986). For the potential moderator of self-identified perceived social class, the categories used were informed by the National Readership Survey (NRS) social grade classification from the 2021 Census (Office for National Statistics, n.d.); however, the labels were adapted using more colloquial and accessible language to ensure that participants could easily understand and relate to the categories.

Spearman's Rho correlation coefficient served as a foundational tool in initial moderation analyses. Using this analysis for initial moderation analyses could be justified due to its suitability for non-parametric data and rank order correlation assessment (Field, 2018), making an ideal starting point for exploring potential moderation effects. By assessing the strength and direction of associations between the predictor, moderator, and outcome variables, valuable insights into the relationship between the various variables could be gained. Meanwhile, regression-based moderator analyses offered a more nuanced examination of the nature of the interaction between variables, by estimating coefficients that explicitly represented the moderating effect, such as interaction terms (Aiken & West, 1991; Hayes, 2022). By considering both direct and indirect effects, deeper insights into the complex relationship between variables could be gained.

2.6.1 Data Processing

Missing data

In the absence of appropriate handling of missingness, missing data can introduce substantial biases and errors into statistical analyses. Ignoring missing data or employing ad-hoc techniques such as list-wise deletion, can lead to biased parameter estimates and inflated Type I error rates (Little & Rubin, 2019). Such unmitigated biases can compromise the validity and generalisability of study findings, undermining the credibility of research outcomes. In light of this, not adjusting for missing data is unfavourable. In addressing missing data within the dataset, employing multiple imputation (MI) emerged as a methodologically robust strategy (Enders, 2023; Graham et al., 2007; Rubin, 1976; Van Buuren, 2018). The presence of missing data posed a significant challenge, primarily due to the inherent uncertainty regarding the missing data mechanism, whether it adhered to the Missing at Random (MAR) assumption or deviated towards Missing Not at Random (MNAR) patterns. As Rubin (1976) highlighted, MI accommodates this uncertainty by generating multiple plausible values for each missing observation, thereby preserving the variability and uncertainty associated with the imputed values. This approach was particularly advantageous over complete case analysis (CCA), which excludes observations with missing data, leading to potential biases and loss of statistical power (Schafer, 1997). By adopting MI, the study aimed to address missing data comprehensively, minimise potential biases, and produce robust and reliable results.

Data Cleaning

The data cleaning procedure commenced with thorough checks to identify and rectify any potential data entry errors, ensuring the accuracy of the dataset. This involved scrutinising measure response values for any mis-codings, such as erroneously assigning numerical values. For instance, responses indicating "never" may have been erroneously

coded as 0 instead of the intended 1, necessitating correction to align with the intended scale. The rationale behind this procedure was to uphold data integrity by rectifying inconsistencies that could compromise the validity of subsequent analyses (Rahm & Do, 2000). Assumptions made during this process included the assumption that responses were accurately recorded and that any discrepancies were the result of data entry errors rather than deliberate misreporting. Furthermore, to ensure consistency across measures, values were reclassified where necessary to align with standardised conventions. This involved reviewing and adjusting categorical variables to ensure uniformity in interpretation across the dataset. The rationale behind this procedure was to enhance the comparability of responses and facilitate meaningful analysis (Rahm & Do, 2000). Assumptions made here included assuming that the original coding scheme was not intended to convey different meanings across measures and that reclassification would improve clarity without distorting the intended meaning of the responses.

A derived variable was created to enrich the dataset's analytical depth. A variable for "racial diversity level" was derived from participants' geographical location with the UK, to provide further insight into regional variations. The rationale behind this procedure was to introduce additional dimensions for analysis and explore potential relationships between regional factors and study outcomes. Assumptions made in this context included assuming that participants' locality could serve as a proxy for racial diversity level and that this derived variable would accurately capture relevant variations across regions.

The Gini-Simpson index was used to determine which geographic locations would be categorised as being of 'low', 'medium', or 'high' racial diversity (see Table 3). Simpson (1949) developed an index of diversity that originated from ecology, specifically in the field of population ecology and biodiversity studies, in the context of measuring the diversity of species within a biological community. The Gini-Simpson index is the complement of the

Simpson index, often expressed as 1−D, and referred to as ‘Simpson's index of diversity’ (Kelly, 2019; Kiernan, 2024).

Table 3

Regional Racial Diversity Levels Based on Gini-Simpson Index Values

Geographical Location	Gini-Simpson Index Value	Region Racial Diversity Level
England - London	.243	High
England - South West	.793	Low
England - South East	.670	Medium
England - East	.654	Medium
England - East Midlands	.610	Medium
England - West Midlands	.540	Medium
England - Yorkshire and The Humber	.646	Medium
England - North West	.650	Medium
England - North East	.915	Low
Northern Ireland	.963	Low
Scotland	.824	Low
Wales	.822	Low

Note. The Gini-Simpson Index is interpreted as 0 indicating maximum diversity and 1 indicating no diversity. 0 to .4 is high diversity, .4 to .7 is medium diversity, .7 to 1.0 is low diversity (Kelly, 2019).

Standardisation

Within the current study, standardisation was employed as a step to facilitate the comparison and interpretation of variables with different scales and units. The rationale behind standardisation lies in its ability to transform data into a common scale, thereby removing the inherent biases introduced by varying measurement units and magnitudes (Fischer & Milfont, 2010). Specifically, z-scores were used to standardise the data for each measure. Using SPSS, z-scores were calculated by subtracting the mean and dividing by the standard deviation. This method ensured that each variable's distribution had a mean of zero and a standard deviation of one, allowing for meaningful comparisons and analyses across variables (Fischer & Milfont, 2010).

2.6.2 Statistical Test Assumptions

Parametric tests, including Pearson's correlation coefficient and multiple regression analyses, assume the normality of the included variables, the linearity between the variables, the interval or ratio nature of data, the presence of homoscedasticity, and the absence of outliers (Field, 2018; Hair et al., 2019).

Normality and outliers

The assumption of normality refers to the distribution of each variable involved in the analysis. It assumes that the relationship between two variables is best represented by a straight-line association (Cohen et al., 2013; Howell, 2013; Tabachnick et al., 2019). Normality plays a key role in ensuring that estimations of correlation and regression coefficients are both unbiased and efficient. Violations of this assumption affect the accuracy and interpretability of the regression and correlation coefficients (Field, 2018). Correlation coefficient and regression analyses are both notably sensitive to outliers. In assessing the normality of the study variables, Shapiro-Wilk tests were employed and further insights into the distributional characteristics of the examined variables were obtained through histograms (see Appendix Q), skewness and kurtosis analyses (see Table 4).

When dealing with categorical variables, including them directly in a regression model violates the assumption because it is not anticipated that the overarching distribution of the outcome variable, or its corresponding residuals, would conform to a normal distribution. (Field, 2018). To address this concern, categorical variables where more than two categorical levels were represented in the data, were dummy coded to facilitate their integration into regression models, while preserving the linearity assumption. By dummy coding the categorical variables, they were converted into multiple binary variables with two levels (e.g., 0 and 1). This transformation simplified the categorical variables into a format that could be interpreted more easily within a regression framework (Garavaglia & Sharma,

1998). These binary variables created through dummy coding were then included in the regression model as predictor variables. Because binary variables have a clear linear relationship with the outcome variable (i.e., they either contribute or do not contribute to the outcome), their inclusion in the regression model did not violate the assumption of normality. Additionally, dichotomising categorical variables allowed for the assessment of the effect of each category, relative to a reference category. This simplified the interpretation of the regression coefficients and facilitated comparisons between different levels of the categorical variable.

Linearity

The linearity assumption in correlation coefficient and regression analyses assumes that the relationship between two variables is best represented by a straight-line association. It implies that as one variable changes, the other variable changes in a systematic and predictable manner (Casson et al., 2014). Correlation coefficient and regression analyses assume that deviations from a perfect linear relationship are due to random error, and the correlation coefficient may not accurately reflect the true strength and direction of association if the relationship is non-linear (Schober & Schwarte, 2018). The linearity assumption was assessed through the visual inspection of scatterplots depicting racial trauma plotted against each predictor variable.

As the relationship between variables followed a non-linear pattern, Spearman's rank correlation, a non-parametric correlation measure which does not assume linearity and is robust to non-linear relationships (Field, 2018), was utilised instead of Pearson’s correlation coefficient.

Multicollinearity

The multicollinearity assumption in multiple regression analysis assumes that the independent variables included in the model are characterised by a reasonable degree of

independence from each other (Daoud, 2017). This assumption underpins the accurate estimation of regression coefficients, and deviations from this assumption can introduce challenges in the stability and reliability of the model's results, as well as decrease the statistical significance observed (Allen, 1997). The evaluation of multicollinearity in the regression analysis was conducted using the Variance Inflation Factor (VIF). The VIF assesses the degree to which the variance of an estimated regression coefficient is inflated due to collinearity among independent variables (Thompson et al., 2017), with a VIF value above 10 being indicative of high multicollinearity and suggesting substantial correlation among independent variables and casting doubt on the reliability of the regression coefficients. Instances where VIF scores exceeded 5 were considered indicative of potential multicollinearity, and those surpassing 10 would have been excluded from the analysis (Field, 2018), though none were present within in the current dataset.

Homoscedasticity

Homoscedasticity is an assumption in regression analyses, that ensures the variance of residuals remains constant across all levels of predictors (Starbuck, 2023; Yang et al., 2019). Homoscedasticity refers to the assumption that the variability between the predicted values and actual values is consistent across all levels of the independent variable(s) in a regression analysis (Cohen et al., 2013). It is a key assumption in regression analysis (Pedhazur, 1997), as violations of this assumption can lead to biased standard errors, affecting the reliability of the statistical tests and confidence intervals. To test for homoscedasticity, standardised predicted values were plotted against the standardised residuals (Appendix S).

2.7 Dissemination

The research will be disseminated through this thesis. In the information sheet, participants were informed that if they wanted to receive a copy or summary of the research findings, they could email the principal investigator. The study findings will be shared on the

social media platforms used for recruitment in order to reach a broader audience, including those who may have participated in or supported the research. The charity organisation At The Heart, which assisted in recruitment through their mailing list, will also receive a detailed summary of the findings for dissemination to their network.

The presentation and publication of findings in peer-reviewed journals, such as 'Cultural Diversity and Ethnic Minority Psychology', and 'Ethnic and Racial Studies', will be considered, in addition to conferences such as the Community Trauma Conference and the Trauma and Mental Health Conference.

CHAPTER THREE: RESULTS

3.1 Chapter Overview

This chapter presents a comprehensive analysis of the relationship between racial trauma and other mental health outcomes among racialised young adults in the UK, considering socio-demographic factors as potential moderators. It confirms that racial adversity is a significant issue in the UK, particularly for racialised young adults. Findings revealed moderate levels of racial trauma symptoms, alongside a moderate level of racial/ethnic discrimination being reported across the sample; additionally, there were particularly strong correlations between racial trauma and experiences of racial adversity. The findings from correlation coefficient analyses confirmed a strong positive relationship between racial trauma and symptoms of depression, anxiety and PTSD, with regression analyses further confirming the predictive power of racial trauma for PTSD symptoms, even when accounting for covariates. ANOVA results suggested potential differences in mental health outcomes across the different levels of regional racial diversity. Finally, variables, including gender, sexual orientation and immigration generation, were found to exhibit varying degrees of moderation for the relationship between racial trauma and the other mental health outcomes.

3.2. Statistical Test Assumptions

It was important to acknowledge and ascertain whether the data had satisfied the underlying assumptions of correlation coefficient and regression analyses, to ensure the validity and reliability of the statistical inferences drawn.

3.2.1 Normality and Outliers

The Shapiro-Wilk statistics for the standardised variables ranged from .871 to .959, indicating deviations from the normal distribution. Skewness and kurtosis analyses allowed for a further understanding of the variables' distributional characteristics (see Table 4).

Table 4

Shapiro Wilk Statistic, Skewness and Kurtosis Values of Standardised Variables

Standardised Variable	Shapiro Wilk Statistic	Skewness	Kurtosis
Depression	.871	1.328	1.465
Anxiety	.887	.926	-.118
Racial Trauma	.958	.372	-.852
PTSD	.951	.708	-.087
Recent Racial/Ethnic Discrimination	.885	1.382	2.568
Lifetime Racial/Ethnic Discrimination	.959	.789	.803

The study variables demonstrated varying degrees of departure from normality, as indicated by the calculated skewness and kurtosis values. Specifically, depression exhibited a positive skewness of 1.328, indicating a right-skewed distribution with a kurtosis of 1.464, and suggesting a leptokurtic pattern; this implied heavier tails and a sharper peak compared to a normal distribution. Anxiety demonstrated a positive skewness of .926, indicating a slight right skew, coupled with a negative kurtosis of -.118, signifying a platykurtic pattern, and suggesting flatter tails and a less pronounced peak. PTSD displayed a similar right skew with a skewness of 0.708 and a slightly negative kurtosis of -.087, suggesting a platykurtic pattern as well. Racial trauma showed a positive skewness of .372 and a negative kurtosis of -.852, indicating a right-skewed distribution with a platykurtic pattern. Recent racial/ethnic discrimination presented a notable positive skewness of 1.382 and a high kurtosis of 2.568, suggesting a heavy-tailed, peaked distribution, possibly indicating the presence of outliers. Finally, lifetime racial/ethnic discrimination demonstrated a positive skewness of .789 and a positive kurtosis of .803, suggesting a right-skewed distribution with a leptokurtic pattern. These results, alongside histograms showing the distribution of each measure (see Appendix Q), contributed to a comprehensive understanding of the shape of the data distribution for each variable and provided additional context to the Shapiro-Wilk tests, Overall, while some variables exhibited deviations from normality and the presence of outliers, careful

consideration was taken in employing parametric analyses, as assumptions regarding normality were not fully met for all variables. Non-parametric analyses (Spearman's Rho), were therefore more appropriate for exploring the relationships between the variables.

3.2.2 Linearity

Scatterplots (see Appendix R) were used to visualise the relationship between racial trauma and each of the other mental health outcome variables (depression, anxiety, PTSD), as well as the racial/ethnic discrimination variables (recent, lifetime). They were scrutinised to identify any discernible patterns or deviations from linearity. The scatterplots determined that there were weak to moderate positive associations, suggesting that there was some degree of linearity between the variables. It is, however, important to recognise that the strength of the relationships may be limited, and the predictive power of the model may be relatively modest.

Multicollinearity

Multicollinearity was systematically examined using VIF values in the present study. In our analysis, VIF values were computed for each predictor variable, with results indicating values ranging from 2.661 to 3.839. Given that the VIF values were below the critical threshold, the results suggested low to moderate multicollinearity amongst the independent variables. While some correlation may exist between predictors, it is not severe enough to substantially affect the estimation of regression coefficients or inflate standard errors. Consequently, the study was deemed suitable for proceeding with multiple linear regression analyses, and the estimated coefficients were expected to be reliable and interpretable.

3.2.3 Homoscedasticity

The scatterplot (see Appendix S), depicting the standardised predicted dependent variable scores plotted against the standardised residuals (the errors of prediction) for the multiple regression analysis (see section 3.5.2), was scrutinised to discern whether the

variability of the residuals was consistent across the range of predicted values. The scatterplot revealed a random spread of points around the horizontal axis, indicating that the variability of the residuals was approximately constant across all levels of predicted values, meaning that the assumption of homoscedasticity was met. This finding enhanced the validity of the regression analysis, as it indicated that the estimated coefficients were likely to have unbiased standard errors and that hypothesis tests conducted on the regression coefficients were reliable.

3.3 Data Completeness

One hundred and fifty-six participants completed the online survey. No responses were excluded, and of the 156 participants, 46 were missing all data for the IES-R questionnaire and 48 for the ITQ questionnaire. Without further information about the relationship between the missingness of the PTSD measures and other observed variables, it was challenging to definitively determine whether the missing values were MAR or MNAR. The MI procedure implemented in most statistical software relies on the MAR assumption (Schafer & Graham, 2002), however, it has also been reported to handle MNAR scenarios (Pedersen et al., 2017; Van Buuren, 2018). MI was therefore employed to handle the missingness, ensuring that the analysis was conducted on a complete dataset. By generating multiple plausible values for each missing observation, MI allowed for the preservation of variability and uncertainty associated with imputed values.

3.4 Descriptive Statistics

The mean age of the study participants was 25.06 (*SD* = 2.688; range: 18-30), with the majority (84.6%) being female, and just over half (52.6%) residing in London, England. A majority of the study participants racially identified as Black (51.3%) or Asian (32.1%). The full socio-cultural and demographic landscape of the study participants are presented in Appendix T.

Table 5 provides a summary of descriptive statistics for each measure used, whilst Table 6 shows the distribution of data on each measure. The range of scores across measures indicated variability in symptom severity and experiences of discrimination and mental health symptomology among participants. The study participants, on average, reported relatively low levels of depressive symptoms (*Mean* = 6.50, possible mean range: 0–27; *SD* = 5.74) and moderate levels of anxiety symptoms (*Mean* = 6.19, possible mean range: 0–21; *SD* = 5.53). The average PTSD symptoms measured by the IES-R and ITQ were moderate, with mean scores of 27.80 (possible mean range: 0–88; *SD* = 20.49) and 7.44 (possible mean range: 0–72; *SD* = 6.05), respectively. The participants, on average, reported a moderate level of racial trauma symptoms (*Mean* = 44.72, *SD* = 15.48), with scores ranging from 21 to 81, out of the possible maximum of 84. The mean scores for recent discrimination (RDSF) and lifetime discrimination (LDSF) were 35.59 (possible mean range: 0–90; SD = 15.08) and 45.04 (possible mean range: 0–90; SD = 15.59), respectively, indicating that participants experienced a moderate amount of racial/ethnic discrimination, with potentially ongoing experiences of discrimination over time.

Table 5

Descriptive Statistics for Mental Health, Racial Discrimination, and Racial Trauma Measures

	N	Mean	SD
PHQ-9	156	6.50	5.74
GAD-7	156	6.19	5.53
IES	110	27.80	20.49
ITQ	108	7.44	6.05
TSDS	156	44.72	15.48
GEDS – Recent Racial/Ethnic Discrimination	156	35.59	15.08
GEDS – Lifetime Racial/Ethnic Discrimination	156	45.04	15.59

Table 6

Distribution of Data on Each Measure

Measure	Descriptive Test					
	Mean Error	*95% CI*	*Median*	*Variance*	*SD*	*Range*
PHQ-9	0.459	(5.00, 8.00)	5.00	32.897	5.736	26.00
GAD-7	0.443	(4.89, 7.49)	4.00	30.608	5.532	21.00
IES-R	1.954	(23.48, 32.12)	24.00	419.910	20.492	87.00
ITQ	0.582	(6.06, 8.82)	6.50	36.641	6.053	24.00
TSDS	1.240	(41.85, 47.59)	42.00	239.736	15.483	60.00
GEDS (RRED)	1.207	(32.80, 38.38)	31.00	227.366	15.079	79.00
GEDS (LRED)	1.248	(42.22, 47.86)	44.00	243.153	15.593	79.00

Note. RDSF = Recent Racial/Ethnic Discrimination; LDSF = Lifetime Racial/Ethnic Discrimination.

3.5 Statistical Analysis

3.5.1 The Relationship between the Frequency of Racial Adversity and Symptoms of Racial Trauma

The Spearman's rank-order correlation coefficient revealed a strong positive association between lifetime racial/ethnic discrimination and racial trauma scores, with a coefficient of 0.618 ($p < .01$), and a strong positive association between recent racial/ethnic discrimination and racial trauma scores, with a coefficient of 0.601 ($p < .01$). These statistically significant correlations highlighted the strength of this relationship, suggesting that as individuals encountered an increased frequency of racial adversity throughout their lives, there was a corresponding escalation in the manifestation of symptoms related to racial trauma.

The findings of the regression analysis (see Table 7) revealed a significant and moderate to strong positive relationship between racial trauma and lifetime racial/ethnic discrimination among the sample population ($\beta = 0.618$, $t(154) = 9.753$, $p < .001$). Notably, the model accounted for a substantial portion of the variance in racial trauma, with lifetime racial/ethnic discrimination explaining approximately 38.2% of the variance ($R^2 = .382$,

Adjusted $R^2 = .378$). This indicated that individuals who reported experiencing higher frequencies of racial adversity across their lifetime also tended to report higher levels of racial trauma.

The regression statistics for recent racial discrimination showed similar results to those for lifetime racial discrimination, indicating a significant and moderate to strong positive relationship with racial trauma. In the analysis of recent racial adversity, the coefficient ($\beta = 0.621$, $t(154) = 9.835$, $p < .001$) suggested that for every one-unit increase in the frequency of recent racial adversity, there was a corresponding increase of .621 units in racial trauma. The model also accounted for a substantial portion of the variance in racial trauma, explaining approximately 38.6% of the variance ($R^2 = .386$, Adjusted $R^2 = .382$).

Table 7

Regression Coefficients between Racial/Ethnic Discrimination and Racial Trauma

Variable	Coefficient β	Std. Error	Std. Coefficient (Beta)	t-value	Sig.
Lifetime racial/ethnic discrimination	0.618	0.063	.618	9.753	.000
Recent racial/ethnic discrimination	0.621	0.063	.621	9.835	.000

Overall, these findings indicated a consistency across different time frames of racial adversity exposure, reaffirming the cumulative effect of racism on psychological well-being among young adults within the UK context. They also suggest that repeated exposure to racial adversity contributes significantly to the manifestation of racial trauma in young adulthood within the UK context.

