

From “Crib to Coffin”: Navigating Coping From Racism-Related Stress Throughout the Lifespan of Black Americans

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Despite the proclamation of a “postracial” society, racism in the United States remains “alive and sick” (S. P. Harrell, 2000), negatively impacting the physical, psychological, and emotional well-being of Black Americans. Moreover, the complex impact of racism throughout the life span is inadequately understood. Coping with the insidiousness of racism in its myriad forms requires recognizing how it expresses across development. In this developmental overview, we apply a life-course perspective (Gee, Walsemann, & Brondolo, 2012) to investigate racism-related stress and coping over time. Within each period of development, we first explore how racism-related stress may present for Black Americans and then document what coping from this stress looks like, highlighting extant strategies and interventions where they exist. This work concludes with a set of definitional, methodological, and clinical future directions and recommendations for improving the field’s ability to mitigate the deleterious impact of racism-related stress.

Public Policy Relevance Statement

Racism is a pernicious stressor with the potential to disrupt the psychological health and well-being of Black Americans. Furthermore, racism-related stress operates in different ways, with different implications, at different times in development (childhood, adolescence, adulthood). To promote resilience in the face of and resistance to racism, it is critical to understand its various presentations, as well as culturally relevant ways to cope with and heal from racism-related stressors.

Nearly 2 decades after S. P. Harrell’s (2000) seemingly paradoxical proclamation that racism is “alive and sick” in this society, we are presented with almost daily reminders of its impact for Black Americans of all ages (e.g.,

fashion company “faux pas,” Charlottesville, Virginia, attacks, police shootings and killings, #LivingWhileBlack, etc.). Indeed, recent poll data suggests that as many as 93% of African Americans indicate that they are the targets of racial discrimination

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(National Public Radio, 2017). Moreover, racism is not simply a nuisance nor a racial extension of general stressors (Ong, Fuller-Rowell, & Burrow, 2009); rather, racism experiences get “under the skin” and “into the mind” (Jones & Neblett, 2019), hampering the well-being of Black Americans¹ across the life span (Priest et al., 2013; Williams & Williams-Morris, 2000). As defined by Jones (1997), racism is a belief in the inferiority of a person or people due to their ethnicity, phenotypic characteristics (e.g., skin tone), or assumed biology. Clark, Anderson, Clark, and Williams (1999) explain that the system of racism can manifest as beliefs, attitudes, behaviors, and institutional structures that maintain this disparate treatment. Furthermore, in their seminal work on the life span effects of racism on health, Gee, Walsemann, and Brondolo (2012) noted the importance of adopting a life-course perspective when describing the deleterious impacts of racism, given that exposure to racism is likely to change in nature, importance, and intensity across development.

To illustrate, research suggests that racism—and not simply racial group—drives the persistent low birth weight disparities among Black babies (De Maio, Shah, Schipper, Gurdziel, & Ansell, 2017). As these children develop, research indicates that they will likely face differential treatment as early as preschool, an age wherein Black children’s suspension rates (48%) are nearly twice those of their White counterparts (26%; U.S. Department of Education, Office for Civil Rights, 2014). The period of adolescence then brings stories such as one in which a 16-year-old Black teen was taunted publicly for eating chicken at a pep rally contest, with video and inflammatory narrative shared across social media by his White peers (Wootson, 2017). As racism persists in early and middle adulthood, Black Americans may contemplate abbreviating their names given persistent biases in hiring practices (Nunley, Pugh, Romero, & Seals, 2015). Racist reverberations extend into older adulthood for Black Americans, with burgeoning research suggesting that poverty and racism raise the risk of developing Alzheimer’s (Alzheimer’s Association, 2017). These correlations and numerous others have been further synthesized by an at-once impressive and disheartening number of reviews linking racism and health or well-being across hundreds of studies spanning the last three decades (see Hope, Hoggard, & Thomas, 2015; Pascoe & Smart Richman, 2009; Pieterse, Todd, Neville, & Carter, 2012; Priest et al., 2013; Williams & Mohammed, 2009). These reviews generally congregate around one reality: that racism is a pernicious and unique stressor, with the potential to thwart the physical, physiological, and psychological health of Black Americans. This developmental overview seeks to add to this growing body of literature, applying a life-course perspective to investigate racism-related stress (RRS) and coping over time.