3.5.2 The Relationship between Racial Trauma and the Other Mental Health Outcomes

The observed correlations (see Table 8) provided strong evidence to answer the second research question of whether there is a relationship between racial trauma and other mental health outcomes among racialised young adults in the UK. The robust positive correlation between racial trauma and depression scores ($\rho = .830$, $p < .001$) indicated a

strong association between racial trauma and the severity of depressive symptoms. Similarly, the substantial positive correlation between racial trauma and anxiety scores ($\rho = .571$, $p < .001$) suggested a pronounced positive relationship between racial trauma and the severity of generalised anxiety symptoms. The strong positive correlation found between racial trauma and PTSD ($\rho = 0.712$, $p < .001$) implied a strong association between racial trauma and the severity of PTSD symptoms. A full correlation matrix of the dependent and independent variables can be found in Appendix U.

Table 8

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes

	Racial Trauma	Depression	Anxiety	PTSD
Racial Trauma	-	.532**	.572**	.712**
Depression	.532**	-	.830**	.632**
Anxiety	.571**	.830**	-	.681**
PTSD	.712**	.632**	.681**	-

Note. ** = $p < .01$

The multiple regression analysis conducted to examine the relationship between racial trauma and the other mental health outcomes revealed notable findings (see Table 9).

Table 9

Multiple Regression Coefficients between Racial Trauma and Other Mental Health Outcomes

Variable	Coefficient β	Std. Error	Std. Coefficient (Beta)	t-value	Sig.
Depression	0.030	0.107	.030	0.278	.781
Anxiety	0.067	0.114	.067	0.583	.561
PTSD	0.656	0.102	.611	6.419	.000

Note. The model controlled for the following covariates: gender, immigration generation and regional diversity level. All predictor variables were entered simultaneously into the model.

In a multiple regression analysis controlling for gender, immigration generation and regional diversity levels, the relationship between racial trauma and the other mental health outcomes were explored. The results revealed that racial trauma was not significantly

associated with depression (β = 0.030, t(147) = 0.278, *p* = .781), or anxiety (β = 0.067, t(147) .583, *p* = .561) among racialised young adults. However, the coefficient for PTSD (β = 0.656, t(147) = 6.419, *p* < .001) indicated a significant positive association between racial trauma and PTSD, suggesting that individuals who experienced higher levels of racial trauma were more likely to exhibit symptoms of PTSD. The confidence intervals for PTSD (CI = 0.454, 0.858) suggested a relatively precise estimation of the relationship, while those for depression (CI = -0.182, 0.241) and anxiety (CI = -0.159, 0.253) indicated less precision. These findings suggested that, after accounting for covariates, racial trauma was specifically associated with an increased likelihood of experiencing PTSD symptoms among the studied participants. This comprehensive analysis contributes to a nuanced understanding of the mental health implications of racial trauma within the context of diverse demographic factors, however these results alone are not substantial when exploring the relationship between racial trauma and depression or anxiety in similar contexts.

3.5.3 Mental Health Outcomes Across Regions Varying in Levels of Racial Diversity

Table 10 presents the distribution of the mental health outcomes and racial trauma amongst participants, stratified across regions of low, medium and high racial diversity. Across different levels of regional diversity, distinct patterns emerged regarding participants' experiences of depression, anxiety, PTSD, and racial trauma. Notably, participants residing in regions characterised by higher racial diversity tended to report lower mean scores on mental health outcomes measures, when compared to those in regions with lower diversity levels.

Table 10

Descriptive Statistics for the Mental Health Outcomes and the Racial Trauma Measure, Stratified by Regions of Low, Medium, and High Racial Diversity

Mental Health outcome	Region Diversity Level	Mean (SD)
Depression	*Low*	8.33 (1.826)
	Medium	7.57 (0.760)

	High	5.45 (0.584)
Anxiety	*Low*	8.78 (1.862)
	Medium	7.08 (0.703)
	High	5.21 (0.582)
PTSD	*Low*	0.39 (0.970)
	Medium	0.05 (0.911)
	High	-0.023 (0.922)
Racial Trauma	*Low*	51.44 (4.167)
	Medium	47.20 (1.852)
	High	42.02 (1.745)

Among groups with low racial diversity, there were strong positive correlations observed with racial trauma for depression ($\rho = .791$, $p < .05$), anxiety ($\rho = .851$, $p < .01$) and PTSD ($\rho = .832$, $p < .01$), suggesting a significant relationship between racial trauma and other mental health outcomes, in regions with limited racial diversity. Similarly, in environments with medium racial diversity, significant positive correlations were found with depression ($\rho = .538$, $p < .01$), anxiety ($\rho = .572$, $p < .01$), and PTSD ($\rho = .682$, $p < .01$), indicating the moderate to strong relationship between racial trauma and other mental health outcomes in moderately diverse settings. For regions characterised by high racial diversity, correlations remained significant for depression ($\rho = .433$, $p < .01$), and anxiety ($\rho = .456$, $p < .01$), albeit to a slightly lesser extent compared to the regions with low and medium levels of diversity. Notably, the correlation between racial trauma and PTSD for regions with high racial diversity ($\rho = .687$, $p < .01$), was similar to those from moderately diverse regions. The variation in strength across the different levels of regional racial diversity suggested that racial diversity levels could play a role in the relationship between racial trauma and other mental health outcomes.

An ANOVA analysis (see Table 11) was conducted to explore how mental health outcomes varied across regions with different levels of racial diversity. The findings hinted at potential differences in mean scores among these regions. For depression, the analysis showed a trend towards significance ($p = .051$), suggesting some variability in depression

scores across the varying racial diversity levels. A similar pattern emerged for anxiety, with a significant between-groups effect (p = .043), indicating differences in mean anxiety scores among regions. Although the ANOVA for PTSD yielded a p-value slightly above the conventional threshold (p = .058), the results suggested a trend towards significant differences in mean PTSD scores across the racial diversity levels, implying that racial diversity might play a role in mental health outcomes. It is, however, important to interpret these results with caution.

Table 11

Summary of ANOVA Results for Racial Trauma and Other Mental Health Outcomes Across Regions with Varying Racial Diversity

Outcome	Between-Groups (Sig.)	Sum of Squares	df	Mean Square	F
Depression	.051	5.920	2	2.960	3.038
Anxiety	.043	6.227	2	3.113	3.202
PTSD	.058	4.921	2	2.461	2.907

While the p-values from the ANOVA analyses indicated the statistical significance of these differences, the effect sizes offered a quantification of the magnitude of these effects. The effect size for depression (η^2 = .038) suggested that approximately 3.8% of the variability in depression scores could be attributed to differences in racial diversity levels among regions. Similarly, the effect size for anxiety (η^2 = .040) indicated that around 4.0% of the variability in anxiety scores could be explained by these differences. For PTSD, the effect size (η^2 = .037) suggested that approximately 3.7% of the variability in PTSD scores could be accounted for by variations in racial diversity levels. Despite the effect sizes indicating that differences in regional racial diversity only explained a small percentage of variability in depression, anxiety and PTSD within the context of racial trauma, the statistical significance indicated that there were still significant differences in the mean levels of these mental health

outcomes across regions with varying racial diversity. When considered together, their cumulative impact could be more meaningful.

3.5.4 The Moderating Variables for the Relationship Between Racial Trauma and the Other Mental Health Outcomes

Correlation analyses were initially used to identify moderating variables for the relationship between racial trauma and the other mental health outcomes. Regression-based moderation analyses were used for further analysis, to determine the variables' moderating effects.

Gender

In examining gender as a potential moderator, Table 12 demonstrates that the relationship between racial trauma and depressive symptoms (PHQ-9) were notably stronger and statistically significant for females ($\rho = .584$, $p < .01$) compared to males ($\rho = .254$, $p > .01$). Similarly, in the realm of anxiety symptoms (GAD-7), the correlation with racial trauma was more substantial and significant for females ($\rho = .600$, $p < .01$) than for males ($\rho = .411$, $p < .05$). Regarding PTSD symptoms, females also demonstrated a stronger and statistically significant correlation ($\rho = .724$, $p < .01$) compared to males ($\rho = .680$, $p < .01$). This suggested that gender plays a moderating role, with females experiencing a more pronounced association between racial trauma, and symptoms of depression, anxiety and PTSD.

Table 12

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Gender

Mental Health Outcome	Gender	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Male *(n=24)*	.254
	Female *(n=132)*	.584 **
Anxiety	Male *(n=24)*	.411*
	Female *(n=132)*	.600 **
PTSD	Male *(n=24)*	.680**
	Female *(n=132)*	.724**

Note. ** = $p < .01$; ** = $p < .05$.

Regression-based moderation analyses were employed to further investigate whether gender acted as a moderator in the link between racial trauma and the other mental health outcomes. Based on the analyses conducted for depression (β = 0.007, SE = .190, $p = .971$), anxiety (β = 0.043, SE = .183, $p = .815$), and PTSD (β = -0.035, SE = .164, $p = .831$), gender did not play a significant moderating role in the relationship between racial trauma and the other mental health outcomes. Though findings for anxiety suggested a positive relationship, it was not a statistically significant one.

The mixed findings from the correlation-based and the regression-based moderation analyses, could be attributed to the unequal gender distribution of the sample (132 females, 24 males). An unequal distribution of gender within the dataset may affect regression analyses more than correlation analyses due to potential issues related to statistical power and model estimation.

Immigration Generation

Considering immigration generation as a potential moderator, the findings revealed significant positive associations between racial trauma and other mental health outcomes among first- and second-generation immigrants (see Table 13). Specifically, for first-generation immigrants, a significant positive correlation was found for depression (ρ = .557, $p < .01$), anxiety (ρ = .567, $p < .01$), and PTSD (ρ = .812, $p < .01$) while second-generation immigrants also exhibited significant positive correlations for depression (ρ = .604, $p < .01$), anxiety (ρ = .692, $p < .01$) and PTSD (ρ = .729, $p < .01$).

Table 13

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Immigration Generation

Mental Health Outcome	Immigration Generation	Spearman's Rho correlation coefficient statistic (ρ)

Depression	First generation *(n=54)*	.557**
	Second generation *(n=78)*	.604**
	Third generation *(n=24)*	.109
Anxiety	First generation *(n=54)*	.567**
	Second generation *(n=78)*	.692**
	Third generation *(n=24)*	-0.021**
PTSD	First generation *(n=54)*	.812**
	Second generation *(n=78)*	.729**
	Third generation *(n=24)*	.282

Note. ** = $p < .01$.

For third-generation immigrants, the correlations were negligible for anxiety ($\rho = -.021$, $p < .01$), and for depression ($\rho = .109$) were negligible and not significant. A weak, but not significant correlation was found with PTSD in third-generation immigrants ($\rho = .282$). These outcomes suggested that the relationship between racial trauma and other mental health outcomes diminished across generations, highlighting the moderating influence of immigration status.

Regression-based moderation analyses conducted for depression ($\beta = -0.061$, SE = .101, $p = .547$), anxiety ($\beta = -0.088$, SE = .094, $p = .349$), and PTSD ($\beta = -0.115$, SE = .087, $p = .186$), indicated that immigration generation did not significantly moderate the relationship between racial trauma and the other mental health outcomes.

The correlation-based analysis revealed a diminishing relationship between racial trauma and other mental health outcomes across immigrant generations, whereas regression-based moderation analyses did not find immigration generation to be a significant moderator. It is important to consider the potential limitations of the regression-based moderation analyses, including its reliance on linear relationships and assumptions of homogeneity across groups, which may not have fully captured the nuanced differences within each generation.

First Language

Participants with and without English as a first language exhibited significant positive correlations between racial trauma and other mental health outcomes (see Table 14). For participants with English as a first language, the correlation was significant for depression (ρ = .543, $p < .01$), anxiety (ρ = .584, $p < .01$) and PTSD (ρ = .699, $p < .01$). Similarly, for participants with a different first-language, significant positive correlations were observed for depression (ρ = .493, $p < .01$), anxiety (ρ = .519, $p < .01$) and PTSD (ρ = .755, $p < .01$). This suggests that first language may not serve as a substantial moderator in the relationship between racial trauma and other mental health outcomes.

Table 14

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by First Language

Mental Health Outcome	First Language	Spearman's Rho correlation coefficient statistic (ρ)
Depression	English *(n=127)*	0.543**
	Other *(n=29)*	0.584**
Anxiety	English *(n=127)*	0.493**
	Other *(n=29)*	0.519**
PTSD	English *(n=127)*	.699**
	Other *(n=29)*	.755**

Note. ** = $p < .01$

Regression-based moderation analyses further explored whether first language moderated the association between racial trauma and other mental health outcomes. Based on the analyses conducted for depression (β = 0.160, SE = .175, $p = .359$), anxiety (β = 0.586, SE = .072, $p = .000$) and PTSD (β = 0.127, SE = .149, $p = .397$), first language emerged as a significant moderator for the relationship between racial trauma and anxiety, but not for depression or PTSD. The mixed findings for anxiety, indicate that further research may be needed to clarify the role of first language as a moderator in the racial trauma-anxiety relationship.

Disabilities

In examining disabilities as a potential moderator, the results, as outlined in Table 15, demonstrated significant correlations between racial trauma and other mental health outcomes across different reported disability types. Among individuals reporting no disability, significant positive correlations were observed for depression ($\rho = .507$, $p < .01$), anxiety ($\rho = .584$, $p < .01$), and PTSD scores ($\rho = .708$, $p < .01$), highlighting the significant relationship between racial trauma and other mental health outcomes in this group. Notably, for participants reporting physical disabilities, positive correlations were observed between racial trauma and depression ($\rho = .400$) and PTSD symptoms ($\rho = .400$). For anxiety, participants with physical disabilities exhibited a significant negative correlation ($\rho = -.738$, $p < .01$).

For individuals reporting behavioural/emotional disabilities, significant positive correlations were found for depression ($\rho = .299$), anxiety ($\rho = .196$) and PTSD symptoms ($\rho = .687$, $p < .01$), with PTSD demonstrating a particularly strong association. For sensory impairment the sample sizes were limited, with no correlations being reported for this subgroup. Participants who reported intellectual/developmental disabilities displayed positive, but not significant correlations between racial trauma and depression ($\rho = .523$), anxiety ($\rho = .631$), and PTSD ($\rho = .500$).

While disability status appeared to moderate the relationship between racial trauma and other mental health outcomes, the limited sample sizes for certain disability types, such as sensory impairment, intellectual/developmental, and physical disabilities, could affect the generalisability of these findings.

Table 15

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Disability Type

Mental Health Outcome	Reported disability (*n=)*	Spearman's Rho correlation coefficient statistic (ρ)

Depression	None *(n=129)*	.507**
	Physical *(n=4)*	.400
	Behavioural/Emotional *(n=11)*	.299
	Sensory Impairment *(n=2)*	N/A
	Intellectual/Developmental *(n=7)*	.523
Anxiety	None *(n=129)*	.584**
	Physical *(n=4)*	-.738
	Behavioural/Emotional *(n=11)*	.196
	Sensory Impairment *(n=2)*	N/A
	Intellectual/Developmental *(n=7)*	.631
PTSD	None *(n=129)*	.708**
	Physical *(n=4)*	.400
	Behavioural/Emotional *(n=14)*	.687**
	Sensory Impairment *(n=2)*	N/A
	Intellectual/Developmental *(n=7)*	.500

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

For regression-based moderation analyses, physical and behavioural/emotional disability were grouped, while sensory and intellectual/developmental disability were combined due to limited sub-group sample sizes. The analyses, concerning racial trauma, were conducted for depression (β = 0.001, SE = .140, p = .992), anxiety (β = -0.043, SE = .136, p = .751), and PTSD (β = -0.035, SE = .119, p = .768), and did not reveal disability as a significant moderator of these relationships. The regression-based moderation analysis did not yield significant results, likely influenced by the grouping of the disability categories. Future research should address this limitation by conducting more nuanced analyses with larger sample sizes for each disability subgroup to better understand the moderating role of disability in the association between racial trauma and mental health outcomes.

Employment Status

The analysis of employment status demonstrated significant correlations between racial trauma and other mental health outcomes, as shown in Table 16. For participants who reported being unemployed, strong positive correlations were found for depression (ρ = .803, $p < .01$), anxiety (ρ = .826, $p < .01$), and PTSD symptoms (ρ = .717, $p < .01$). Full-time students also demonstrated significant positive correlations for depression (ρ = .571, $p < .01$),

anxiety (ρ = .439, $p < .01$), and PTSD symptoms (ρ = .839, $p < .01$); however, the correlations for part-time students were not calculable due to the small sample size.

Among employed participants, both full-time and part-time employees displayed significant positive correlations for depression, anxiety, and PTSD symptoms. Specifically, full-time employees showed correlations of ρ = .471 ($p < .01$) for depression, ρ = .530 ($p < .01$) for anxiety, and ρ = .627 ($p < .01$) for PTSD symptoms. Part-time employees showed correlations of ρ = .711 ($p < .01$) for depression, ρ = .773 ($p < .05$) for anxiety, and ρ = .711 ($p < .05$) for PTSD symptoms. The correlations for self-employed individuals were again not calculable due to the small sample size.

Employment status appeared to moderate the relationship between racial trauma and the other mental health outcomes, however further analysis would be beneficial. While unemployed individuals and full-time students consistently demonstrated strong positive correlations across all mental health measures, employed individuals (both full-time and part-time) also exhibited significant associations, albeit with varying strengths.

Table 16

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Employment Status

Mental Health Outcome	Employment status (*n=*)	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Unemployed *(n=9)*	.803**
	Full-time Student *(n=30)*	.571**
	Part-time Student *(n=2)*	N/A
	Full-time Employee *(n=104)*	.471**
	Part-time Employee *(n=9)*	.711**
	Self-Employed *(n=2)*	N/A
Anxiety	Unemployed *(n=9)*	.826**
	Full-time Student *(n=4)*	.439**
	Part-time Student *(n=2)*	N/A
	Full-time Employee *(n=104)*	.530**
	Part-time Employee *(n=9)*	.773*
	Self-Employed *(n=2)*	N/A
PTSD	Unemployed *(n=9)*	.717**

Full-time Student *(n=30)*	.839**
Part-time Student *(n=2)*	N/A
Full-time Employee *(n=104)*	.627**
Part-time Employee *(n=9)*	.711*
Self-Employed *(n=2)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

Regression-based moderation analyses were utilised to further explore whether employment status moderated the association between racial trauma and other mental health outcomes. Unemployed and full-time carer/homemaker were grouped together due to limited sample size, whilst all other sub-categories were grouped as "Employed/Student". Based on the analyses conducted for depression (β = -0.232, SE = .295, $p = .433$), anxiety (β = -0.188, SE = .287, $p = .513$), and PTSD (β = 0.042, SE = .250, $p = .865$), in relation to racial trauma, employment status did not emerge as a significant moderator of these relationships.

Religious Belief

There were significant correlations between racial trauma and other mental health outcomes across various religious beliefs (see Table 17). For individuals identifying as Buddhist, significant perfect positive correlations were observed for the three mental health outcomes: depression (ρ = 1.000, $p < .01$), anxiety (ρ = 1.000, $p < .01$), and PTSD symptoms (ρ = 1.000, $p < .01$), although caution should be applied due to the limited sample size. For Christians, Hindus, and Muslims, significant positive correlations were found for depression, anxiety, and PTSD symptoms, indicating a strong association between racial trauma and other mental health outcomes within these religious groups. These results suggest that the relationships with racial trauma were not confined to specific religious affiliations.

For Sikhs, the correlation with depression was moderate (ρ = .564), while correlations with anxiety (ρ = .103) and PTSD symptoms (ρ = .300) were very weak to weak. For participants with no religious affiliation, there were weak positive correlations with depression (ρ = .345) and anxiety (ρ = .329), but strong positive correlations with PTSD symptoms (ρ = .637). Findings indicated that religious belief did not moderate the

relationship between racial trauma and other mental health outcomes. It is important to acknowledge that the coefficient estimates for some of the religion subgroups (Buddhist, Jewish, Spiritual) were not meaningful due to their sample size.

Table 17

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Religious Belief

Mental Health Outcome	Religious belief (*n=)*	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Buddhist *(n=3)*	1.000**
	Christian *(n=75)*	.517**
	Hindu *(n=5)*	.900**
	Jewish *(n=1)*	N/A
	Muslim *(n=29)*	.493**
	Sikh *(n=5)*	.564
	No religion *(n=32)*	.345
	Other *(n=4)*	.800
	Spiritual *(n=2)*	N/A
Anxiety	Buddhist *(n=3)*	1.000**
	Christian *(n=75)*	.590**
	Hindu *(n=5)*	.975**
	Jewish *(n=1)*	N/A
	Muslim *(n=29)*	.606**
	Sikh (*n=5)*	.103
	No religion *(n=32)*	.329
	Other *(n=4)*	.800
	Spiritual *(n=2)*	N/A
PTSD	Buddhist *(n=3)*	1.000**
	Christian *(n=75)*	.706**
	Hindu *(n=5)*	.700
	Jewish *(n=1)*	N/A
	Muslim *(n=29)*	.872**
	Sikh *(n=5)*	.300
	No religion *(n=32)*	.637
	Other *(n=4)*	.200
	Spiritual *(n=1)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

For regression-based moderation analyses, categories (Spiritual, Jewish, Buddhist, Hindu, Other) were merged due to the limited sample sizes of the included sub-groups. Based on analyses conducted for depression (β = 0.005, SE = .028, p = .862), anxiety (β = 0.016, SE

= .027, p = .553), and PTSD (β = 0.017, SE = .024, p = .486), in relation to racial trauma, religious belief was not suggested as a significant moderator of these relationships.

Overall, religious belief did not appear to moderate the relationship between racial trauma and other mental health outcomes. The limited sub-group sample sizes suggest that further research is required to understand the role that religion plays in the relationship between racial trauma and other mental health outcomes.

Ethnic Identity

Table 18 illustrates significant correlations between racial trauma and other mental health outcomes across various ethnic identities.

Among Black African participants, significant positive correlations were observed for depression (ρ = .575, p < .01), anxiety (ρ = .642, p < .01), and PTSD symptoms (ρ = .784, p < .01). Similarly, Black Caribbean individuals demonstrated significant positive correlations for depression (ρ = .475, p < .05) and anxiety (ρ = .513, p < .05), with the correlation for PTSD symptoms (ρ = .482) not being statistically significant.

Asian Indian participants also displayed significant positive correlations for depression (ρ = .675, p < .01), anxiety (ρ = .665, p < .01), and PTSD symptoms (ρ = .675, p < .01), highlighting a strong relationship between racial trauma and other mental health outcomes for this ethnic group. For Asian Pakistani individuals, there were also significant positive correlations for anxiety (ρ = .599, p < .05) and PTSD symptoms (ρ = .893, p < .01), with a weaker, not significant correlation being present for depression (ρ = .318).

Additionally for participants of Mixed ethnicity, there was a significant positive correlation between racial trauma and PTSD (ρ = .562, p < .05), whereas correlations for depression (ρ = .298) and anxiety (ρ = .125) were not statistically significant. For individuals identifying as Arab, the correlation with depression (ρ = .493) was not statistically

significant, while significant positive correlations were found for both anxiety (ρ = .754, p < .01) and PTSD symptoms (ρ = .600, p < .05).

Notably, for ethnic identities, such as Other, there were particularly strong correlations with depression (ρ = .847, p < .05) and anxiety (ρ = .829, p < .05), however corelations with PTSD were not statistically significant (ρ = .750). The correlations for Asian Other and Latin Americans were not felt to be meaningful due to their sample size.

Overall, ethnic identity appears to moderate the relationship between racial trauma and other mental health outcomes. While individuals across various ethnic groups exhibited significant associations with racial trauma, the strength of these associations varied, suggesting that further analysis would be beneficial.

Table 18

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Ethnic Identity

Mental Health Outcome	Ethnic identity (*n=*)	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Black African *(n=56)*	.575**
	Black Caribbean *(n=23)*	.475*
	Asian Bangladeshi *(n=7)*	.378
	Asian Indian *(n=18)*	.675**
	Asian Pakistani *(n=12)*	.318
	Asian Chinese *(n=6)*	.429
	Asian Other *(n=3)*	1.000**
	Latin American *(n=2)*	N/A
	Arab *(n=6)*	.493
	Mixed *(n=16)*	.298
	Other *(n=7)*	.847*
Anxiety	Black African *(n=56)*	.642**
	Black Caribbean *(n=23)*	.513*
	Asian Bangladeshi *(n=7)*	.321
	Asian Indian *(n=18)*	.665**
	Asian Pakistani *(n=12)*	.599*
	Asian Chinese *(n=6)*	.429
	Asian Other *(n=3)*	1.000**
	Latin American *(n=2)*	N/A
	Arab *(n=6)*	.754
	Mixed *(n=16)*	.125

	Other *(n=7)*	.829*
PTSD	Black African *(n=56)*	.784**
	Black Caribbean *(n=23)*	.482*
	Asian Bangladeshi *(n=7)*	.679
	Asian Indian *(n=18)*	.675**
	Asian Pakistani *(n=12)*	.893**
	Asian Chinese *(n=6)*	.371
	Asian Other *(n=3)*	.500
	Latin American *(n=2)*	N/A
	Arab *(n=6)*	.600
	Mixed *(n=16)*	.562*
	Other *(n=7)*	.750

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

Due to limited sample sizes in certain sub-groups, categorisations (Black Other, Asian Bangladeshi, Asian Chinese, Asian Other, Latin American, Arab, and Other) were merged during regression-based moderation analyses. Results from the analyses conducted for depression (β = -0.004, SE = .014, $p = .785$), anxiety (β = -0.002, SE = .013, $p = .895$), and PTSD (β = 0.006, SE = .012, $p = .613$) indicated that ethnic identity did not significantly moderate the relationship between racial trauma and the other mental health outcomes.

Racial Identity

Participants across various racial identities demonstrated significant positive correlations between racial trauma and other mental health outcomes, as outlined in Table 19. Among Black participants, moderate to strong positive correlations were observed for depression (ρ = .575, $p < .01$), anxiety (ρ = .619, $p < .01$), and PTSD scores (ρ = .733, $p < .01$), indicating a significant association between racial trauma and mental well-being within this racial group. Similarly, Asian individuals displayed significant correlations for depression (ρ = .519, $p < .01$), anxiety (ρ = .565, $p < .01$), and PTSD (ρ = .666, $p < .01$), highlighting the relation between racial trauma and other mental health outcomes within the Asian community.

Arab participants showed a positive correlation between racial trauma and depression (ρ = .493), anxiety (ρ = .754), and PTSD (ρ = .600), although not statistically significant.

Significant positive correlations were observed for PTSD scores among Mixed (ρ = .571, $p < .05$) individuals, however positive correlations with depression (ρ = .340) and anxiety (ρ = .155) were not statistically significant. For the Latin American and Other subgroups, there were insufficient sample sizes for reliable interpretation, and correlations were therefore not reported.

Overall, racial identity appears to moderate the relationship between racial trauma and other mental health outcomes. While individuals across various racial groups exhibited significant associations with racial trauma, the strength of these associations varied, suggesting the need for further analyses.

Table 19

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Racial Identity

Mental Health Outcome	Racial identity (*n=*)	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Black *(n=80)*	.575**
	Asian *(n=50)*	.519**
	Arab *(n=6)*	.493
	Latin American *(n=2)*	N/A
	Asian Chinese *(n=6)*	.429
	Asian Other *(n=3)*	1.000**
	Latin American *(n=2)*	N/A
	Arab *(n=6)*	.493
	Mixed *(n=17)*	.340
	Other *(n=1)*	N/A
Anxiety	Black *(n=80)*	.619**
	Asian *(n=50)*	.565**
	Arab *(n=6)*	.754
	Latin American *(n=2)*	N/A
	Mixed *(n=17)*	.155
	Other *(n=1)*	N/A
PTSD	Black *(n=80)*	.733**
	Asian *(n=50)*	.666**
	Arab *(n=6)*	.600
	Latin American *(n=2)*	N/A
	Mixed *(n=17)*	.571*
	Other *(n=1)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

Regression-based moderation analyses were further employed to investigate whether racial identity moderated the relationship between racial trauma and other mental health outcomes. Categorisations such as Arab, Latin American, White, and Other were grouped together due to the limited sample size of some of the sub-groups. Based on the analyses conducted for depression (β = 0.001, SE = .036, $p = .974$), anxiety (β = 0.002, SE = .034, $p = .959$), and PTSD (β = 0.012, SE = .030, $p = .699$), in relation to racial trauma, racial identity did not emerge as a significant moderator of these relationships. As with ethnic identity, due the limited sample size, further research is needed to explore these findings more confidently.

Sexual Orientation

Table 20 demonstrates significant correlations between racial trauma and other mental health outcomes across different sexual orientations. Among straight/heterosexual individuals, strong positive correlations were observed for depression (ρ = .555, $p < .01$), anxiety (ρ = .580, $p < .01$), and PTSD scores (ρ = .694, $p < .01$), indicating a significant correlation between racial trauma and other mental health outcomes within this group. Notably, gay/lesbian individuals exhibited a particularly strong positive correlation between racial trauma and anxiety (ρ = .800), although this finding was based on a small sample size and was not significant. Similarly, bisexual individuals displayed a significant positive correlation between racial trauma and anxiety (ρ = .731, $p < .01$).

Additionally, significant positive correlations were observed for PTSD scores among gay/lesbian (ρ = 1.000, $p < .01$) and bisexual participants (ρ = .828, $p < .01$), indicating a notable association between racial trauma and PTSD-related symptoms within these subgroups. It was however, important to acknowledge the limited data available for pansexual and queer orientations, which may warrant further investigation to understand the

relationship between racial trauma and other mental health outcomes within these communities.

Overall, sexual orientation appeared to moderate the relationship between racial trauma and other mental health outcomes. While there were significant associations, the strength of these associations varied across the different sexual orientation groups. Caution is however warranted, due to the limited sample sizes in some of the sexual orientation categories, limiting generalisability.

Table 20

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Sexual Orientation

Mental Health Outcome	Sexual orientation (*n=*)	Spearman's Rho correlation coefficient statistic (ρ)
Depression	Straight/Heterosexual *(n=135)*	.555**
	Gay/Lesbian *(n=4)*	.738
	Bisexual *(n=14)*	.482
	Pansexual *(n=2)*	N/A
	Queer *(n=1)*	N/A
Anxiety	Straight/Heterosexual *(n=135)*	.580**
	Gay/Lesbian *(n=4)*	.800
	Bisexual *(n=14)*	.731**
	Pansexual *(n=2)*	N/A
	Queer *(n=1)*	N/A
PTSD	Straight/Heterosexual *(n=135)*	.694**
	Gay/Lesbian *(n=4)*	1.000**
	Bisexual *(n=14)*	.828*
	Pansexual *(n=2)*	N/A
	Queer *(n=1)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

To conduct regression-based moderation analyses, sub-categories (Gay/Lesbian, Bisexual, Pansexual and Queer were merged due to the limited sample sizes. Results from the analyses conducted for depression (β = -0.027, SE = .205, $p = .444$), anxiety (β = 0.139, SE = .201, $p = .489$), and PTSD (β = 0.125, SE = .169, $p = .463$) revealed that, concerning racial trauma, sexual orientation did not appear to be a significant moderator of these

relationships. It is, however, important to acknowledge that the merging of the sub-categories may have impacted the results. This limitation highlights the need for future research where more Lesbian, Bisexual, Gay, Transgender, Queer (LBGTQ+) participants are represented.

Self-Identified Perceived Social Class

A small sample size limited interpretations for those identifying as lower class, but a significant perfect positive correlation was found for PTSD symptoms ($\rho = 1.000$, $p < .01$; see Table 21). For participants identifying as working class, significant positive correlations were observed for depression ($\rho = .517$, $p < .01$), anxiety ($\rho = .556$, $p < .01$), and PTSD symptoms ($\rho = .664$, $p < .01$). Similarly, individuals identifying as middle class demonstrated significant positive correlations for depression ($\rho = .512$, $p < .01$), anxiety ($\rho = .597$, $p < .01$), and PTSD symptoms ($\rho = .760$, $p < .01$). However, correlations for participants identifying as upper class were not calculable due to the limited sample size.

Overall, self-identified perceived social class appeared to moderate the relationship between racial trauma and other mental health outcomes. While there were significant positive correlations with racial trauma, the strength of these associations varied. For lower, working, and middle-class individuals, there were significant associations with racial trauma across depression, anxiety and PTSD scores, with higher perceived social class potentially showing a similar pattern, albeit inconclusive due to the limited sample size. Further explorations would therefore be beneficial.

Table 21

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Self-identified Perceived Social Class

Mental Health Outcome	Perceived social class (*n=)*	Spearman's Rho correlation coefficient statistic (ρ)
PHQ-9 (depression score)	Lower class *(n=3)*	.500
	Working class *(n=94)*	.517**

	Middle class *(n=57)*	.512**
	Upper class *(n=2)*	N/A
GAD-7 (anxiety score)	Lower class *(n=3)*	.500
	Working class *(n=94)*	.556**
	Middle class *(n=57)*	.597**
	Upper class *(n=2)*	N/A
IES-R * ITQ (PTSD score)	Lower class *(n=3)*	1.000**
	Working class *(n=94)*	.664**
	Middle class *(n=57)*	.760**
	Upper class *(n=2)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

Regression-based moderation analyses were utilised to further explore whether self-identified perceived social class moderated the association between racial trauma and other mental health outcomes. Lower- and Working-Class sub-categories were grouped together, whilst Middle and Upper Class were grouped together due to the limited sample size of some of the sub-groups. Based on the analyses conducted for depression ($\beta = 0.001$, SE = .140, $p = .992$), anxiety ($\beta = -0.043$, SE = .136, $p = .751$), and PTSD ($\beta = -0.035$, SE = .119, $p = .768$), in relation to racial trauma, self-identified perceived social class did not emerge as a significant moderator of these relationships.

Geographic Region

Table 22 reveals significant correlations between racial trauma and other mental health outcomes across different geographic regions. For participants from London and South East England, there was a significant positive correlation with depression (London: $\rho = .433$, $p < .01$; South East England: $\rho = .598$, $p < .01$), anxiety (London: $\rho = .456$, $p < .01$; South East England: $\rho = .599$, $p < .01$), and PTSD symptoms (London: $\rho = .687$, $p < .01$; $\rho = .653$, $p < .01$; South East England: $\rho = .653$, $p < .01$). For participants in East England there were significant positive correlations for anxiety ($\rho = .883$, $p < .01$), and PTSD symptoms ($\rho = .883$, $p < .01$), but the association between racial trauma and depression ($\rho = .745$) was not significant for this region.

For participants from South West England, West Midlands, Yorkshire and The Humber, and North West England, there were varying degrees of positive correlations between racial trauma and the other mental health outcomes, although not all reached statistical significance. Although, participants from Scotland showed perfect positive correlations with depression, anxiety, and PTSD symptoms, these values should be interpreted with caution due to limited sample sizes. Notably, the sample size for participants from Wales also limited interpretation, as correlations were not available for this region. Overall, geographic region did not appear to moderate the relationship between racial trauma and other mental health outcomes.

Table 22

Spearman's Rho Correlation Coefficient between Racial Trauma and Other Mental Health Outcomes, Stratified by Geographic Region

Mental Health Outcome	Geographic Region (*n=)*	Spearman's Rho correlation coefficient statistic (ρ)
Depression	London *(n=82)*	.433**
	South West England *(n=4)*	.316
	South East England *(n=21)*	.598**
	East England *(n=7)*	.745
	West Midlands *(n=15)*	.397
	East Midlands *(n=4)*	.800
	Yorkshire & The Humber *(n=6)*	.638
	North West England *(n=12)*	.430
	Scotland *(n=3)*	1.000**
	Wales *(n=2)*	N/A
Anxiety	England – London *(n=82)*	.456**
	South West England *(n=4)*	.800
	South East England *(n=21)*	.599**
	East England *(n=7)*	.883**
	West Midlands *(n=15)*	.624*
	East Midlands *(n=4)*	.632
	Yorkshire & The Humber *(n=6)*	.657
	North West England *(n=12)*	.383
	Scotland *(n=3)*	1.000**
	Wales *(n=2)*	N/A
PTSD	England – London *(n=82)*	.687**
	South West England *(n=4)*	.800

South East England *(n=21)*	.653**
East England *(n=7)*	.883**
West Midlands *(n=15)*	.803**
East Midlands *(n=4)*	.000
Yorkshire & The Humber *(n=6)*	.829**
North West England *(n=12)*	.853*
Scotland *(n=3)*	1.000**
Wales *(n=2)*	N/A

Note. ** = $p < .01$; * = $p < .05$; N/A = not enough participants for meaningful output.

Further regression-based moderation analyses were employed, and geographic region did not emerge as a notable moderator for the relationship between racial trauma and the other mental health outcomes examined in the study. Due to limited sample sizes, regions were merged and categorised as South and East England, the Midlands, and Northern England and Celtic regions. According to the conducted analyses for depression ($\beta = 0.027$, SE = .025, $p = .285$), anxiety ($\beta = 0.024$, SE = .025, $p = .338$), and PTSD ($\beta = 0.018$, SE = .021, $p = .406$), concerning racial trauma.

CHAPTER FOUR: DISCUSSION

This chapter aims to provide a concise overview of the findings and examine them in light of existing literature. It will critically examine the results in connection to the formulated research questions, assess the degree to which they are answered, and explore the theoretical and clinical implications of this research. It will additionally aim to analyse the strengths and limitations of the study and offer suggestions for future research directions.

4.1 Summary of Findings

Drawing upon the existing literature on negative race-based experiences and their psychological implications, the objective of this thesis was to investigate the prevalence of racial trauma and its relationship with other mental health outcomes among racialised young adults in the UK. Additionally, it aimed to explore how demographic and socio-cultural factors intersect to shape individuals' experiences of racial trauma and its relationship with other mental health difficulties. To achieve this, a quantitative survey approach was employed, utilising a range of measures related to racial trauma, racial/ethnic discrimination, and other mental health outcomes. There is limited research exploring racial trauma within the UK context, and to my knowledge this is the first study to directly explore the relationship between racial trauma and other mental health outcomes within the context of young adults in the UK.

4.1.1 Cumulative Effect of Racism on Racial Trauma

The first research question asked whether the experience of racial adversity relates to the experience of racial trauma, and the extent to which this relationship demonstrates a cumulative effect. This question is rooted in the recognition that racial trauma is often the result of repeated exposure to racial discrimination, microaggressions, and structural inequalities, which can accumulate over time and exacerbate psychological distress (Pascoe & Richman, 2009; Williams et al., 2003).

Cumulative Racial Adversity and Racial Trauma

Findings from the current study suggest a significant relationship between racial adversity and experiences of racial trauma in a UK setting. As individuals experience more instances of racial adversity across their lifetime, there is a corresponding increase in their experience of symptoms associated with racial trauma. The observed correlation echoes previous research that has demonstrated the detrimental effects of chronic exposure to discrimination on mental health (Wallace et al., 2016). Despite the difference being relatively small, it appears that the association between lifetime racial adversity and racial trauma is stronger than that between recent racial adversity and racial trauma. This suggests that both lifetime and recent racial adversity are important factors contributing to racial trauma, but experiencing racial adversity over one's lifetime may have a slightly stronger association with racial trauma than recent experiences of racial adversity. As per existing developmental trauma literature (Cruz et al., 2022; Zlotnick et al., 2008), the current findings suggest that childhood exposure to racial adversity may cause greater harm when compared to exposure in young adulthood. Further longitudinal research across the lifespan may help to confirm such, as the current study does not specify when in their lifetime participants experienced racial adversity.

Regression analyses reveal a meaningful relationship between lifetime experience of racial adversity and racial trauma, with experiences of racial/ethnic discrimination across one's lifetime playing a significant role in determining the extent to which individuals exhibit symptoms of racial trauma. These results reinforce the notion that individuals who report experiencing higher frequencies of racial adversity across their lifetime also tend to report higher levels of racial trauma, highlighting the cumulative impact of racial adversity on psychological well-being. Similarly, when considering recent experiences of racial adversity, there is a notable and meaningful association with symptoms of racial trauma. The similarity

in the strength of the relationships between lifetime and recent experiences of racial discrimination suggests that the experience of racial adversity tends to persist overtime. This implies that if individuals experience racial discrimination earlier on (lifetime exposure), it is likely to continue or reoccur in their life (recent exposure). These findings reaffirm the cumulative effect of racism on psychological well-being among young adults in the UK context, across different time frames of racial adversity exposure.

Overall, these findings provide empirical support for the notion that the enduring effects of racial adversity contribute significantly to the heightened experience of racial trauma (Awad et al., 2019; Carter, 2007; Williams et al., 2018). In addition to a moderate level of adversity being reported across the sample (see table 6), these findings also challenge the Sewell Report (HM Government, 2021), which minimises the existence and impact of racial adversity as a significant issue in the UK.

Frameworks for Understanding the Relationship between Racial Stressors and Racial Trauma

The current findings also align closely with existing theoretical frameworks that propose a relationship between racial trauma and stress processes, particularly within the context of chronic exposure to racial adversity. These frameworks offer valuable insights into the mechanisms through which the cumulative effects of racism contribute to the manifestation of racial trauma symptoms and exacerbate mental health disparities among racialised populations. As highlighted in section 1.4.2, Carter's (2007) RBTS theory and Awad and colleagues' (2019) CRET model expand upon traditional conceptualisations of stress and trauma by specifically addressing the unique stressors and traumatic experiences faced by individuals from racialised groups. Carter's model highlights the multifaceted nature of race-based stress and trauma, which encompasses both acute incidents of racial discrimination and the chronic stressors stemming from systemic racism and structural

inequalities (Williams, 2018). Racial stressors can trigger physiological, psychological, and emotional responses, leading to symptoms of trauma and distress among individuals from racialised communities (Carter, 2007). Importantly, the CRET model (Awad et al., 2019) further emphasises the cumulative impact of racial stress over time, suggesting that repeated exposure to racial adversity can exacerbate the severity of trauma symptoms and contributes to long-term mental health consequences.

Additionally, the Transactional Model of Stress and Coping, proposed by Lazarus and Folkman (1984), provides a comprehensive framework for understanding how individuals perceive and respond to stressors related to racism and discrimination. According to this model, individuals engage in cognitive appraisal processes to evaluate the significance of stressors and assess their coping resources to manage the associated distress (Chun et al., 2006; Gross, 2013; Lazarus & Folkman, 1984). In the context of racial trauma, individuals from racialised groups engage in cognitive appraisal to evaluate the significance and potential threat of racially motivated stressors (Fani et al., 2021; Lazarus & Folkman, 1984; Lee et al., 2018; Sawyer et al., 2012). This appraisal involves assessing factors such as the perceived severity and controllability of the stressor, as well as one's perceived ability to cope effectively with the situation. Chronic exposure to racial adversity can disrupt these cognitive appraisal processes, leading individuals to perceive racial stressors as more severe and less controllable, thereby increasing their levels of distress and vulnerability to trauma symptoms (Bird et al., 2021).

4.1.2 The Relationship between Racial Trauma and the Other Mental Health Outcomes

The second research question queried whether there is a relationship between racial trauma and other mental health outcomes such as anxiety, depression, and PTSD. This research question stemmed from the recognition that racial trauma, characterised by exposure to race-based discrimination and violence, profoundly affects psychological well-being and is

potentially linked to symptoms of depression, anxiety, and trauma-related disorders (Carter, 2007; Williams et al., 2018).