Before continuing, it is important to express explicitly what this article is (and is not) intending to achieve. First, consistent with Gee and colleagues’ (2012) call for a “systematic documentation of [the impact of] racial bias changes over major developmental stages” (p. 971), we begin by reviewing the extant literature on RRS in developmental stages of childhood, adolescence, and adulthood. In doing so, we understand that certain typologies of RRS may occur, co-occur, and recur, and we have attempted to be consistent in our language across these stages, referring to overlaps as we expect they exist in development. Specifically, we identify stressors we term *instrumental* (i.e., those stressors that involve critical developmental tasks), *interpersonal* (i.e., those stressors

that involve interfacing with others), and *institutional* (i.e., those stressors that occur due to systems and policies).

Second, within each stage, we outline developmentally appropriate strategies (extant and potential) for coping with the RRS likely to be experienced across these same periods. This approach reflects the nondeterministic nature of RRS and is consistent with research indicating how Black Americans can remain resilient in the face of such incidents (Brown & Tylka, 2011; Neblett et al., 2016). Importantly, despite the unique experience of RRS, we invoke both general (e.g., Lazarus & Folkman, 1984) and race-specific (e.g., Clark et al., 1999; Hardy, 2013; Murry, Butler-Barnes, Mayo-Gamble, & Inness-Thompson, 2018; Slavin, Rainer, McCreary, & Gowda, 1991) models of stress and coping, because the priority is to identify as many avenues for adaptive coping as possible. Yet, even in this framing, we recognize that there may be experiences of stress or strategies of coping unaccounted for in our article. Third, this article concludes with an integrated discussion, one that simultaneously acknowledges that there remain several unanswered questions and offers recommendations, both research and practice-related, to deepen our understanding of RRS and coping for Black Americans.

Defining Racism-Related Stress

As articulated by S. P. Harrell (2000) and derived from Lazarus and Folkman’s (1984) broader conceptualization of stress, RRS refers to “race-related transactions between individuals or groups and their environment that emerge from the dynamics of racism, and that are perceived to tax or exceed existing individual and collective resources or threaten well-being” (S. P. Harrell, 2000, p. 44). Harrell describes six prominent types of RRS: (a) racism-related life events (time-limited, specific life experiences), (b) vicarious racism experiences (observation and report of others’ racism experiences), (c) daily racism microstressors (subtle slights and exclusions), (d) chronic-contextual stress (social systemic and institutional racism), (e) collective experiences (“cultural-symbolic and sociopolitical manifestations of racism,” p. 46), and (f) trans-generational transmission (discussions of historical events). Importantly, these various types of racism-related stressors may (and often do) co-occur and interact, as well as interact with other stressors, including general and other-social-roles-related stressors (e.g., sexism, heterosexism, Islamophobia).

Defining Coping With Racism-Related Stress

Central to combating most stressors are Lazarus and Folkman’s (1984) constructs of (a) appraisal, or the way in which an individual perceives a situation as stressful and related to a certain stimulus and (b) coping, defined as emotions, cognitions, and behaviors that represent attempts to ameliorate or overcome stress. Importantly, coping can exist along active/passive and adaptive/maladaptive dimensions (Billings & Moos, 1981; Nielsen & Knardahl, 2014) and can be both general (e.g., mindfulness) and culturally specific (e.g., racial socialization; Anderson, Jones,

¹In this article, Black American refers to individuals from the African diaspora (e.g., African American, continental African, Afro-Caribbean, Afro-Latinx) residing in a U.S. context.

Anyiwo, McKenny, & Gaylord-Harden, 2018) in nature. In this article, we consider approach-oriented (e.g., problem-focused) and avoidance-oriented (e.g., emotion-focused) coping strategies, describing both general and race-relevant approaches. Several models focused on coping with RRS outline the interplay between stress, appraisal, and coping. In the biopsychosocial effects of perceived racism model (Clark et al., 1999), for example, the authors articulate that the initial appraisal of an event as racist mediates the relationship between perceived stressors and negative health outcomes. More specifically, both adaptive and maladaptive coping responses to RRS influence psychological and physiological stress responses, and the evolution of these stress responses affect health outcomes over time. Likewise, in the racial encounter coping appraisal and socialization theory (Anderson & Stevenson, 2019; Stevenson, 2014), authors argue the importance of coping reactions during racially stressful encounters. The theory utilizes racial socialization as a moderator of the appraisal, negotiation, and efficacious outcomes families strive to achieve to resolve RRS. Finally, Murry and colleagues' (2018) integrative model for the study of stress in Black American families evaluates RRS in the context of historical and current stressors which can be modulated by coping processes facilitated by families and other communal assets (including but not limited to racial socialization and identity), helping to yield Black youth's positive development and outcomes. Taken together, appraisal and active coping through individual and interpersonal means provide possible avenues by which children, adolescents, and adults can traverse RRS and arrive at optimal well-being.

Experiences of Racism-Related Stress in Childhood

Childhood (defined here as birth to 11 years old) is typically regarded as one of the most critical developmental periods in one's life. It is during these formative years that children progress toward concrete thinking while still lacking advanced abstract thinking that emerges in adolescence (Piaget, 1970). Exposure to adverse events in childhood thus poses relatively greater risk than later developmental periods due to limitations in thinking, language, and expression (Deblinger, Mannarino, Cohen, & Steer, 2006; Quintana, 1998). For Black American children, RRS can negatively impact their psychological well-being, whether expressed as adverse sociodemographic (e.g., García Coll et al., 1996; Murry et al., 2018) or historical (e.g., Hale, 1982; Murry et al., 2018) inequality, or as interpersonal mistreatment (Anderson, 2015; McLoyd, 1990). As such, childhood may be a sensitive period for the effects of race (Quintana, 2007), not only for understanding identity development from an early age (McAdoo, 2002), but also for elucidating the nascent linkage between RRS and psychological injury (Spears Brown & Bigler, 2005). Infants as young as 4-months-old are able to discriminate in their looking times with same- and other-race faces (Liu et al., 2011; Xiao, Quinn, Pascalis, & Lee, 2014). Although infant eye-tracking is challenging to interpret, researchers suggest that perceiving phenotypic difference may be hardwired from birth. Moreover, researchers have replicated the finding of young children's explicit preferences for White and lighter skin (Gibson, Robbins, & Rochat, 2015; Horowitz, 1939), and such preferences are associated with distress and isolation for children of color (Park, 2011). Such distress for young

children may be present in a variety of biopsychosocial environments and experiences.

Instrumental: Child Care and Early Education

Although Black children may be able to accurately identify their racial group as early as the preschool years (Katz, 2003), they, like most children (and some adults for that matter) lack the affective language and more sophisticated cognitive understanding to comprehend racial dynamics within the United States (Jernigan & Daniel, 2011). Furthermore, young children are also at risk for encountering racially stressful or traumatic events in school environments. First, research suggests that Black children are likely to receive lower quality, less affirming, and less culturally appropriate early child care and education relative to other (James & Iruka, 2018; Rothwell, 2016). A related set of findings conducted by the Yale Child Study Center has noted that implicit biases by teachers may play a role in the expectation of problem behaviors for Black children (Gilliam, Maupin, Reyes, Accavitti, & Shic, 2016). This work is in-line with previous studies that highlight others' perception of Black youth as being older and more dangerous than they are (Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014; Yates & Marcelo, 2014). Such frequent opportunities to internalize negative meanings about the Black race comes at a time when youth are more vulnerable to RRS than those with more developed understanding (Sanders-Phillips, 2009).

In addition to the perception and expectation of teachers and providers, research indicates that youth themselves maintain either a preference for Whiteness or negative reaction toward Blackness, whether it be for toys (Clark & Clark, 1947) or playmates (Katz, 2003; Van Ausdale & Feagin, 2001; for exceptions, see Kinzler & Spelke, 2011). Within the classroom setting, this preferential treatment is demonstrated by peers and teachers alike (Franklin, Boyd-Franklin, & Kelly, 2006). However, given the dearth of measurements of stressful responses to Black children's reaction to and treatment pursuant to discrimination (see LaFont, Brondolo, Dumas, Lynk, & Gump, 2018 for newly developed and promising measure in this domain), the field has yet to establish the clear impact of these phenomena on their mental health.

Interpersonal: Parents and Families

Studies exploring biological determinants of health have demonstrated the ways in which racism impacts women during pregnancy and the ensuing stress on the unborn children (e.g., Collins, David, Handler, Wall, & Andes, 2004; Geronimus, 1992) and within the first year of life (Giscombé & Lobel, 2005). Before children are even born, RRS may impact their well-being via gestation, as maternal experiences of racial discrimination have been linked to low birth weight and preterm births in offspring (see review; Heard-Garris, Cale, Camaj, Hamati, & Dominguez, 2018). As children develop, parents play a role in children's perception of racism through the transmission of knowledge about racial identity and the vicarious witnessing of racially discriminatory experiences and RRS (e.g., Anderson et al., 2015; Simons et al., 2002). Preparing children for racial bias is a more common feature in Black American households relative to other groups and may increase