The observed correlations between racial trauma and the other mental health outcomes suggest that individuals who experience more symptoms of racial trauma are also more likely to exhibit symptoms of depression, anxiety and PTSD. This aligns with the framework of complex trauma, which suggests that exposure to chronic traumatic events, often of an interpersonal nature, can lead to a higher complexity of symptoms and an increased likelihood of co-morbidities (Briere & Scott, 2015; Kliethermes et al., 2014). This complexity arises from the impact of trauma on various aspects of psychological functioning, including emotional regulation, interpersonal relationships, identity development, and cognitive processing (Briere & Lanktree, 2012). This echoes previous literature that suggests the conceptualisation of racial trauma as being comparable to that of complex trauma (Cénat, 2023). The multiple regression analysis provides further insights into the relationship between racial trauma and the other mental health outcomes. Depression and anxiety not being significantly associated with racial trauma, echoes literature from Williams, (2018) that highlighted the concept of racial trauma as a distinct form of trauma that can impact mental health in ways that may not always align with traditional depressive or anxiety symptomatology, but can nonetheless contribute to significant psychological distress among racialised people. The significant associations between racial trauma and PTSD highlights the unique and profound impact of race-based trauma on the development and manifestation of PTSD symptoms, aligning with previous research highlighting the role of race-related stressors in shaping trauma responses (Bryant-Davis & Ocampo, 2006; Carter, 2007).

The current study is aligned with existing studies that have consistently shown that experiences of racial discrimination are linked to an increased risk for depression, anxiety disorders, and PTSD among racialised individuals in the US (e.g., Bryant-Davis & Ocampo,

2006; Pascoe & Richman, 2009; Williams et al., 2003; Williams & Mohammed, 2009). Within the existing body of research based in the US, there is a consideration for the exploration of this relationship within the young adulthood life stage (e.g., Auguste et al., 2021; Huynh et al., 2023; Portillo et al., 2022), however this consideration is seemingly missing from UK-based studies. As young adulthood has been identified as a critical period marked by increased identity exploration, sensitivity to social experiments and susceptibility to stressors, all of which influence mental health outcomes (Arnett, 2000; Carter, 2007; Settersten & Ray, 2010), focusing on young adulthood within this field of study is important. The current study contributes to the literature by specifically examining the relationship between racial trauma and other mental health outcomes in a diverse sample of young adults within the UK context.

A Framework for Understanding the Social Ecology of Racial Trauma and the Other Mental Health Outcomes

The Social-Ecological Model (SEM), originally proposed by Bronfenbrenner (1979), highlights the dynamic relationship between individual, interpersonal, community, and societal factors in shaping human development and behaviour. Existing literature (Harper Browne & O'Connor, 2021; Watson-Thompson et al., 2022) has applied this theoretical framework to the context of racism, suggesting that exposure to racial aggression operates at multiple levels of the social ecology (systemic, institutional, interpersonal, individual).

At the individual level, experiences of racial adversity may directly impact psychological well-being by eliciting emotional distress, triggering maladaptive coping strategies (Griffin & Armstead, 2020; Polanco-Roman et al., 2016; Shorter-Gooden, 2004), and undermining self-esteem (Major et al., 2007) and identity development (Carter, 2007). This aligns with the observed relationship between racial adversity and racial trauma, and between racial trauma and the other mental health outcomes in the current study and existing

literature (Danyluck et al., 2021; Haft et al., 2022; Lavner et al., 2022; Lui et al., 2022; Marks et al., 2020; Rodriguez-Seijas et al., 2015).

Cenat and colleagues (Cénat, 2023; Cénat et al., 2022), suggest that racial adversity is embedded within broader social structures characterised by systemic racism and inequality (Banaji et al., 2021), and does not tend to present as an isolated incident. These structural factors contribute to the perpetuation of racial trauma and create environments that are conducive to the development and exacerbation of mental health problems among racialised individuals. Thus, the SEM (Bronfenbrenner, 1979), adapted to be applied to racism (Harper Browne & O'Connor, 2021; Watson-Thompson et al., 2022), emphasises the importance of addressing not only individual-level experiences of racial adversity but also the broader social context in which these experiences occur to effectively mitigate the adverse mental health outcomes associated with racial trauma.

4.1.3 Mental Health Outcomes Across Regions Varying in Levels of Racial Diversity

The third research question queried whether racialised young adults from regions of low racial diversity in the UK, experience more racial trauma and exhibit poorer mental health outcomes compared to those from more diverse areas. Overall, the findings from the current study provide nuanced insights into the relationship between racial trauma, regional racial diversity and other mental health outcomes.

Trends and Associations Across Regions of Varying Racial Diversity

The mean scores for racial trauma across regions, stratified by racial diversity levels, revealed a notable trend, where areas of higher racial diversity report lower levels of racial trauma. The mean scores for the mental health outcomes (racial trauma, depression, anxiety, PTSD) highlighted a similar pattern of consistent decrease as the diversity level of regions increased. The findings indicate that when compared to those from more diverse areas, young adults from regions characterised by low racial diversity in the UK, are more likely to

experience negative racial experiences, which is associated with poorer mental health outcomes. Similarly, participants living in regions characterised by higher racial diversity report better mental health outcomes, when compared to those in regions with lower diversity levels.

The relationships between racial trauma and the other mental health outcomes remained positive across all diversity levels, with the findings revealing moderate to strong positive correlations between racial trauma and depression, anxiety, and PTSD. This is further supported by analyses that show significant positive correlations being found for depression, anxiety and PTSD in regions like London, South East England, and East England, where racial diversity is moderate to high (see Table 3). These results suggest that racial adversity continues to influence mental health outcomes even in settings with greater racial heterogeneity. This is consistent with previous literature, that identified similar patterns for racialised groups sampled from a racially diverse population (Polanco-Roman et al., 2016). Although these findings further affirm the significant connection between experiences of racial trauma and subsequent mental health issues, they challenge the assumption that higher levels of racial diversity inherently buffer against the negative effects of racial adversity (Pettigrew & Tropp, 2006). As the presence of racial trauma and other mental health outcomes appear to persist regardless of regional diversity levels, it can therefore be argued that there is a core issue of racism and racial trauma being experienced by racialised young adults in the UK.

Though the observed results merely trended towards significance for the ANOVA analyses, one can still suggest that there is a meaningful relationship between racial trauma and the other mental health outcomes (depression, anxiety, PTSD scores), across the different regional levels of racial diversity. This warrants further investigation or consideration for practical applications. Additionally, the ANOVA effect sizes highlighted the extent of these

differences, emphasising the relevance of considering regional racial diversity as a significant influence for mental health outcomes.

The findings of this current study are supported by existing literature that recognise the influence of regional racial composition on experiences of racial adversity (English et al., 2014) and well-being outcomes (Hunt et al., 2007; Kershaw et al., 2011; Shaw et al., 2012). These findings align with existing theoretical frameworks which highlight the importance of considering the socio-cultural context in understanding the impact of racial trauma on mental health outcomes.

Frameworks for Understanding the Relationship between Racial Diversity, Racial Trauma, Belongingness and Group Identity

As the negative impact of racial trauma on mental health can be interpreted through the lens of group-based identity, this thesis' findings resonate with the SIT (Tajfel et al., 1979). The SIT offers a foundational framework for understanding how individuals construct their identities based on their group memberships and the dynamics of intergroup relations. In the context of the UK, where racial diversity varies significantly across regions (Office for National Statistics, 2022), the social dynamics within these homogeneous and heterogeneous communities play a pivotal role in shaping individuals' experiences of racial trauma. According to SIT, people categorise themselves and others into various social groups, forming a sense of self and belonging derived from these affiliations (Tajfel et al., 1979). Importantly, when individuals face discrimination or marginalisation within their social group, it threatens their personal identity and sense of belonging, leading to psychological distress (Major & O'Brien, 2004). In the context of racial diversity and racial trauma, individuals from racialised groups residing in regions of lower racial diversity may encounter heightened instances of discrimination and exclusion, increasing their experiences of racial trauma and contributing to adverse mental health outcomes.

An alternative perspective is that the heightened experiences of racial trauma in these areas may be linked to the threat that difference and the other, have on the established group membership of the ‘majority’ (e.g. the context of the UK, White British). Existing literature (Hill, 2022; Weil & Piaget, 1951) suggests that the ostracization of ‘the other’ plays a role in the understanding of the self, which in turn causes psychological distress to those marginalised (Baumeister & Leary, 2007). Similar conclusions were found in US-based studies (Choi et al., 2021; Freire & Hurd, 2023; McCready et al., 2021), which found that racial aggressions and a lack of belongingness significantly predicted negative mental health outcomes for the marginalised group. Turner (Turner, 2016; Turner, 2018) proposes that those from the 'majority' background struggle to recognise how their narcissism towards difference and 'the other' perpetuates the racial adversity experienced by their racialised counterparts. Turner (2016) suggests that Eurocentric approaches to understanding difference and otherness contribute to a form of cultural narcissism by perpetuating power imbalances and fostering an environment where the majority group's perspective is prioritised. This narcissism manifests in various ways, including the denial of systemic racism, the minimisation of the experiences of racialised individuals, and the assumption that the cultural norms of the majority are universal (DiAngelo, 2011). It can be argued that this narcissism is not only a personal failing but is deeply embedded in societal structures and institutions. This is further supported by the MSM (Meyer, 2003), which in the context of regional racial diversity, suggests that individuals residing in areas of higher homogeneity, may face increased exposure to overt and systemic forms of racism, leading to heightened levels of distress and trauma.

The findings of this study thus highlight the need for a more nuanced understanding of the relationship between regional diversity levels and mental health outcomes, emphasising the importance of considering contextual factors and individual experiences. It

also suggests that while racial diversity is influential in shaping the relationship between racial trauma and other mental health outcomes, other contextual factors may also play a role in more racially diverse regions.

4.1.4 Intersectionality: The Moderating Variables for the Relationship Between Racial Trauma and the Other Mental Health Outcomes

The fourth research question asked how intersectional factors moderate the relationship between racial trauma and other mental health outcomes, and which groups experience greater vulnerability as a result.

Gender

Gender emerged as a potential moderator for depression, anxiety and PTSD, with females experiencing a more pronounced relationship with racial trauma, compared to males.

One possible explanation for the stronger correlation between racial trauma and the other mental health outcomes (depression, anxiety, PTSD) among females, is rooted in gender socialisation processes. From a young age, females are often socialised to express and internalise emotions more openly than males, leading to greater vulnerability to internalising disorders such as depression and anxiety (Nolen-Hoeksema, 2001). Consequently, when females experience racial trauma, they may be more inclined to internalise the resulting distress, manifesting in heightened depressive and anxiety symptoms. This tendency to internalise stressors and emotions may exacerbate the impact of racial trauma on mental health outcomes for females. Additionally, females may face unique stressors and challenges related to gender-based discrimination and societal expectations, which intersect with experiences of racial discrimination to compound psychological distress (Mekawi & Watson-Singleton, 2021; Moody & Lewis, 2019) during this life stage. Intersectional experiences of discrimination can create a cumulative burden on mental health, leading to increased

vulnerability to depressive, anxiety and PTSD symptoms among females exposed to racial trauma.

The weaker associations among males may be attributed to differences in coping mechanisms and symptom manifestation (Hu et al., 2017). Males are often socialised to employ externalising coping strategies, such as aggression or substance use, in response to stressors (Agnew, 1992). Furthermore, societal norms and expectations regarding masculinity may discourage males from seeking help or acknowledging vulnerability, resulting in the underreporting or misinterpretation of symptoms (Kulesza et al., 2015). As a result, males exposed to racial trauma may be more likely to suppress or mask their symptoms of distress, with symptoms that manifest differently from those observed in females (Pooley et al., 2018).

Sexual Orientation

The observed correlation-based moderation effects of sexual orientation align with previous studies that have highlighted the unique experiences and vulnerabilities of LGBTQ+ individuals facing racial discrimination (Balsam et al., 2011). The MSM (Meyer, 2003) provides insights into the experiences of individuals from sexual minority groups, highlighting the role of stigma, prejudice, and discrimination in contributing to adverse mental health outcomes. The significant positive correlations observed for PTSD symptoms among gay/lesbian and bisexual individuals, and anxiety symptoms among bisexual individuals, suggest that the cumulative effects of racial trauma and sexual minority stress may compound mental health challenges within these communities. SIT (Tajfel et al., 1979) suggests that individuals derive a sense of self-concept from their membership in social groups, which includes gender and sexual orientation. According to this theory, individuals may experience heightened distress when their social identities are threatened or marginalised. In the context of the findings, the strong positive correlations between racial trauma and anxiety among gay/lesbian and bisexual individuals suggest that experiences of

discrimination based on both race and sexual orientation can significantly impact mental health. These results suggest that individuals from sexual minority groups face compounded challenges due to the intersection (Crenshaw, 1989) of their racial and sexual identities. Alessi and Martin (2017) suggest that sexual minority individuals are more likely than heterosexual individuals to experience prejudice-related events and develop symptoms suggestive of trauma following exposure to these events. Additionally, research indicates that LGBTQ+ individuals who are also part of racialised groups, are even more likely to experience prejudice-related events and develop symptoms indicative of trauma (Norris et al., 2021). This highlights the intersectional nature of trauma experienced by LGBTQ+ individuals, where discrimination based on both race and sexual orientation can exacerbate mental health disparities, contributing to elevated levels of anxiety and PTSD symptoms among these populations. This intersectional perspective acknowledges that LGBTQ+ individuals may face compounded discrimination based on both their sexual orientation and racial/ethnic identity, leading to distinct mental health challenges. However, the limitations of our study, such as the small sample size of LGBTQ+ participants, highlight the need for future research with larger and more diverse samples to further examine the intersectional dynamics at play.

Additionally, the Gender Role Strain Paradigm (Levant & Powell, 2017; Pleck, 1995), suggests that traditional gender roles and societal expectations may contribute to stress and psychological distress, particularly among marginalised groups. In this case, the strong correlation between racial trauma and other mental health outcomes among individuals with non-heterosexual orientations may be influenced by the unique stressors and discrimination faced by sexual minority populations. These stressors could exacerbate the impact of racial trauma on mental health, resulting in higher levels of anxiety and PTSD symptoms.

The findings of this study are consistent with Intersectionality Theory (Crenshaw, 1989), which suggests that people experience overlapping and intersecting forms of oppression based on their multiple social identities. The moderating effects of sexual orientation and gender emphasise the importance of considering the unique experiences and vulnerabilities of diverse groups within the context of racial trauma and other mental health outcomes.

Immigration Generation

In the current study, the correlation coefficients for depression, anxiety and PTSD scores were highest among first-generation immigrants, indicating a stronger association between racial trauma and these mental health outcomes compared to second and third-generation immigrants. The varying susceptibility to mental health outcomes among different generations of immigrants, as evidenced by these findings, can be further understood through theories related to assimilation and identity formation.

Gordon's (1964) assimilation theory and Berry's (1997) acculturation model suggest that individuals from migrant families undergo a process of cultural and social adaptation to their host society, which can influence their sense of identity and belonging. In the current study, correlations for depression and anxiety were highest among first-generation immigrants, indicating a stronger association between racial trauma and these mental health outcomes, compared to second and third-generation immigrants. This finding aligns with the theory that first-generation immigrants, who are more recently arrived and may have stronger ties to their cultural heritage, are likely to experience greater psychological distress when faced with racial adversity (Berry, 1997; Gordon, 1964). This heightened vulnerability among first-generation immigrants could be attributed to factors such as cultural dissonance (Choi et al., 2008; Martinez-Taboada et al., 2017), language barriers (Szaflarski & Bauldry, 2019), and the challenges of adapting to a new social environment (Almutairi, 2015; Carswell et al.,

2009), all of which can contribute to a heightened sense of perceived discrimination. Kuo (2014) has suggested that as immigrants acculturate and assimilate into their host society over subsequent generations, they may develop stronger coping mechanisms and social support networks, which could buffer the impact of racial trauma on mental health outcomes.

Experiences of racial trauma may also be reciprocally related to cultural identity, as individuals' experiences of discrimination and marginalisation can shape their understanding of themselves within the context of their racial or ethnic group. Racial trauma experienced by first-generation immigrants could potentially disrupt their initial stages of racial identity development, leading to feelings of confusion, insecurity, and vulnerability (Cross, 1991). In the context of SIT (Tajfel et al., 1979), experiences of racial trauma can profoundly impact individuals' cultural identity formation and sense of belonging within their racial or ethnic group. SIT suggests that individuals form part of their self-concept from their membership in social groups and strive to maintain a positive social identity. For first-generation immigrants, who have recently migrated to a new country, experiences of racial trauma may be particularly salient as they navigate unfamiliar social landscapes (Christmas & Barker, 2014; Cole et al., 2023). These individuals may encounter discrimination, prejudice, and marginalisation based on their racial or ethnic background, which could challenge their sense of belonging and connection to their cultural identity (Lincoln et al., 2021). In response to these experiences, first-generation immigrants may engage in processes of social categorisation and comparison, whereby they seek to understand their place within the host society and maintain a positive sense of self within their ethnic or racial group. However, the impact of racial trauma may lead to heightened levels of psychological distress and adjustment difficulties among first-generation immigrants, as they strive to reconcile their cultural identity with experiences of discrimination (Phinney et al., 1998). Second-generation immigrants, born to immigrant parents in the host country, may also grapple with the effects

of racial trauma on their cultural identity. Growing up in a multicultural environment, these individuals may face identity conflicts as they navigate between their parents' cultural heritage and the dominant culture of the host society, as suggested by Giguère and colleagues (2010). Experiences of discrimination and marginalisation, based on their racial or ethnic background, could influence their self-concept and social identity formation. Second-generation immigrants may actively seek to negotiate their cultural identity, balancing aspects of their heritage with the desire to assimilate into mainstream society (Cohen & Kassan, 2018; Dizon et al., 2021; Giguère et al., 2010; S. Liu, 2015). However, the presence of racial trauma may complicate this process, leading to feelings of ambivalence or alienation regarding their cultural identity.

When immigrants experience race-based stress, it may trigger a process of identity negotiation and exploration within their cultural context (Tummala-Narra, 2014), leading individuals to re-evaluate their cultural identity, question their sense of belonging, and navigate the complexities of assimilation versus cultural preservation (Liu et al., 2019).

Correlations depression and PTSD among third-generation immigrants, were notably lower compared to first and second-generation immigrants, although not statistically significant. This result may also be explained by SIT, as third-generation immigrants may exhibit more complex patterns of cultural identity development. By this generation, the influence of racial trauma on cultural identity may be less direct, as individuals may feel more integrated into the host society and less connected to their ancestral culture (Erikson, 1968; Phinney, 1990). According to CRET model (Awad et al., 2019), the experience of intergenerational trauma and historical marginalisation is still likely to shape their understanding of racial identity and influence their perceptions of discrimination and inequality, though, it is essential to interpret these findings cautiously, as the small sample

size of third-generation immigrants in the current study may limit the generalisability of the results.

Other Intersectional Factors

Other intersectional factors such as ethnic identity, perceived social class and employment status did not yield significant moderation effects in the analysis. This suggests that the relationship between racial trauma and other mental health outcomes may be influenced by complex interactions among multiple socio-cultural factors, and further research is needed to elucidate these dynamics.

4.2 Study Implications

The findings of this study carry significant implications for clinical practice, further research, and policy development in the field of mental health, particularly concerning the impact of racial trauma on young adults in the UK.

4.2.1 Clinical Practice Implications

The findings of this study highlight the need for clinicians to adopt culturally responsive practices in assessing and diagnosing individuals who have experienced racial trauma. Traditional assessment tools, as revealed by the study, may overlook or misinterpret the psychological and emotional manifestations of racial trauma, leading to inaccurate diagnoses and ineffective treatment plans (Sellbom & Suhr, 2019). In response, it can be suggested that clinicians should be encouraged to undergo training that recognises the unique cultural contexts and socio-cultural factors shaping individuals' experiences of racial trauma, and the need to tailor assessment protocols accordingly. While racial trauma may not be explicitly named in the DSM-5 (American Psychological Association, 2013), the manual provides a framework for understanding and assessing the psychological distress that individuals may experience in response to racial discrimination, harassment, or violence. The Cultural Formulation Interview (CFI; (Aggarwal & Lewis-Fernández, 2015; American

Psychological Association, 2013; Lewis-Fernandez et al., 2014) can therefore be used to provide a framework for cultural formulations, where clinicians are able to explore how cultural factors, including experiences of racism, influence individuals' mental health (Aggarwal & Lewis-Fernández, 2015). By integrating cultural formulation into assessments, clinicians can develop more nuanced understandings of clients' experiences and tailor interventions accordingly. An awareness of clients' intersectional identities is also crucial, as these factors significantly influence the expression and interpretation of racial trauma symptoms (Comas-Díaz et al., 2019; Galán et al., 2022) .

Regardless of racial/ethnic identity, all clinicians should undergo training that supports them to work with racial trauma sensitively and with an anti-racist mindset (Williams et al., 2023). When racial/ethnic identity is shared between clinician and service-user, it would be important to acknowledge and validate the service-user's experiences of racial trauma, while recognising the unique socio-cultural and intersectional contexts in which these experiences occur (Bryant-Davis, 2019; Comas-Díaz et al., 2019; Galán et al., 2022; Saleem et al., 2019). Whilst clinicians can leverage their shared identity to establish rapport and trust with the client, facilitating open communication, a deeper understanding of their lived experiences, and creating a safe and validating therapeutic environment, can help service-users better explore and process their experiences of racial trauma (Williams et al., 2023; Williams et al., 2021). Clinicians should approach therapy with an awareness of their own cultural biases and privileges, actively seeking to understand the client's cultural background and perspective (Sue & Torino, 2004; Vasquez, 2007). Building a collaborative therapeutic relationship based on mutual respect and trust is essential for creating a supportive environment where individuals feel heard and understood (Chang & Berk, 2009; Noyce & Simpson, 2018). Clinicians should also remain mindful of power dynamics and avoid imposing their own worldview onto clients (Carter, 1995; Gottlieb, 2021; Pérez Foster,

1998), instead prioritising the patient's autonomy and self-determination in the therapeutic process. To equip clinicians with the necessary skills, tailored training programmes are essential, particularly for those operating in less diverse regions. Psychology services operating in less diverse regions should adapt their clinical approaches to better meet the needs of racialised individuals.

Clinicians should acknowledge and address the potential effects of racial trauma on the well-being of their clients, especially in regions with lower racial diversity. This involves prioritising comprehensive assessments, targeted interventions, and collaborative efforts with community organisation, to provide necessary resources and support. The study emphasises the role of clinicians in actively safeguarding individuals affected by racial trauma, highlighting the importance of a proactive approach to mental health care that extends beyond traditional diagnostic boundaries. Vigilance to avoid iatrogenic harm and re-traumatisation in mental health settings requires a trauma-informed approach that recognises the potential triggers and sensitivities associated with racial trauma. Using trauma-focused interventions that prioritise trauma-informed care, and anti-oppressive practices are of paramount importance (Flavin et al., 2022; McAdoo et al., 2023; Morgan-Mullane, 2023).

Whilst the study aligns with the CRET model (Awad et al., 2019), which emphasises the compounding effects of multiple traumas on mental health, it's important to note that this model may overlook the resilience and coping strategies employed by marginalised communities. As a response, clinical practice should adopt a strengths-based approach (Flückiger et al., 2023; Tse et al., 2016), focusing on individuals' inherent strengths and resources to overcome the adverse effects of racial trauma on mental health outcomes and build resilience in the face of racial trauma. The Post-Traumatic Growth (PTG) framework (Tedeschi & Calhoun, 2004) offers a strengths-based perspective on coping with trauma, highlighting the potential for personal growth and resilience in the aftermath of adversity.

Strategies and tools aimed at fostering the cognitive processes of PTG can serve as an effective treatment approach for addressing racial trauma (Chin et al., 2023). Additionally, Ungar's (2012) Socioecological Theory of Resilience (STR), emphasises the importance of identifying and mobilising individual and community strengths in overcoming adversity. Clinicians can collaborate with service-users to cultivate resilience and adaptive coping strategies, fostering a sense of agency and empowerment in navigating racial trauma (Ungar, 2012) and re-framing resilience as a form of resistance against structural racism (Sims-Schouten & Gilbert, 2022).

Building on these insights, the study advocates for an intersectional approach to treatment, acknowledging the intricate relationship between multiple social identities and experiences of racial oppression. Clients who have experienced racial trauma often contend with intersecting forms of discrimination based on factors such as gender, sexual orientation, socioeconomic status, disability status, or immigration status (Hatch & Dohrenwend, 2007; Williams et al., 2018). To address these complexities, clinicians should be attuned to these intersectional dynamics and consider how they may influence clients' experiences of racial trauma and corresponding mental health outcomes. By acknowledging the interconnected nature of oppression and privilege (Khan, 2023; Moradi, 2016), clinicians can develop interventions that address the unique needs and challenges faced by clients with intersecting identities, fostering a more holistic approach to treatment.

In addition to individual therapy, the study highlights the importance of community-based interventions that address the systemic roots of racial trauma and promote collective healing and social change (Anderson, 2018; Chioneso et al., 2020; French et al., 2020). Recognising that the effects of racial adversity extend beyond the individual to impact entire communities, (Cénat, 2023; Comas-Díaz et al., 2019; Harrell, 2000) community-based interventions can engage individuals, families, and communities. By mobilising community

resources and fostering collective action, these interventions create supportive networks and solidarity among individuals affected by racial trauma. A sense of belonging and solidarity can help racialised individuals to reclaim agency and resilience in the face of racial adversity (Hill, 2022).

4.2.2 Further Research Implications

The findings of this study support the growing recognition of racial trauma as a distinct form of psychological distress (Cénat, 2023; Saleem et al., 2020), and therefore highlight the necessity for future research to disentangle the distinct constructs of PTSD and racial trauma, to advance our understanding of their unique etiological pathways, symptom presentations, and treatment implications. By disentangling PTSD and racial trauma, researchers can refine diagnostic criteria, develop targeted interventions, and inform policy initiatives that address the specific needs of individuals affected by racial trauma, ultimately fostering more comprehensive and culturally responsive approaches to mental health care. To build upon the acknowledgement of racial trauma's distinct nature, future research should address the limitations highlighted within the current study.

The study's small sample size for particular socio-cultural and demographic sub-groups (e.g. within the disabilities, sexual orientation, ethnic identity, and geographic region categories) raises concerns about the generalisability of the findings for specific groups. Future research should prioritise recruiting larger and more diverse samples to ensure that the racial experiences and mental health outcomes of various racial and cultural groups are adequately represented. This would enhance the robustness and applicability of the study's conclusions to broader populations.

Expanding on the need for broader representation, the study's identification of immigration generation as a potential moderator for the relationship between racial trauma and other mental health outcomes, highlights the enduring impact of historical and

intergenerational trauma within immigrant communities. Whilst the current thesis focuses on young adults, future research could extend investigations to explore how these intergenerational effects persist across the lifespan. Such research would shed light on the long-term implications of racial adversity on racial trauma and other mental health outcomes, and how the experiences of racial trauma being transmitted across generations can inform interventions aimed at breaking the cycle of trauma and promoting resilience within immigrant communities.

Considering the complexities of immigrant experiences, the study's consideration of the relationship between assimilation theory, identity formation models, and the reciprocal relationship between racial trauma and cultural identity (see section 4.1.4), suggests avenues for deeper investigation. Future research could further explore these interactions and their implications for interventions aimed at supporting the mental health and well-being of immigrant populations. Incorporating qualitative methodologies could also allow for a deeper understanding of the subjective experiences of immigrants and their descendants in navigating racial trauma and cultural identity within diverse cultural contexts (Schwartz et al., 2014).

Recognising the dynamic nature of mental health outcomes, the study's call for longitudinal investigations serves as a natural progression. Future research should aim to deepen our understanding of the complex relationship between racial trauma and other mental health outcomes. Longitudinal studies are needed to explore how racial trauma unfolds over time and its lasting effects on mental health. Investigating moderating variables such as gender, immigration status, language, and disabilities can provide insights into how these factors influence the impact of racial trauma and provide a more comprehensive understanding of intersecting identities.

4.2.3 Advocacy and Policy Change

Finally, the study emphasises the importance of advocacy and policy change in addressing the systemic injustices that perpetuate racial trauma and inequities in mental health outcomes. Recognising racial trauma as a significant public health issue in the UK, allows for the understanding of its significant impact on individual well-being but also highlights the need to advocate for systemic changes that address these disparities. According to a report by the United Nation's Human Rights Council (2023), the UK's lack of action following numerous reviews and reports on systemic racism and the impact of racial adversity on racialised people, has been a source of concern. From an economic and social productivity perspective, it is particularly important to consider the findings of the current study that suggests the significant impact of racial adversity on young racialised adults. According to a report by Hampson and Jacob (2020), poor mental health outcomes in young adults, represents a significant financial cost to UK businesses compared to other age groups. Young adults have innovative potential that can be used to solve societal and economic challenges (Dougherty & Clarke, 2017), however poor mental health has also been found to stifle innovation and creativity (Hampson & Jacob, 2020).

In line with the findings of the current study, policymakers should prioritise efforts to promote racial diversity and inclusion across various sectors, including education, employment, healthcare, and housing. By fostering environments that prioritise racial diversity and inclusion, policymakers create spaces where individuals from racially marginalised backgrounds feel a greater sense of belonging (Hussain & Jones, 2019; Wu et al., 2011), and affirmation of their identities (Purdie-Vaughns et al., 2008). This sense of belonging can serve as a protective factor against the negative psychological impacts of racial trauma.

Moving beyond sectoral focus, policymakers should allocate resources to strengthen mental health services in regions with lower racial diversity, ensuring they can effectively

support racially marginalised individuals. Implementing support and safeguarding measures, such as early intervention programmes and accessible mental health services, can help mitigate the impact of racial trauma. Additionally, increasing access to culturally competent mental health services and providing resources for trauma-informed care, are essential steps in addressing the specific needs of racialised communities.

Recognising the interconnected nature of these initiatives, collaboration between policymakers, mental health professionals, and community stakeholders is essential to create inclusive and equitable policies that support individuals affected by racial trauma.

By demonstrating the cumulative effect of racial adversity on psychological well-being, particularly among young adults, this study challenges the narrative perpetuated by government reports like the Sewell Report (HM Government, 2021), which downplay the prevalence and impact of racial adversity within the UK. The current findings highlight the importance of acknowledging and addressing systemic racism as a fundamental determinant of mental health disparities. The study's exploration of racial trauma highlights the multifaceted nature of racial adversity and the need for comprehensive and targeted interventions aimed at addressing its root causes at the systemic level. Additionally, as the current study suggests that there are higher levels of racial trauma and poorer mental health outcomes among racialised young adults in regions with lower levels of racial diversity, the need to address structural inequalities and promote inclusivity in all communities is recognised. This need aligns with human rights principles, which assert the rights of all individuals to live free from discrimination and to enjoy equal access to opportunities and resources (UN General Assembly, 1948). According to the Working Group of Experts on People of African Descent (United Nation's Human Rights Council, 2023), during their recent visit to the UK, it was determined that human rights violations related to systemic racism, had persisted or worsened since their visit in 2012. Though this report addresses the

failure of UK policy to address concerns of systemic racism against the Black population, (Webber, 2022) suggests that recent legislation, such as the Nationality and Borders Act (2022), further enforces racist state policies for a broad range of racialised groups within the UK. Addressing disparities in racial diversity and promoting social cohesion across diverse communities are essential steps towards realising these rights and fostering a more equitable society. By addressing the structural factors contributing to racial trauma, policymakers can foster a more supportive environment for all individuals impacted by these experiences. Clinicians have a unique role to play as advocates for social justice and policy change (Jantzer et al., 2023; Melton, 2018), leveraging their expertise and influence to promote policies and practices that advance equity, diversity, and inclusion in mental health care.

4.3 Study Limitations and Strengths

4.3.2 Limitations

A limitation of the current study was the cross-sectional research design, which restricted the ability to establish causality or examine temporal relationships between variables. Cross-sectional studies provide a snapshot of data at a single point in time and do not allow for assessments of change over time or causal inferences (Wang & Cheng, 2020). Future research could benefit from employing a longitudinal design to track changes in racial trauma and other mental health outcomes over time, providing a more comprehensive understanding of these phenomena.

Another limitation was the reliance on self-report measures, which introduced the potential for social desirability bias and retrospective recall bias (Holtgraves, 2004). Participants may have been inclined to provide socially desirable responses or may have had difficulty accurately recalling past experiences, leading to inaccuracies in the data (Furnham & Henderson, 1982; Rosenman et al., 2011). To mitigate these biases, future research could incorporate multiple methods of data collection, such as observational measures or informant

reports, to triangulate findings and enhance the validity of results. Additionally, the study's use of clinical measures of depression, anxiety, and PTSD may pathologise normal responses to racial trauma and overlook the potential for traumatic growth or resilience. By focusing solely on clinical symptoms, the study may fail to capture the full range of psychological experiences associated with racial trauma, including adaptive coping strategies and post-traumatic growth (Anderson, 2018; Ching et al., 2023; Grier-Reed et al., 2023). Future research could benefit from incorporating measures that assess both clinical and non-clinical dimensions of mental health, allowing for a more comprehensive understanding of individuals' psychological well-being in the context of racial trauma.

Moreover, certain aspects of the study's methodology may have introduced sources of bias or confounding that necessitate scrutiny. For instance, the survey's formulation of questions pertaining to the frequency of negative racial experiences and/or the time since racial experience(s) may have been ambiguous, potentially compromising the accuracy and reliability of participant responses (Fowler, 1992), or contributing to the potentially systematic missing data for the IES-R and ITQ measures. Similarly, the decision not to track IP addresses for anonymity purposes, while ethically sound, may have inadvertently led to the inclusion of duplicate responses or participation by non-authentic respondents, thereby introducing noise and bias into the data.

Furthermore, concerns regarding the initial recruitment process highlight potential shortcomings in participant engagement and retention. For instance, the initial failure to specify the expected duration of the survey in the recruitment process may have contributed to participant attrition, underscoring the importance of transparent communication in recruitment efforts (Gelinas et al., 2017). Similarly, the failure to initially check for typographical errors or missing information in the recruitment materials may have deterred

potential participants. Although this was resolved early on in the recruitment process, this may have still affected the representativeness of the sample (Shreffler & Huecker, 2023).

Additionally, another limitation of the study is related to use of opportunity and snowball sampling. These methods, while useful for accessing participants within specific networks, likely resulted in an overrepresentation of participants with similar characteristics to the researcher, such as age, gender, and racial background. Approximately 82% of the participants were female and predominantly working class, which may not accurately represent the broader population. This recruitment bias limits the generalisability of the findings, as the experiences and perspectives of this particular group may not fully capture the diversity of racial trauma and mental health outcomes across different demographics. To address this limitation, future studies should utilise a range of recruitment strategies, including randomised sampling and outreach to diverse communities, to ensure a more representative sample and enhance the validity of the research findings.

These methodological shortcomings highlight the importance of clear and transparent communication with participants and robust data management procedures to ensure the integrity of research findings.

The researcher's perception of hastiness in selecting measures due to project constraints raises questions about the adequacy and appropriateness of the chosen instruments. Given the complex and multifaceted nature of racial trauma experiences, using measures that do not capture the full spectrum of symptoms and manifestations may limit the validity and comprehensiveness of the findings (DeVellis & Thorpe, 2021). For instance, the TSDS, while widely used, may not adequately capture nuanced manifestations of racial trauma beyond psychological and emotional symptoms, particularly those related to embodied or societal expressions. This limitation underscores the need for careful

consideration and piloting of measurement tools to ensure their appropriateness and validity in capturing the constructs of interest.

Additionally, although, standardised clinical measures of mental health were chosen to allow for better interpretation and comparison with existing research findings, the study's use of clinical measures of depression, anxiety, and PTSD may overlook non-clinical manifestations of distress. By pathologising normal responses to abnormal experiences, these measures may inadvertently exclude individuals whose distress falls below clinical thresholds (Johnson et al., 2022), thereby obscuring the true prevalence and severity of mental health outcomes associated with racial trauma. Additionally, the assumption of traumatic stress without consideration of potential pathways to growth and resilience overlooks the adaptive strategies and coping mechanisms individuals may develop in response to racial trauma (Griffin & Armstead, 2020; Holmes et al., 2024; Polanco-Roman et al., 2016).

4.3.2 Strengths

Alignment with Research Aims and Questions

The findings of the study are consistent with the research aims and questions outlined in the introduction chapter. The study aimed to examine the prevalence of racial trauma and its link to mental health outcomes in young adults from diverse ethnicities and regions within the UK, as well as to investigate the intersectionality of demographic and socio-cultural factors in shaping these experiences. Significant positive associations suggest that there are relationships between racial trauma and depression, anxiety, and PTSD. Additionally, the study's focus on demographic and socio-cultural moderators, such as gender, immigration generation, and ethnic identity, aligns with the aim of investigating intersectional factors that may influence the experience of racial trauma and other mental health outcomes (Choi et al., 2013; Pilver et al., 2011; Stevens-Watkins et al., 2014; Watson et al., 2016). By

demonstrating consistency between the findings and the research aims and questions, the study enhances the credibility and validity of its conclusions.

Comprehensive Data Analysis

A notable strength of the current study lies in its comprehensive data analysis approach, particularly the utilisation of bivariate correlation analyses. By using Spearman's rank-order correlation coefficient, the study was able to uncover strong positive associations between lifetime racial discrimination and racial trauma scores, as well as significant relationships between racial trauma and various mental health outcomes such as depression, anxiety, and PTSD. This methodological choice is particularly advantageous in the context of non-normally distributed or ordinal data, as it does not rely on assumptions of linearity or homoscedasticity like Pearson's correlation (Temizhan et al., 2022). The use of Spearman's rho enhances the robustness of the findings and ensures that the observed relationships are not influenced by violations of parametric assumptions (Wilcox, 2012).

Handling of Missing Data

Missing values from the IES-R and ITQ measures were handled through MI. Methodologically, this approach ensured that potential biases and loss of statistical power, that may occur when missing data is simply ignored or excluded from the analysis, were mitigated. By generating multiple completed datasets with imputed values, more reliable estimates and standard errors were obtained. By handling the data through MI, a more accurate representation of the true variability in the data, and enhancement of the validity of study findings were achieved (Enders, 2023; Little & Rubin, 2019). Moreover, adopting this approach enhanced the transparency and credibility of the research findings. By considering the systematic nature of the missing data, the limitations of the data and the potential impact of missing values on the study outcomes were conveyed (Graham, 2009). This transparency enabled the study's audience to assess the robustness of the findings and understand the

nuances of the relationship between racial trauma, other mental health outcomes, and the presence of missing data.

Varied Participant Sample

One of the notable strengths of this study is its inclusion of participants from different geographic regions across the United Kingdom. The recruitment strategy ensured representation from regions such as London, South East England, East England, Scotland, and the East Midlands, among others. This geographic diversity is essential, as it allows for a more comprehensive understanding of the relationship between racial trauma and other mental health outcomes across different socio-cultural contexts within the UK, though more participants from regions such as Scotland, Wales and East Midlands would have been welcomed. Previous research has highlighted the importance of considering regional differences in racial discrimination experiences and their effects on psychological well-being (Chen & Mallory, 2021; Kim et al., 2017).

Additionally, the study's participant sample demonstrated considerable racial and ethnic diversity, encompassing individuals from various racial and ethnic backgrounds, reflecting the multicultural nature of contemporary UK society. This diversity was essential for several reasons. First, it acknowledged the heterogeneity of racial trauma experiences among different racial and ethnic groups, highlighting the unique challenges faced by each group within the broader context of racism and discrimination (Gong et al., 2017). Second, it allowed for a more nuanced exploration of the relationships between racial trauma and other mental health outcomes across diverse racial and ethnic identities. Research has shown that experiences of racial discrimination can vary significantly based on racial and ethnic identity, with implications for mental health (Cho et al., 2022). By including participants from diverse racial and ethnic backgrounds, the study captures this variability and provides insights into the complex relationship between race, racism, and psychological well-being.

These strengths underscore the significance of the study's findings and provide a solid foundation for future research and implications for clinical practice.

4.4 Self-Reflexivity

As the researcher conducting this quantitative study, I recognise the importance of critically reflecting on my positionality and how it may have influenced the research process and interpretation of findings. Despite the absence of direct contact with the study participants, my identity and personal experiences as a 29-year-old Black woman, living in the UK, undoubtedly shaped my approach to exploring racial trauma and its relationship with mental health outcomes.

As someone with personal experiences of racial adversity within the UK context, I brought a nuanced perspective to the study that went beyond academic curiosity. This insider perspective allowed me to empathise with the experiences of the study participants and recognise the significance of their narratives within broader social and historical contexts. However, this insider perspective also posed challenges, as it required careful navigation to prevent assumptions based on personal experiences from influencing the study's objectivity. The intersectionality of my identity, encompassing both race and gender, inherently influenced the framing, interpretation, and emphasis of the study. It is important to recognise that my standpoint brings a particular lens to the exploration of racial trauma, emphasising the importance of acknowledging and critically examining these positionalities.

While quantitative methods were employed in this study, I recognise the limitations of this approach in fully capturing the lived experiences of racially marginalised individuals. The choice to use quantitative methods was driven by the need to examine large-scale patterns and associations across diverse demographic groups, however, I acknowledge that qualitative methods may have offered a more in-depth understanding of the subjective experiences of racialised individuals. Additionally, as the researcher, my identity as a 29-

year-old Black woman has likely influenced both the recruitment process and the demographic composition of the study participants through the use of opportunity and snowball sampling methods. While this may offer valuable insights into the experiences of a specific group, it also highlights the impact of my own background on the study's participant composition. This self-awareness is crucial for understanding how the findings might relate to the broader population.

With this study, I aimed to bridge the gap between academic research and the real-world impact of racial trauma on mental health. However, this choice required heightened self-awareness to avoid over-generalisation and to recognise the diversity of experiences within racialised communities. It is however essential to acknowledge that despite my efforts to maintain reflexivity and self-awareness, I am aware of how my positionality as a researcher inevitably influenced certain aspects of the study; for example, how my lived experiences as a Black woman navigating various socio-cultural contexts will have likely shaped the formulation of research aims and questions, as well as the selection of measures and analytical techniques. My alignment with the experiences of racialised individuals adds depth to the research but also introduces potential biases rooted in personal subjectivity. Throughout the research process, I maintained a reflexive stance, constantly interrogating my own biases and assumptions to ensure transparency and rigour in the study; this involved critically examining my role as a researcher, acknowledging the potential limitations of my perspective, and actively seeking feedback from supervisors to mitigate the impact of my positionality on the research outcomes. Engaging in reflexivity has allowed me to navigate the complexities of conducting research on a topic that holds personal significance.

My dual positionality as both an academic and a member of the racialised community influenced my choice to conduct this study in the manner in which it was executed. Completing my training in a region with limited racial diversity made me more aware of the

need to address gaps in the existing literature, however, it is important to acknowledge that my positionality as a researcher is multifaceted and dynamic, influenced by intersecting dimensions of identity, social location, and my professional role.

4.5 Conclusion

To conclude, the current study explored the relationship between racial trauma and other mental health outcomes, shedding light on the significant impact of racial adversity on young adults' psychological well-being within the UK. A cumulative effect of racial adversity on mental health was found, with repeated exposure to racial adversity seeming to exacerbate this relationship. The study considered the socio-cultural and historical contexts of the UK and explored the potential moderating role of variables including regional diversity levels, ethnic identity, immigration generation and self-identified perceived social class. Though few intersectional factors moderated the relationship between racial trauma and the other mental health outcomes, there is a need for a larger and more diverse sample in order to make more robust conclusions. Though the levels of psychological distress decreased as regional diversity levels increased, the persistent experience of racial trauma and racial adversity across regions would suggest that the impact of racial adversity on racialised young adults in the UK, is a key concern. As young adulthood is an important life stage for transitions, socialisation and identity development, it is critical to acknowledge the impact that racial trauma has on young adults' developmental pathways and the interconnectedness of identity development during this stage of life. With the nature of racial trauma being inherently chronic and recurring, it is important for policymakers, mental health professionals, and community stakeholders to work together in developing treatment and legislation that fosters equity, safety, support and the potential for PTG. Future research should aim to disentangle the distinct constructs of PTSD and racial trauma to advance understanding of their unique

etiological pathways, symptom presentations, and treatment implications. Longitudinal studies are also recommended to explore how racial trauma unfolds over time.

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Appendices

Appendix A. NICE QAC Checklist

Appendix G Quality appraisal checklist – quantitative studies reporting correlations and associations

A correlates review (see section 3.3.4) attempts to establish the factors that are associated or correlated with positive or negative health behaviours or outcomes. Evidence for correlate reviews will come both from specifically designed correlation studies and other study designs that also report on correlations.

This checklist[15] has been developed for assessing the validity of studies reporting correlations. It is based on the appraisal step of the 'Graphical appraisal tool for epidemiological studies (GATE)', developed by Jackson et al. (2006).

This checklist enables a reviewer to appraise a study's internal and external validity after addressing the following key aspects of study design: characteristics of study participants; definition of independent variables; outcomes assessed and methods of analyses.

Like GATE, this checklist is intended to be used in an electronic (Excel) format that will facilitate both the sharing and storage of data, and through linkage with other documents, the compilation of research reports. Much of the guidance to support the completion of the critical appraisal form that is reproduced below also appears in 'pop-up' windows in the electronic version[16].

There are 5 sections of the revised GATE. Section 1 seeks to assess the key population criteria for determining the study's **external validity** – that is, the extent to which the findings of a study are generalisable beyond the confines of the study to the study's source population.

Sections 2 to 4 assess the key criteria for determining the study's **internal validity** – that is, making sure that the study has been carried out carefully, and that the identified associations are valid and are not due to some other (often unidentified) factor.

Checklist items are worded so that 1 of 5 responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
–	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
Not reported (NR)	Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered.
Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case–control studies).

In addition, the reviewer is requested to complete in detail the comments section of the quality appraisal form so that the grade awarded for each study aspect is as transparent as possible.

Each study is then awarded an overall study quality grading for internal validity (IV) and a separate one for external validity (EV):

- ++ All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.
- + Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
- – Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Checklist

Study identification: Include full citation details	

Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? • Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?	++ + – NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? • Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? • Was the eligible population representative of the source? Were important groups underrepresented?	++ + – NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? • Was the method of selection of participants from the eligible population well described? • What % of selected individuals or clusters agreed to participate? Were there any sources of bias? • Were the inclusion or exclusion criteria explicit and appropriate?	++ + – NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		

2.1 Selection of exposure (and comparison) group. How was selection bias minimised? • How was selection bias minimised?	++ + – NR NA	Comments:
2.2 Was the selection of explanatory variables based on a sound theoretical basis? • How sound was the theoretical basis for selecting the explanatory variables?	++ + – NR NA	Comments:
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + – NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled? • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	++ + – NR NA	Comments:
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + – NR NA	Comments:
Section 3: Outcomes		

3.1 Were the outcome measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking –)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + – NR NA	Comments:
3.2 Were the outcome measurements complete? • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	++ + – NR NA	Comments:
3.3 Were all the important outcomes assessed? • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + – NR NA	Comments:

3.5 Was follow-up time meaningful? • Was follow-up long enough to assess long-term benefits and harms? • Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? • A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. • Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	++ + – NR NA	Comments:
4.2 Were multiple explanatory variables considered in the analyses? • Were there sufficient explanatory variables considered in the analysis?	++ + – NR NA	Comments:
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + – NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:

Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? • Are there sufficient details given about the study to determine if the findings are generalisable to the source population? • Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	++ + –	Comments:

[15] Appraisal form derived from: Jackson R, Ameratunga S, Broad J et al. (2006) The GATE frame: critical appraisal with pictures. Evidence Based Medicine 11: 35–8.

[16] Available from CPHE on request.

Appendix B. Ethical Approval

Decision - Ethics ETH2223-1028: Miss Blessing Bakare

ERAMS <erams@essex.ac.uk>
Thu 01/06/2023 10:35
To:Bakare, Blessing A <bb21223@essex.ac.uk>

University of Essex ERAMS

01/06/2023

Miss Blessing Bakare

Health and Social Care

University of Essex

Dear Blessing,

Ethics Committee Decision

Application: ETH2223-1028

I am pleased to inform you that the research proposal entitled "The influence of racial trauma on mental health outcomes in young adulthood" has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Beverley Pascoe

Ethics ETH2223-1028: Miss Blessing Bakare

Appendix C. Study Recruitment Poster

RESEARCH PARTICIPANTS NEEDED

The influence of racial trauma on mental health outcomes in young adulthood

Are you aged 18-30, currently living in the UK?

Are you from a racialised background*?

then you are invited to participate in an online survey about the influence of racial trauma on mental health outcomes in early adulthood.

SCAN THE QR CODE TO FIND OUT MORE & TAKE PART IN THE STUDY

participation is voluntary and you are free to withdraw at any time

Got questions? Contact me to find out more

Blessing Bakare
Trainee Clinical Psychologist (Principal Investigator)

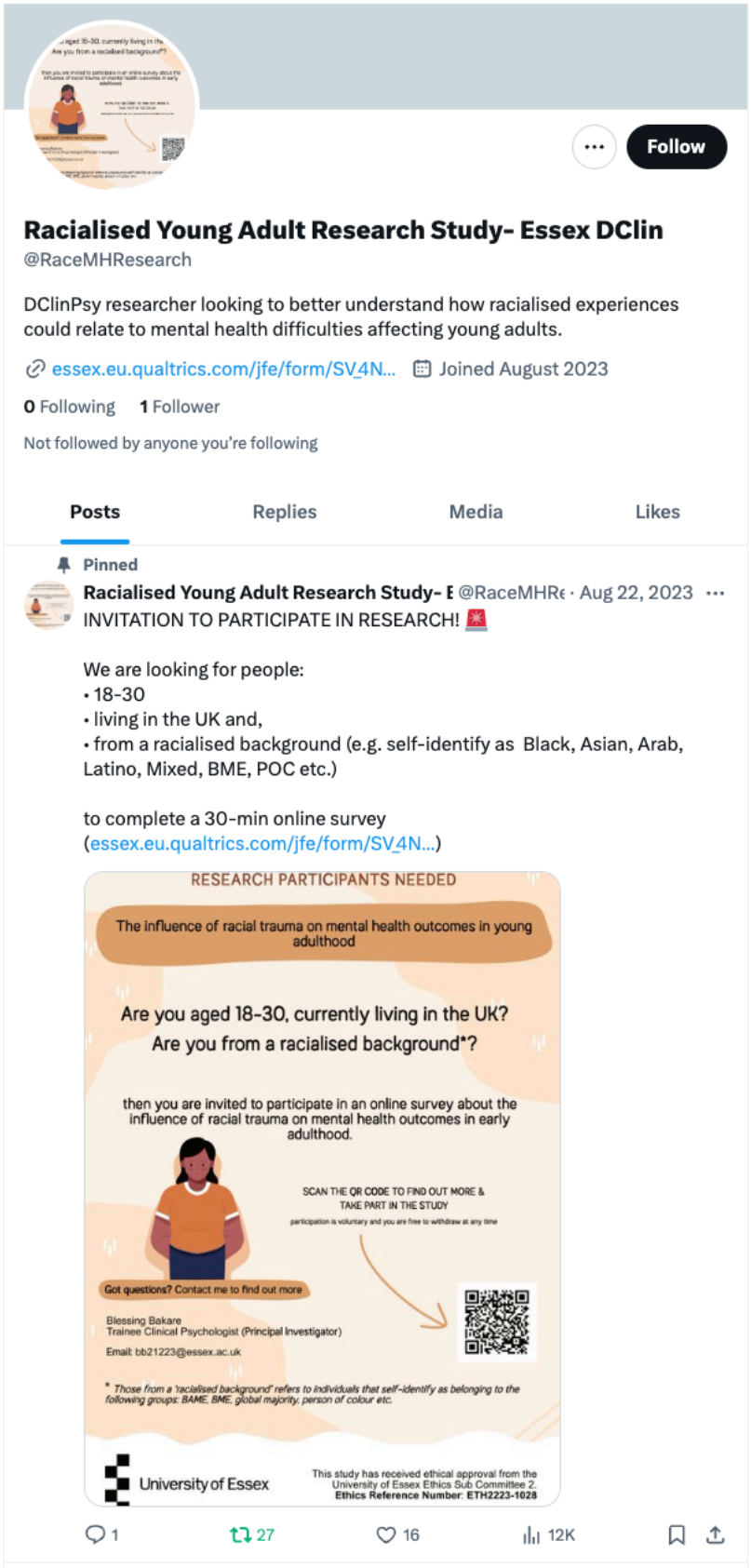
Email: bb21223@essex.ac.uk

* *Those from a 'racialised background' refers to people who self-identify as belonging to the following groups: BAME, BME, global majority, person of colour etc.*

University of Essex

This study has received ethical approval from the University of Essex Ethics Sub Committee 2.
Ethics Reference Number: **ETH2223-1028**

Appendix D. X Recruitment



Appendix E. LinkedIn Recruitment

[redacted]
Trainee Clinical Psychologist [redacted]
7mo

INVITATION TO PARTICIPATE IN RESEARCH!
(inclusion criteria updated)

criteria to participate:
• 18-30
• living in the UK and,
• from a racialised background*

you do not need to self-identify as having experienced racial trauma to participate.

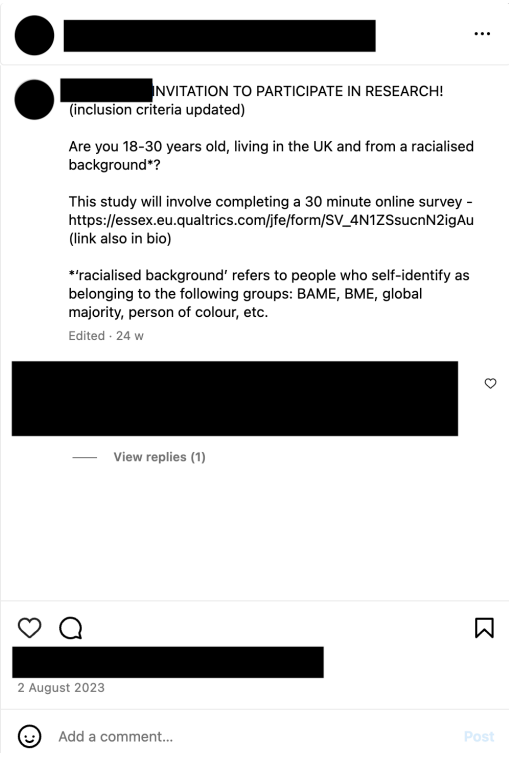
to complete an anonymous 30-minute online survey
(https://lnkd.in/eadKxMMm)

*'racialised background' refers to people who self-identify as belonging to the following groups: e.g., Black, Asian, Arab, Latino, Mixed, BME, BAME, global majority, person of colour, etc.

#research #traumaresearch #racialtrauma
#bame #bme #mentalhealthresearch #dyclinpsy #thesis

[redacted]
3 comments · 128 reposts

Appendix F. Instagram Recruitment



Appendix G. Information Sheet

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Wivenhoe Park
Colchester, Essex
CO4 3SQ

The influence of racial trauma on mental health outcomes in young adulthood

PARTICIPANT INFORMATION SHEET

My name is Blessing Bakare and I am a Trainee Clinical Psychologist. I would like to invite you to take part in a research study. I am carrying out this research as a part of a Doctorate in Clinical Psychology with the Department of Health and Social Care at the University of Essex. This research will form the basis of a doctoral thesis.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

If after reading the information you have any additional questions, you are welcome to email me, the principal investigator (see contact details below). After you are satisfied that you understand this study, and wish to take part, you can move on to the next page where you will be provided with a consent form to sign and can continue with the rest of the study. If you do not wish to take part, please close your browser window and this will exit the survey for you.

Study Title: The influence of racial trauma on mental health outcomes in young adulthood

Invitation to participate: If you are 18-30 years old, living in the UK and from a racialised background, then you are invited to participate in an online survey about the influence of racial trauma on mental health outcomes in young adulthood.

For the purpose of this study, those from a "racialised background" refers to people who self-identify as belonging to the following groups: BAME, BME, global majority, person of colour etc.

Background Information: This study aims to explore the relationship between racial trauma and mental health issues, particularly for those in the young adulthood life stage. The term 'racial trauma' describes events connected to a real or perceived experience of racial discrimination, including incidents of humiliation and shame, threats of injury and personal harm, and witnessing harm to others because of real or perceived racism (Carter, 2007). Most research in this area has been conducted in the United States, where racial discourse differs from here in the UK.

Your participation: It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part, you will be asked to provide written consent on the next page.

Your participation in this study is voluntary and you are free to exit the study at any time, without any reason and without penalty. You can exit the survey, even after you have started, by closing the browser window. All incomplete survey responses will automatically be removed. Due to the anonymous nature of your responses, you will be unable to withdraw from the study once your responses have been submitted.

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References:

Carter, R. T. (2007). Racism and psychological emotional injury: Recognizing and assessing race-based traumatic stress. *Counseling Psychologist*, 35, 13–105. http://dx.doi.org/10.1177/0011000006292033

Thank you for reading this information sheet and for considering to take part in this research study.

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- **BAATN** (Black, African and Asian Therapy Network):
  https://www.baatn.org.uk/find-a-psych-therapist
  It is a UK-based organisation that provides support and a therapist directory that connects clients with Black, African, and Asian therapists.

- **The Mix:**
  https://www.themix.org.uk
  One-to-one chat and messenger services, discussion boards and information for under 25s.

- **Mind:**
  https://www.mind.org.uk/
  InfoLine: 0300 123 3393
  The Mind InfoLine can help you find specialist services in your area. Helplines and listening services.

- **Samaritans:**
  https://www.samaritans.org
  24 hours a day, 365 days a year. Call 116 123 (free from any phone).

- **Shout:**
  https://www.giveusashout.org
  For immediate support text SHOUT to 85258 to chat by text to a trained and supervised volunteer. Free, confidential and available 24 hours a day, 365 days a year.

- **Sane:**
  https://www.sane.org.uk
  SANELine: 0300 304 7000
  Online support forum and SANEline that is open between 4pm to 10pm, 365 days a year

- **Hub of Hope:**
  https://hubofhope.co.uk/
  A national mental health database, bringing help and support together in one place.

- For more options, visit the Helplines Partnership website for a directory of UK helplines:
  https://www.helplines.org/helplines

- You can also contact your GP, who can provide support and refer you to the relevant local services.

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Contact details:

Principal investigator
Blessing Bakare (Trainee Clinical Psychologist)
School of Health and Social Care,
University of Essex, Wivenhoe Park, Colchester, CO4 3SQ
Email: bb21223@essex.ac.uk

Research Supervisor
Dr Danny Taggart
School of Health and Social Care,
University of Essex, Wivenhoe Park, Colchester, CO4 3SQ
Email: dtaggart@essex.ac.uk
Phone: 01206 874100

Research Supervisor
Prof. Winifred Eboh
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University of Essex, Wivenhoe Park, Colchester, CO4 3SQ
Email: w.eboh@essex.ac.uk
Phone: 01206 874659

Clinical Director for the Doctorate in Clinical Psychology
Dr Frances Blumenfeld
University of Essex, Wivenhoe Park, Colchester, CO4 3SQ
Email: fblume@essex.ac.uk
Phone: 01206 873125

University of Essex Research Governance and Planning Manager
Sarah Manning-Press
Research & Enterprise Office
University of Essex, Wivenhoe Park, Colchester, CO4 3SQ
Email: sarahm@essex.ac.uk.
Phone: 01206 873561

Resources for support:
The following services and resources are available if you have been affected by the contents of the study and would like some support:

- **NHS IAPT** (Improving Access to Psychological Therapy):
  Local NHS IAPT service search: https://www.nhs.uk/service-search/other-services/Psychologicaltherapies(IAPT)/LocationSearch/10008

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saved and stored in a University of Essex Box folder. The research team will have access to and manage your data, and ensure UK General Data Protection Regulation (UK GDPR) rules are met.

Research data used for the study will be retained for a period of at least ten years after the completion of the project, at which point all stored data will be destroyed. Our legal basis for processing your data is that you have consented to it. The data controller is the University of Essex and Essex University's Data Protection Officer can be contacted on dpo@essex.ac.uk.

Dissemination of findings: Once data has been collected, the findings will be written as a part of a doctoral thesis in Clinical Psychology. The presentation and publication of findings in conferences, online platforms, magazines and peer-reviewed journals will also be considered. If you would like to receive a copy or summary of the research findings, please email the principal investigator (see contact details below). All data will be anonymised, and you will not be identifiable in any report, publication or presentation.

As part of the principal investigator's thesis submission, the research project will also be uploaded to the University of Essex Research Repository.

The benefits of participating: I aim to study this concept so that we can better understand how mental health difficulties develop through certain trauma. The benefits of conducting this research will therefore include a better understanding of the relationship between racial trauma and mental health issues, so that new treatment and prevention strategies can be developed.

There is no guarantee or promise that you will receive any personal benefits from this study.

Possible risks, discomforts, and inconveniences: In some cases, there is a risk of you experiencing anxiety, distress, or increasing symptoms of PTSD or suicidal ideation whilst completing the measures. In such case, you are encouraged to discontinue the study or take a break at any time.

If you experience any of the above, there are contact details below for services that can provide you with support if you require psychological input or need someone to talk to.

Concerns and complaints: If you have any concerns or complaints about any aspect of the study, in the first instance please contact the principal investigator, Blessing Bakare (see contact details below). If are still concerned or you think your complaint has not been addressed to your satisfaction, please contact Dr Frances Blumenfeld (Clinical Director for the Doctorate in Clinical Psychology - Email: fblume@essex.ac.uk, phone: 01206 873125). If you are still not satisfied, please contact the University's Research Governance and Planning Manager (Sarah Manning-Press - Email: sarahm@essex.ac.uk, phone: 01206 873561).

Funding: This research is not funded.

Ethical approval: This study has been reviewed by the University of Essex Ethics Sub-Committee 2 and has been given ethical approval.

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What the research involves: This study will involve completing an online consent form and providing demographic and sociocultural information (age, sex, socioeconomic status, class, racial identity, ethnic identity, disability, gender identity, sexual orientation, religion, first-language, immigration, employment). You will then be invited to complete the following measures:

- The Patient Health Questionnaire (PHQ-9): This involves indicating how often you have been bothered by nine problems, on a scale of 0-3.
- The Generalized Anxiety Disorder Scale (GAD-7): This involves indicating how often you have been bothered by seven problems, on a scale of 0-3.
- Impact of Events Scale-Revised (IES-R): This involves indicating how much you agree with 22 statements, on a scale of 0-4.
- International Trauma Questionnaire (ITQ): This involves indicating how often you have been bothered by 18 problems, on a scale of 0-4.
- Trauma Symptoms of Discrimination Scale (TSDS): This involves indicating how often you have experienced 21 problems, on a scale of 0-4, and indicating the types of discrimination you have experienced in your lifetime.
- General Ethnic Discrimination Scale (GEDS): This involves indicating how often you have experienced 18 scenarios of racial discrimination, on a scale of 1-6.

The study should take approximately 30 minutes to complete.

Confidentiality and Data Management Plan: All data will be stored and collected in accordance with the Data Protection Act (2018). Participant responses will be collected through the survey site Qualtrics. This is a secure and confidential network will be used to collect your responses, and will not record personal details or IP addresses. All data collected will be anonymous and confidential. Survey responses will not contain any personal information as participants will not be required to provide their names, emails, or any other identifying information. Your data will not be identifiable at any stage of the research.

Once data collection has ended and the survey is closed, the principal investigator (Blessing Bakare) will export and download raw data from Qualtrics as an SPSS data file, which will be used for statistical analysis. Once the raw data is downloaded, it will be kept on Qualtrics for 12 months before being deleted. After initial analysis, the research team may decide that further data may need to be collected. Data may also be requested as part of the principal investigator's thesis submission, which will be submitted to the Doctorate of Clinical Psychology programme administrator and Registry.

All data will be stored anonymously and securely, and will only be accessed by direct members of the research team (Blessing Bakare, Dr Danny Taggart, Prof. Winifred Eboh). Raw data files will be

Appendix H. Consent Form

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CONSENT FORM

Researcher: Blessing Bakare **Researcher Email:** bb21223@essex.ac.uk

Please read and consider the following statements. Click the relevant box to give your consent to take part in the study:

- You have read and understand the information presented in the information sheet

☐ Yes ☐ No

- You have been given the opportunity to consider the information and ask questions by emailing the researcher

☐ Yes ☐ No

- You understand that due to the topic being studied as part of this research, there is a risk of you experiencing anxiety, distress, or increasing symptoms of PTSD or suicidal ideation whilst completing the measures. You understand that you are able to discontinue the study or take a break at any time

☐ Yes ☐ No

- You understand that if you require psychological support following participation in the study, you can access the resources and services mentioned in the information sheet

☐ Yes ☐ No

- You understand that your data will be stored securely and anonymously, and accessible only to members of the research team directly involved with this study. As the data being collected is anonymous, it will not be possible for your specific responses to be removed from the dataset once submitted.

☐ Yes ☐ No

- You understand that your data will be treated confidentially and any publication resulting from this work will report only data that does **not** identify you

☐ Yes ☐ No

- You understand that your participation is voluntary and that you are free to withdraw at any time prior to data submission, without any reason and without penalty.

☐ Yes ☐ No

Appendix I. Socio-Demographic Questions

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You will now be asked some socio-demographic questions.

How old are you?

18 20 22 24 26 28 30

Age

How would you describe your gender

- ○ Male
- ○ Female
- ○ Transgender
- ○ Non-binary / third gender
- ○ Other

How would you describe your sexual orientation?

- ○ Straight or Heterosexual
- ○ Gay or Lesbian
- ○ Bisexual
- ○ Other

How would you describe your racial identity?

- ◯ Black
- ◯ White
- ◯ Asian
- ◯ Arab
- ◯ Latin American
- ◯ Mixed
- ◯ I Don't Know
- ◯ Other

How would you describe your ethnic identity?

- ◯ Black African
- ◯ Black Caribbean
- ◯ Black Other
- ◯ Asian Bangladeshi
- ◯ Asian Indian
- ◯ Asian Pakistani
- ◯ Asian Chinese
- ◯ Asian Japanese
- ◯ Asian Other
- ◯ Latin American
- ◯ Arab
- ◯ Mixed (please state)

[ ]

- ◯ Other (please state)

[ ]

Is English your first language?

- ◯ Yes
- ◯ No (please state)

Which immigration generation do you feel you belong to?

- ◯ 1st generation (born overseas and now lives in the UK)
- ◯ 2nd generation (born in the UK, child of at least one 1st generation parent)
- ◯ 3rd generation (born to parents who were born in the UK, child of 2nd generation parents)

Where in the UK do you live (if you live if multiple parts of the UK, where do you live a majority of the time)?

- ◯ England - London
- ◯ England - South West
- ◯ England - South East
- ◯ England - East
- ◯ England - West Midlands
- ◯ England - East Midlands
- ◯ England - Yorkshire and TheHumber
- ◯ England - North West
- ◯ England - North East
- ◯ Northern Ireland
- ◯ Scotland
- ◯ Wales

How would you describe your religious beliefs?

- ◯ Buddhist
- ◯ Christian
- ◯ Hindu
- ◯ Jewish
- ◯ Muslim
- ◯ Sikh
- ◯ No Religion
- ◯ Other

How would you describe your social class?

- ◯ Lower Class
- ◯ Working Class
- ◯ Middle Class
- ◯ Upper Class

How would you describe your employment status

- ◯ Unemployed
- ◯ Full-time Student
- ◯ Part-time Student
- ◯ Full-time Employee
- ◯ Part-time Employee
- ◯ Self-Employed
- ◯ Full Time Carer/Homemaker

Appendix J. PHQ-9 Measure

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Please complete the following questionnaires.

The Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

Appendix K. GAD-7 Measure

The Generalized Anxiety Disorder Scale (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid, as if something awful might happen	○	○	○	○

Appendix L. IES-R Measure

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Please complete the below questions based on a significant stressful race-based event. If you feel that you have not experienced such event, please move on to the next set of questions.

Impact of Events Scale-Revised (IES-R)

Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to (the event):

that occurred on (date):

How much have you been distressed or bothered by these difficulties?

	None at all	A little bit	Moderately	Quite a bit	Extremely
Any reminder brought back feelings about it	○	○	○	○	○
I had trouble staying asleep	○	○	○	○	○
Other things kept making me think about it	○	○	○	○	○
I felt irritable and angry	○	○	○	○	○
I avoided letting myself get upset when I thought about it or was reminded of it	○	○	○	○	○
I thought about it when I didn't mean to	○	○	○	○	○
I felt as if it hadn't happened or wasn't real	○	○	○	○	○
I stayed away from reminders of it	○	○	○	○	○
Pictures about it popped into my mind	○	○	○	○	○
I was jumpy and easily startled	○	○	○	○	○

I tried not to think about it	○	○	○	○	○
I was aware that I still had a lot of feelings about it, but I didn't deal with them	○	○	○	○	○
My feelings about it were kind of numb	○	○	○	○	○
I found myself acting or feeling like I was back at that time	○	○	○	○	○
I had trouble falling asleep	○	○	○	○	○
I had waves of strong feelings about it	○	○	○	○	○
I tried to remove it from my memory	○	○	○	○	○
I had trouble concentrating	○	○	○	○	○
Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	○	○	○	○	○
I had dreams about it	○	○	○	○	○
I felt watchful and on-guard	○	○	○	○	○
I tried not to talk about it	○	○	○	○	○

Appendix M. ITQ Measure

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Please complete the below questions based on a significant stressful race-based event. If you feel that you have not experienced such event, please move on to the next set of questions.

International Trauma Questionnaire (ITQ)

Please identify the experience that troubles you most and answer the questions in relation to this experience. Brief description of the experience

When did the experience occur? (select one)

- ◯ less than 6 months ago
- ◯ 6 to 12 months ago
- ◯ 1 to 5 years ago
- ◯ 5 to 10 years ago
- ◯ 10 to 20 years ago
- ◯ more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Having upsetting dreams that replay part of the experience or are clearly related to the experience?	◯	◯	◯	◯	◯

Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	○	○	○	○	○
Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	○	○	○	○	○
Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	○	○	○	○	○
Being "super-alert", watchful, or on guard?	○	○	○	○	○
Feeling jumpy or easily startled?	○	○	○	○	○

In the past month have the above problems:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Affected your relationships or social life?	○	○	○	○	○
Affected your work or ability to work?	○	○	○	○	○
Affected any other important part of your life such as parenting, or school or college work, or other important activities?	○	○	○	○	○

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
When I am upset, it takes me a long time to calm down.	○	○	○	○	○
I feel numb or emotionally shut down	○	○	○	○	○
I feel like a failure	○	○	○	○	○
I feel worthless	○	○	○	○	○
I feel distant or cut off from people	○	○	○	○	○

I find it hard to stay emotionally close to people	○	○	○	○	○

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Created concern or distress about your relationships	○	○	○	○	○
or social life?	○	○	○	○	○
Affected your work or ability to work?	○	○	○	○	○
Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	○	○	○	○	○

Appendix N. TSDS Measure

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Trauma Symptoms of Discrimination Scale (TSDS)

When answering the following questions, keep in mind that discrimination is defined as: Being unfairly treated due to an individual characteristic of yourself (e.g., race/ethnicity, gender, sexual orientation, religion).

PART 1: Frequency of Experiences

Experiencing discrimination can be very stressful, and sometimes people can feel specific types of stress due to discrimination that impact their daily lives. This can be caused by **one very** stressful experience of discrimination, or **several smaller** experiences of discrimination over the course of one's life. Based on these experiences in your life, answer the following questions. Please keep in mind that ratings should reflect whether the type of stress was **caused** by discrimination.

	Never	Rarely	Sometimes	Often
Due to past experiences of discrimination, I often worry too much about different things	○	○	○	○
Due to past experiences of discrimination, I often try hard not to think about it or go out of my way to avoid situations that remind me of it	○	○	○	○
Due to past experiences of discrimination, I often fear embarrassment	○	○	○	○
Due to past experiences of discrimination, I often feel nervous, anxious, or on edge, especially around certain people	○	○	○	○
Due to past experiences of discrimination, I often feel afraid as if something awful might happen	○	○	○	○
Due to past experiences of discrimination, I often have nightmares about the past experience or think about it when I do not want to	○	○	○	○
Due to past experiences of discrimination, I often have trouble relaxing	○	○	○	○

Due to past experiences of discrimination, I often feel numb or detached from others, activities, or my surroundings	○	○	○	○
Due to past experiences of discrimination, I often avoid certain activities in which I am the center of attention (i.e., parties, meetings, answering questions in class)	○	○	○	○
Due to past experiences of discrimination, I often cannot stop or control my worrying	○	○	○	○
Due to past experiences of discrimination, I often find that being embarrassed or looking stupid are one of my worst fears	○	○	○	○
Due to past experiences of discrimination, I often become easily annoyed or irritable	○	○	○	○
Due to past experiences of discrimination, I often feel constantly on guard, watchful, or easily startled, especially around certain people or places	○	○	○	○
Due to past experiences of discrimination, I often feel so restless that it is hard to sit still	○	○	○	○
Due to past experiences of discrimination, I feel the world is an unsafe place	○	○	○	○
Due to past experiences of discrimination, in social situations I feel a rush of intense discomfort, and may feel my heart pounding, muscles tense up, or sweat	○	○	○	○
Due to past experiences of discrimination, I feel isolated and set apart from others	○	○	○	○
Due to past experiences of discrimination, I avoid certain situations or speaking to certain people	○	○	○	○
If I think about past experiences of discrimination, I cannot control my emotions	○	○	○	○
Due to past experiences of discrimination, I am nervous in social situations, and am afraid people will notice that I am sweating, blushing, or trembling	○	○	○	○
Due to past experiences of discrimination, fear of social situation causes me a lot of problems in my daily functioning	○	○	○	○

PART 2: : Types of Discrimination Experienced

Below, please indicate the **types** of discrimination you have experienced in your lifetime. Please note that you must enter a corresponding percentage to the type of discrimination experienced. For example, if you've experienced discrimination due to your racial/ethnic background **and** gender, attach a percentage indicating how much of each you have experienced (i.e., Racial/Ethnic = 70%, Gender = 30%).

0 10 20 30 40 50 60 70 80 90 100

Racial/Ethnic

Gender

Sexual Orientation

Social Class

Religion

Age

Disability

Other

Appendix O. GEDS Measure

University of Essex

School of Health & Social Care
Colchester Campus
Wivenhoe Park
Colchester, Essex
CO4 3SQ

General Ethnic Discrimination Scale (GEDS)

We are interested in your experiences with racism. As you answer the questions below, please think about your **ENTIRE LIFE**, from when you were a child to the present. For each question, please circle the number that best captures the things that have happened to you. Answer each questions 3 times.

1. How often have you been treated unfairly by **teachers and professors** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

2. How often have you been treated unfairly by your **employers, bosses and supervisors** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

3. How often have you been treated unfairly by your **co-workers, fellow students and colleagues** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

4. How often have you been treated unfairly by **people in service jobs (by store clerks, waiters, bartenders, bank tellers and others)**

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

5. How often have you been treated unfairly by **strangers** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

6. How often have you been treated unfairly by **people in helping jobs** (by doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers and others) because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

7. How often have you been treated unfairly by **neighbors** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

8. How often have you been treated unfairly by **institutions** (**schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office and others**) because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

9. How often have you been treated unfairly by **people that you thought were your friends** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

10. How often have you been accused or **suspected of doing something wrong** (such as **stealing, cheating, not doing your share of the work, or breaking the law**) because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

11. How often have people **misunderstood your intentions and motives** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

12. How often did you **want to tell someone off for being racist towards you but didn't say anything?**

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

13. How often have you been **really angry about something racist that was done to you?**

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

14. How often have you been **forced to take drastic steps** (such as **filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions**) to deal with some racist thing that was done to you?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

15. How often have you **been called a racist name?**

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

16. How often have you **gotten into an argument or a fight about something racist that was done to you or done to another member of your race/ethnic group?**

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

17. How often have you been **made fun of, picked on, pushed, shoved, hit, or threatened with harm** because of your race/ethnic group?

	Never	Once in a while	Sometimes	A lot	Most of the time	All of the time
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

18. How **different** would your life be now if you ***HAD NOT BEEN*** treated in a racist and unfair way

	The same as it is now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
How often in the past year?	○	○	○	○	○	○
How often in your entire life?	○	○	○	○	○	○

	Not at all stressful (1)	2	3	4	5	Extremely Stressful (6)
How stressful was this for you?	○	○	○	○	○	○

Appendix P. Debrief Sheet

School of Health & Social Care
Colchester Campus
Wivenhoe Park
Colchester, Essex
CO4 3SQ

The influence of racial trauma on mental health outcomes in young adulthood

STUDY DEBRIEF

This study explores the relationship between racial trauma and the development of mental health symptoms in young adulthood. Previous research has highlighted the increased physical and psychiatric distress following experiences of racial trauma in early adulthood, but most research in this area has been conducted in the United States, where racial discourse differs from here in the UK.

How was this tested?
In this study, you answered questions about your identity, your experience of different traumas and symptoms of common mental health difficulties.

What if I have been affected by the contents of the study?
If you have been affected by the contents of the study, there are contact details below for services that can provide you with support if you require psychological input or need someone to talk to.

Why is this study important?
From this research I expect to explore the relationship between racial trauma and the development of mental health symptoms.

I aim to study this concept so that we can better understand how mental health difficulties develop through certain trauma, and therefore the benefits of conducting this research will include a better understanding of the development of mental health issues so that new treatment and prevention strategies can be developed.

What if I want to know more?
If you would like to receive a report of this research when it is completed, or a summary of the research findings, please contact the principal investigator (see contact details below)

What if I want to withdraw from the study?
Your participation in the study is voluntary and you free to withdraw any time until data submission, without any reason and without penalty. Due to the anonymous nature of your responses, you will be unable to withdraw from the study once your responses have been submitted.

What if I have any concerns or complaints?
If you have any concerns or complaints about any aspect of the study, in the first instance please contact the principal investigator (see contact details below).

If are still concerned or you think your complaint has not been addressed to your satisfaction, please contact the Clinical Director for the Doctorate in Clinical Psychology (see contact details below).

If you are still not satisfied, please contact the University's Research Governance and Planning Manager (see contact details below).

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It is a UK-based organisation that provides support and a therapist directory that connects clients with Black, African, and Asian therapists.

- **The Mix:**
  https://www.themix.org.uk
  One-to-one chat and messenger services, discussion boards and information for under 25s.

- **Mind:**
  https://www.mind.org.uk/
  InfoLine: 0300 123 3393
  The Mind InfoLine can help you find specialist services in your area. Helplines and listening services.

- **Samaritans:**
  https://www.samaritans.org
  24 hours a day, 365 days a year. Call 116 123 (free from any phone).

- **Shout:**
  https://www.giveusashout.org
  For immediate support text SHOUT to 85258 to chat by text to a trained and supervised volunteer. Free, confidential and available 24 hours a day, 365 days a year.

- **Sane:**
  https://www.sane.org.uk
  SANELine: 0300 304 7000
  Online support forum and SANEline that is open between 4pm to 10pm, 365 days a year

- **Hub of Hope:**
  https://hubofhope.co.uk/
  A national mental health database, bringing help and support together in one place.

- For more options, visit the Helplines Partnership website for a directory of UK helplines:
  https://www.helplines.org/helplines

  You can also contact your GP, who can provide support and refer you to the relevant local services.

Thank you again for your participation.

Please feel free invite other people to join the study if you feel they would be eligible to participate.

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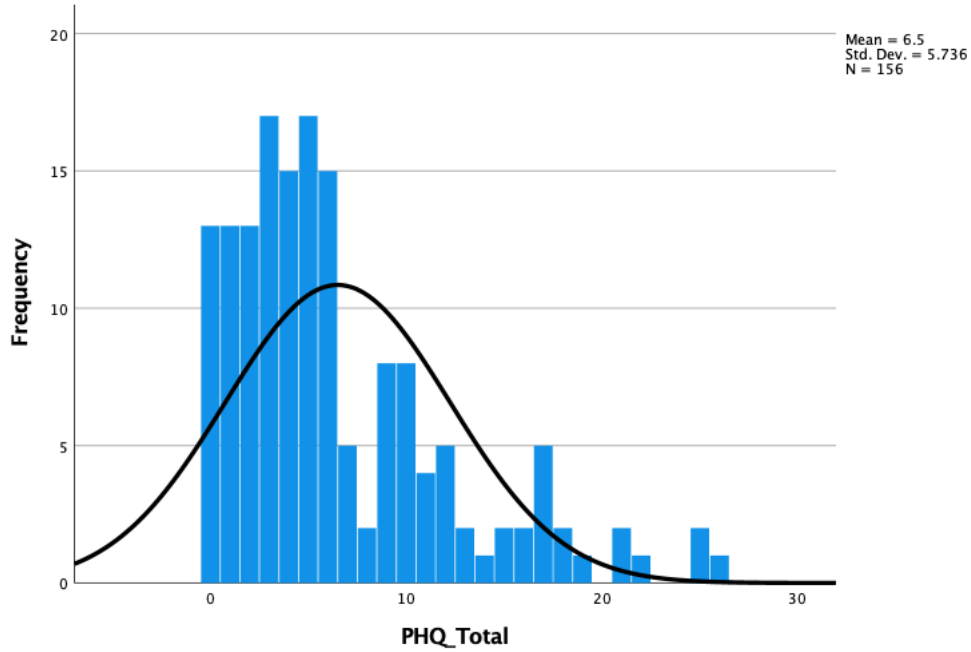
Phone: 01206-873561

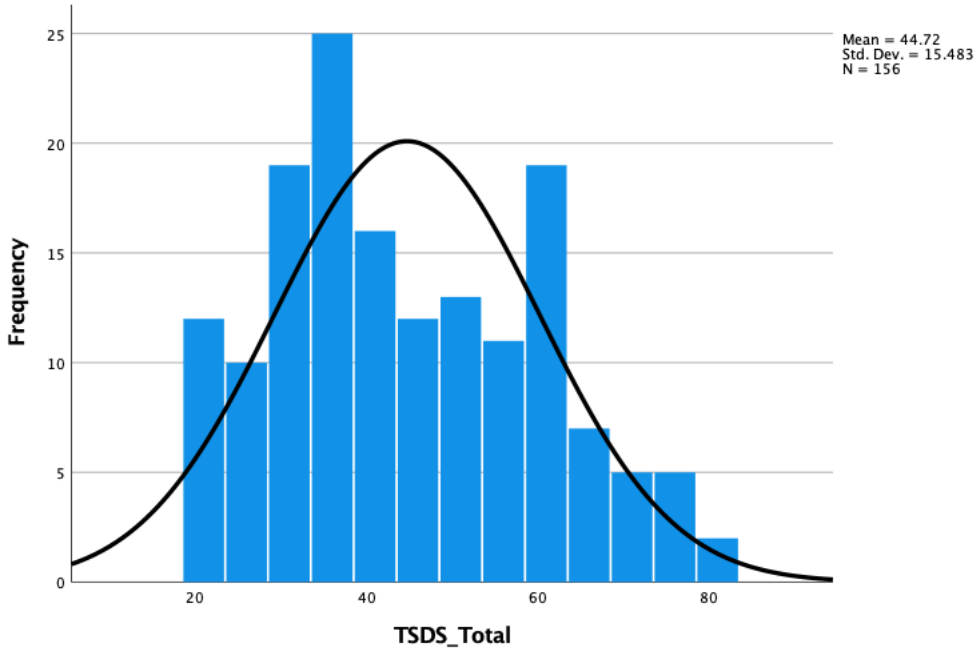
Resources for support:
The following services and resources are available if you have been affected by the contents of the study and would like some support:

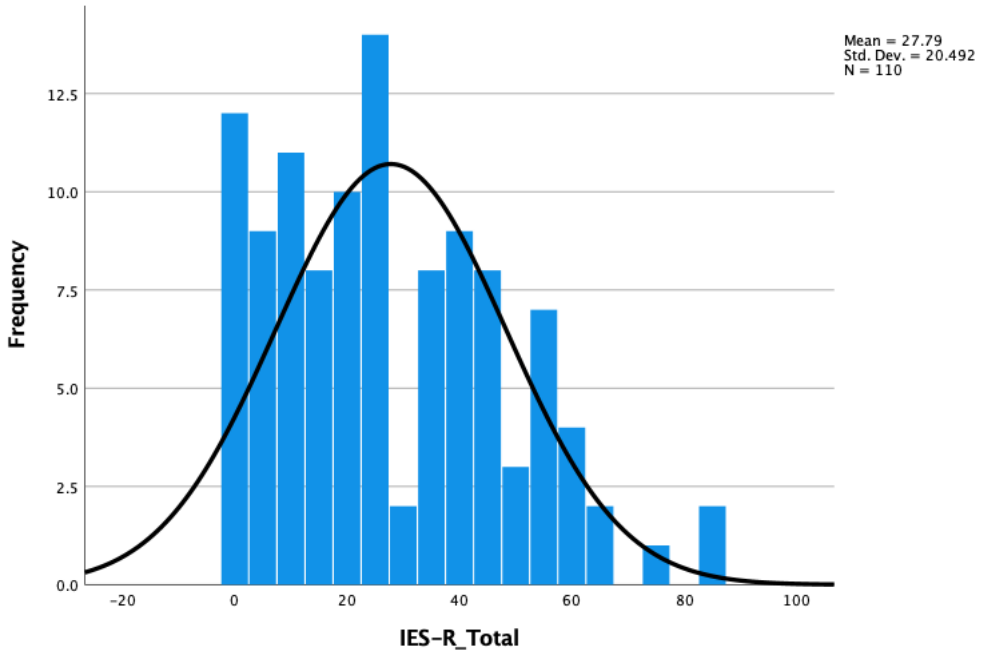
- **NHS IAPT** (Improving Access to Psychological Therapy):
  Local NHS IAPT service search: https://www.nhs.uk/service-search/other-services/Psychologicaltherapies(IAPT)/LocationSearch/10008

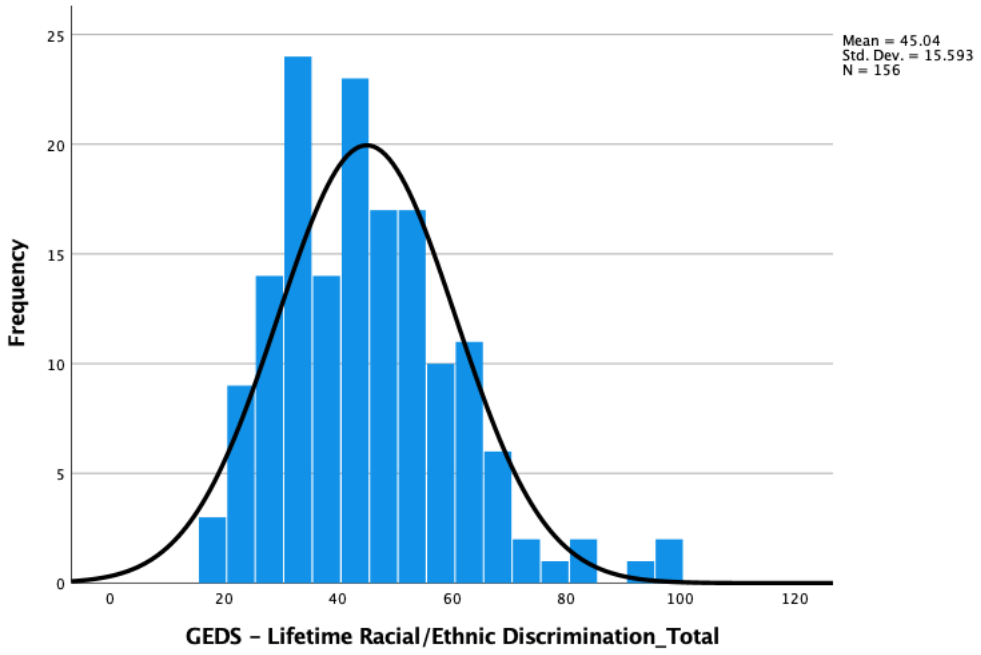
- **BAATN** (Black, African and Asian Therapy Network):
  https://www.baatn.org.uk/find-a-psych-therapist

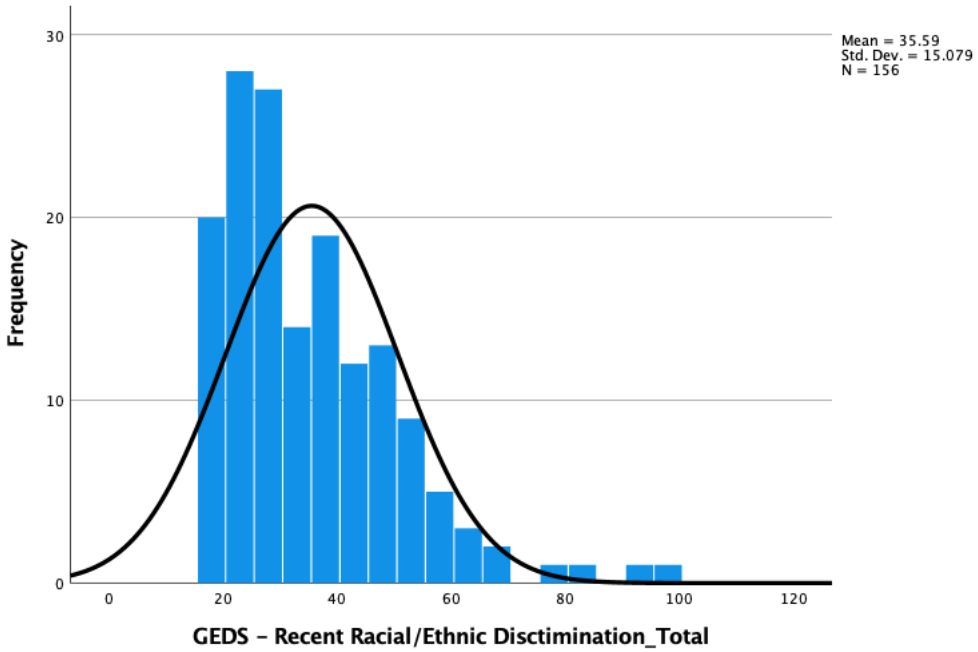
Appendix Q. Histograms for Testing Normality Assumption

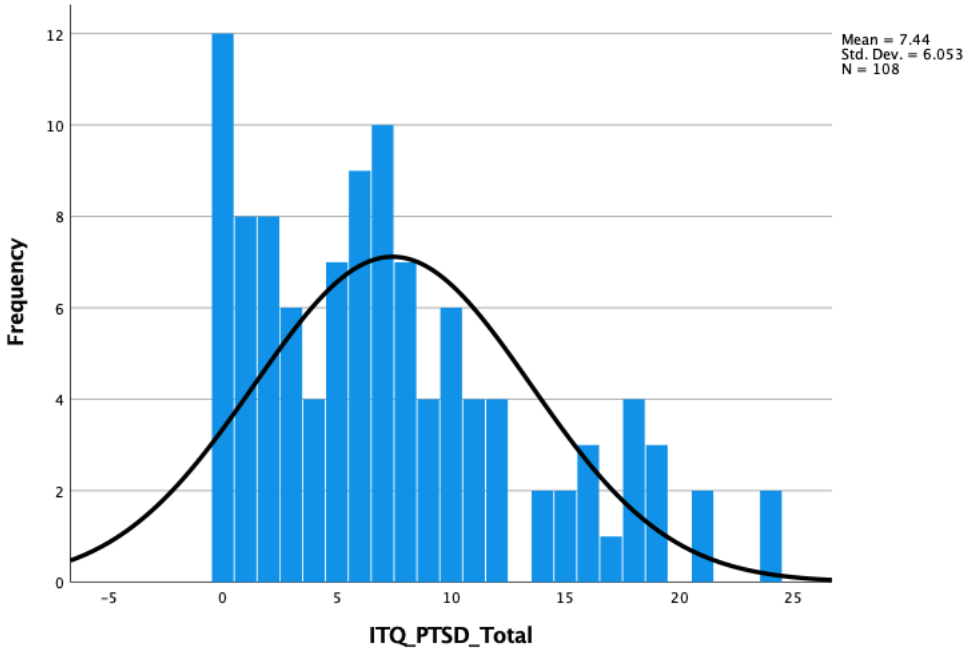




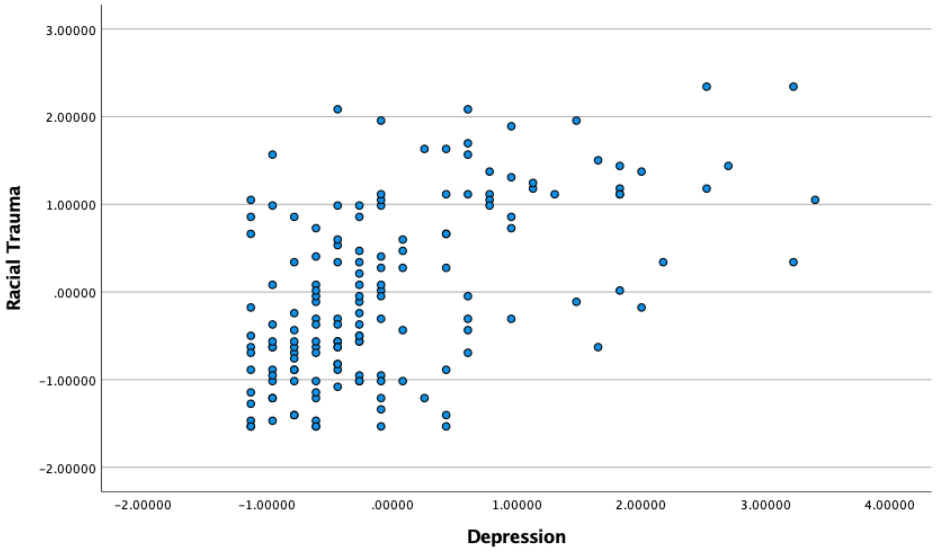

Mean = 27.79
Std. Dev. = 20.492
N = 110
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
-20
0
20
40
60
80
100
IES-R_Total

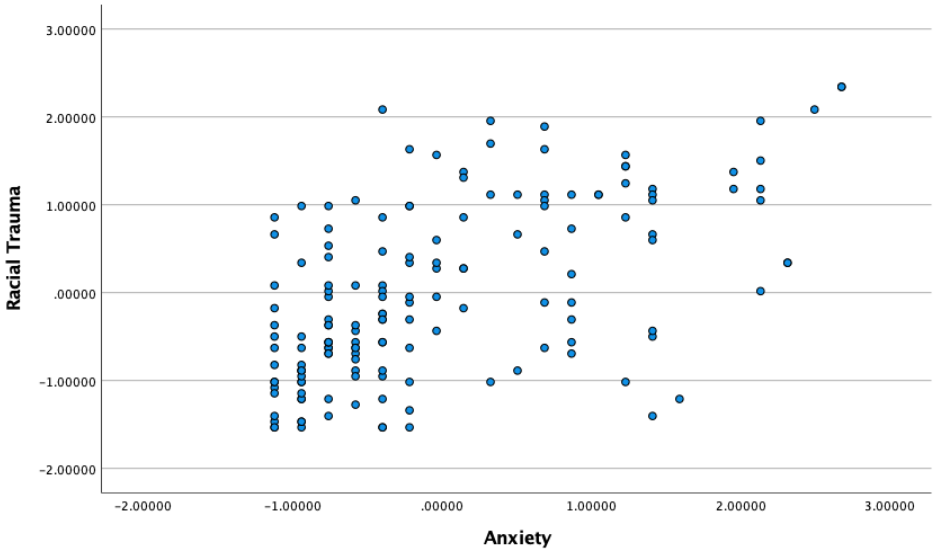

Mean = 45.04
Std. Dev. = 15.593
N = 156
Frequency
25
20
15
10
5
0
0
20
40
60
80
100
120
GEDS – Lifetime Racial/Ethnic Discrimination_Total

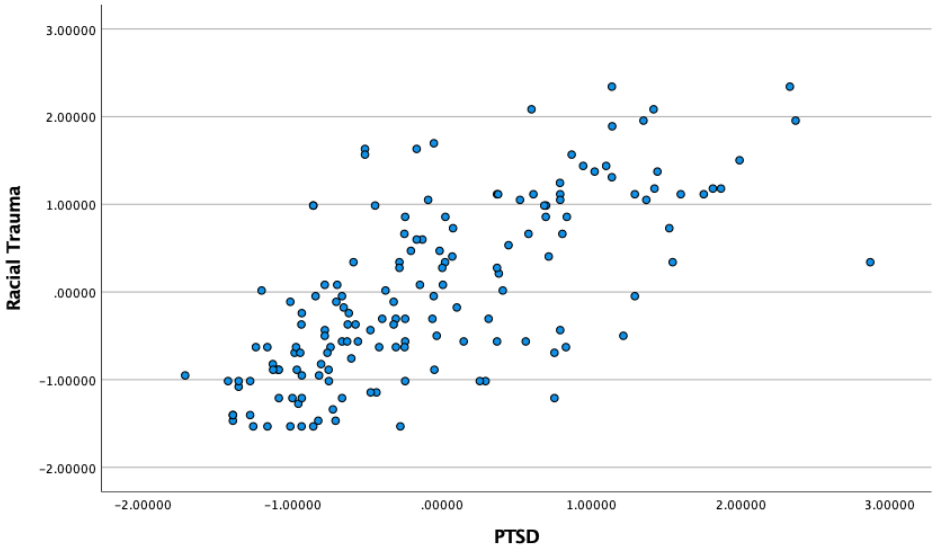

Mean = 35.59
Std. Dev. = 15.079
N = 156
Frequency
30
20
10
0
0
20
40
60
80
100
120
GEDS – Recent Racial/Ethnic Disctimination_Total

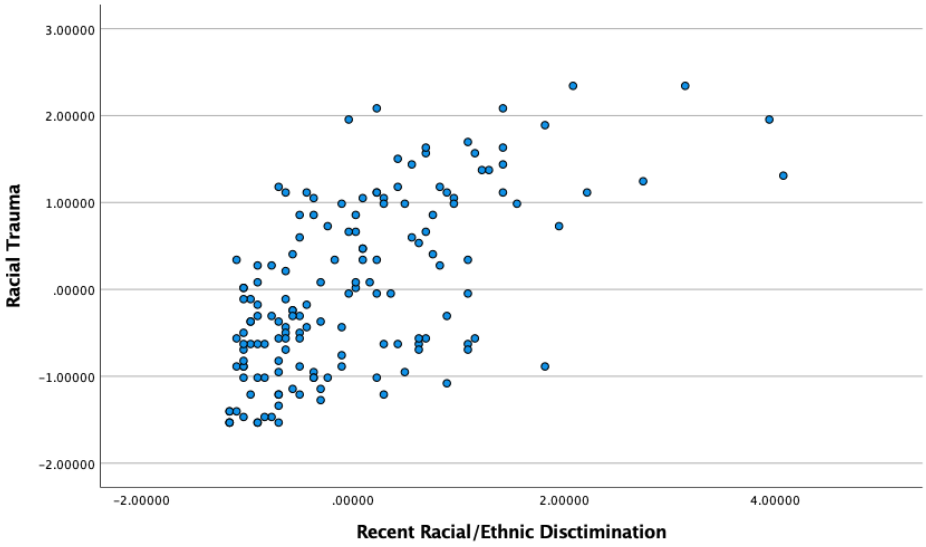

Mean = 7.44
Std. Dev. = 6.053
N = 108
Frequency
12
10
8
6
4
2
0
-5
0
5
10
15
20
25
ITQ_PTSD_Total

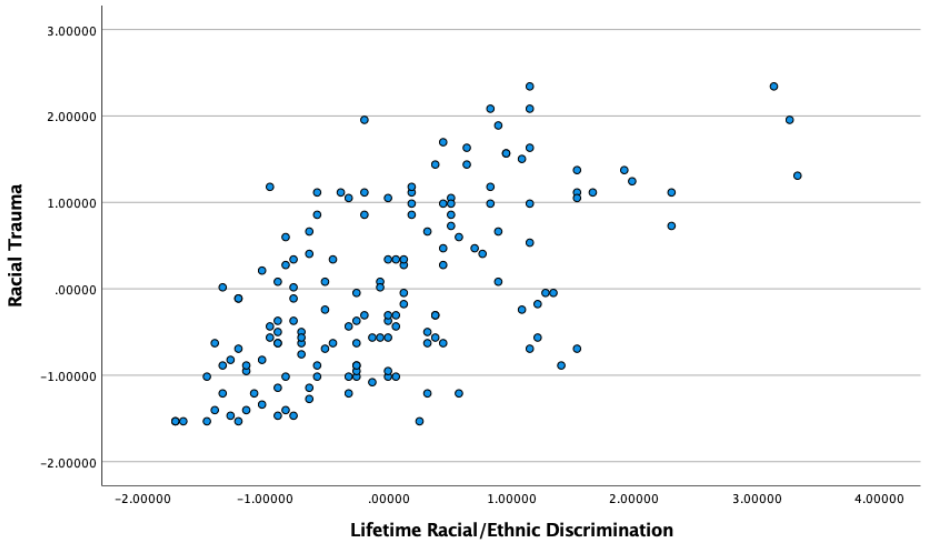
Appendix R. Scatterplots for Testing Linearity Assumption



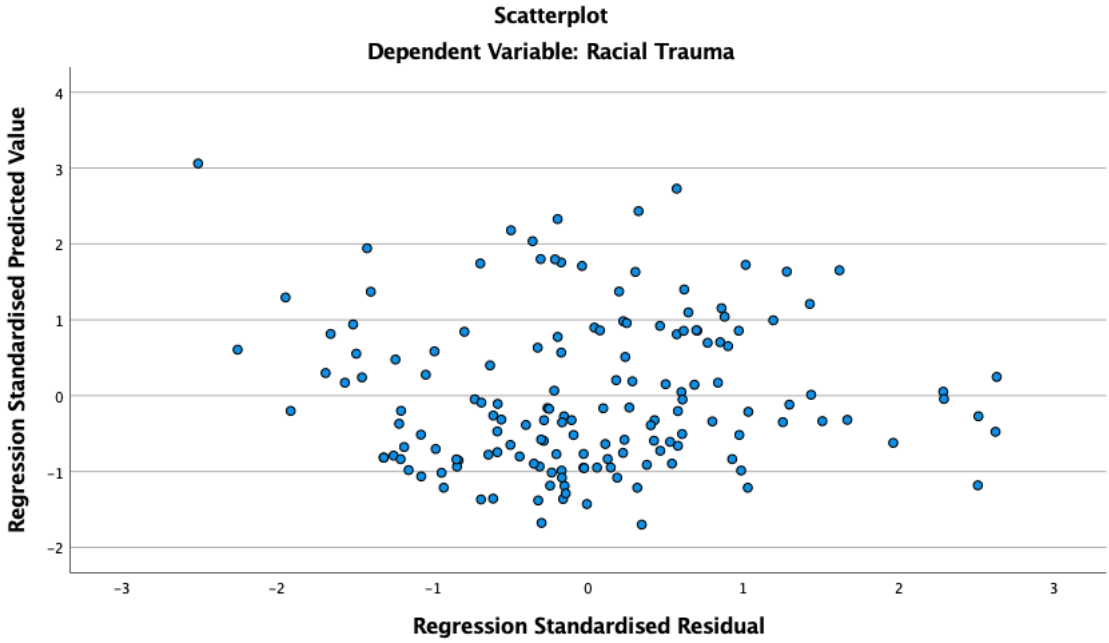





3.00000
2.00000
1.00000
.00000
-1.00000
-2.00000
Racial Trauma
-2.00000
.00000
2.00000
4.00000
Recent Racial/Ethnic Disctimination


3.00000
2.00000
1.00000
.00000
-1.00000
-2.00000
Racial Trauma
-2.00000
-1.00000
.00000
1.00000
2.00000
3.00000
4.00000
Lifetime Racial/Ethnic Discrimination

Appendix S. Scatterplot for Testing Homoscedasticity Assumption



Appendix T. Descriptive Statistics for Socio-Cultural and Demographic Variables

	N (%)
Gender Identity	
Male	24 (15.4)
Female	132 (84.6)
Transgender	0 (0.0)
Non-Binary / Third Gender	0 (0.0)
Other Gender	0 (0.0)
Sexual Orientation	
Straight or Heterosexual	135 (86.5)
Gay or Lesbian	4 (2.6)
Bisexual	14 (9.0)
Pansexual	2 (1.3)
Queer	1 (0.6)
Racial Identity	
Black	80 (51.3)
Asian	50 (32.1)

Arab	6 (3.8)
Latin American	2 (1.3)
Mixed	17 (10.9)
Other	1 (0.6)
White	0 (0.0)
Ethnic Identity	
Black African	56 (35.9)
Black Caribbean	23 (14.7)
Black Other	1 (0.6)
Asian Bangladeshi	7 (4.5)
Asian Indian	18 (11.5)
Asian Pakistani	12 (7.7)
Asian Chinese	6 (3.8)
Asian Other	3 (1.9)
Latin American	2 (1.3)
Arab	6 (3.8)
Mixed	16 (10.3)
Other	7 (4.5)
First Language	
English	127 (81.4)
Other	29 (18.6)
Immigration Generation	
1st Generation	54 (34.6)
2nd Generation	78 (50.0)
3rd Generation	24 (15.4)
Geography	
England - London	82 (52.6)
England - South West	4 (2.6)
England - South East	21 (13.5)
England - East	7 (4.5)
England - West Midlands	15 (9.6)
England - East Midlands	4 (2.6)
England - Yorkshire and The Humber	6 (3.8)
England – North West	12 (7.7)
Scotland	3 (1.9)
Wales	2 (1.3)
Northern Ireland	0 (0.0)

Religious Beliefs	
Buddhist	3 (1.9)
Christian	75 (48.1)
Hindu	5 (3.2)
Jewish	1 (0.6)
Muslim	29 (18.6)
Sikh	5 (3.2)
No Religion	32 (20.5)
Spiritual	2 (1.3)
Other	4 (2.6)
Self-Identified Perceived Social Class	
Lower Class	3 (1.9)
Working Class	94 (60.3)
Middle Class	57 (36.5)
Upper Class	2 (1.3)
Employment Status	
Unemployed	9 (5.8)
Full-time Student	30 (19.2)
Part-time Student	2 (1.3)
Full-time Employee	104 (66.7)
Part-time Employee	9 (5.8)
Self-Employed	2 (1.3)
Full-Time Carer/Homemaker	0 (0.0)
Disability	
Physical	4 (2.6)
Behavioural or Emotional	14 (9.0)
Sensory Impairment	2 (1.3)
Intellectual or Developmental	7 (4.5)
None	129 (82.7)

Appendix U. Correlation Matrix for Dependent and Independent Variables

	Depression	Anxiety	PTSD	Racial Trauma	Recent Discrimination	Lifetime Discrimination
Depression	-	.830**	.632**	.532**	.263**	.342**
Anxiety	.830**	-	.641**	.571**	.284**	.269**
PTSD	.632**	.641**	-	.581**	.340**	.327**
Racial Trauma	.532**	.571**	.581**	-	.601**	.605**
Recent Discrimination	.263**	.284**	.340**	.601**	-	.757**
Lifetime Discrimination	.342**	.269**	.327**	.605**	.757**	-

Note. ** correlation is significant at the 0.01 level