children's perception of threat and physiological hyperarousal (Hughes et al., 2006). Caughy, O'Campo, and Muntaner (2004) indicate that parents' behavioral response to racism is negatively associated with depressive and anxious symptoms in preschool-aged children, with proactive socialization associated with more positive psychological youth outcomes. Regarding vicarious racism, because of children's dependency on their caregivers, young children may be particularly vulnerable when caregivers or loved ones are being mistreated (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). Researchers indicate the importance of intersectionality in RRS, noting the possibility for gender-differential susceptibility to racism for young girls who may be socialized to be more aware of familial interpersonal stress (Ford, Hurd, Jagers, & Sellers, 2013; Mandara, Varner, & Richman, 2010). Finally, experiences with RRS may negatively impact various aspects of family functioning. Scholars indicate that higher rates of discrimination negatively impact parental well-being and child rearing practices and subsequent psychological outcomes of Black kindergarten (Anderson et al., 2015) and preadolescent (Murray, Haynie, Howard, Cheng, & Simons-Morton, 2010) children.

Coping With Racism-Related Stress in Childhood

Although young children may have a limited vocabulary for explaining and attending to the impact of RRS through a problem-focused lens, there are strategies that have been used to aid in children's emotion-focused coping with negative experiences. Various culturally attuned coping assets (e.g., family cohesion, kinship support, etc.) take into account the unique structure, history, and everyday realities encountered by Black families (Murry et al., 2018), and may thus be useful as tools for intervention for increased protective capacity within Black units. Interventions that attend to the child by means of familial processes are important given the often-limited capacity young children have to engage with racialized content directly and effectively (e.g., Black Parenting Strengths and Strategies Program [BPSS]; Coard, Herring, Watkins, Foy-Watson, & McCoy, 2013). In fact, a growing literature documents experiences of children from their parents' perspective (e.g., Sue, Capodilupo, & Holder, 2008), with family based therapies as a means to address RRS for young children. Regarding direct services to youth, psychologists have advocated for greater representation of ethnically diverse providers in community mental health settings (e.g., Carr & Miller, 2017) and understanding cultural contexts in various forms of therapy (e.g., play: Coleman, Parmer, & Barker, 1993; family: Boyd-Franklin, 1987). Therapists and teachers may need to become better equipped to address racialized incidents (Milner, 2017; Helms, Nicolas, & Green, 2010), particularly considering the uptick in school-based racial encounters following the 2016 Presidential Election (Southern Poverty Law Center, 2016). In one of the few texts exploring racial trauma in Black youth, Jernigan and Daniel (2011) underscore the importance of appropriate treatments including culturally relevant protective factors (e.g., racial socialization and racial identity).

Familial: Racial Socialization

Racial socialization is associated with youth's development of appraisal and coping skills (Gatson, 2011)—for both general and race-specific events (Anderson, Jones, et al., 2018)—and psychological well-being (Neblett, Rivas, & Umaña-Taylor, 2012). The integration of racially specific appraisal factors along with proactive racial socialization is grounded in the aforementioned racial encounter coping appraisal and socialization theory (Anderson & Stevenson, 2019; Stevenson, 2014). In addition to changing attitudes and providing knowledge, racial socialization processes enhance the relationship between RRS and self-efficacy by catalyzing the deliberate and practiced development of racial coping skills. From this reappraisal process, racial socialization can include instruction on the types of social and emotional skills parents and children need to successfully engage in both problem- and emotion-focused coping with racial encounters. Practicing how to effectively recognize, appraise, reappraise, and negotiate stressful encounters is essential in developing racial socialization competence for youth and their families (see Anderson & Stevenson, 2019). Although racial socialization is a mechanism for coping in adolescent children, the emotional benefits may still be present for young children as parents engage in socialization processes in everyday tasks. Discussions between parent and child on the unique features of Blackness (e.g., hair texture during hair combing) may help to express both the joys and challenges in racial features and experiences (Lewis, 1999). Moreover, established (e.g., BPSS) and burgeoning therapeutic interventions (e.g., Engaging, Managing, and Bonding Through Race; Anderson, Mc Kenny, & Stevenson, 2019) use racial socialization to reduce stressful and traumatic experiences for middle-aged children and their parents. Finally, it is important to note that though Black parents and families have and continue to use racial socialization as a means of protecting Black youth, it is critically important that White parents and families recognize their role in teaching their children about power and privilege (Hagerman, 2017). In addition, other socialization agents (e.g., teachers, schools) must equip themselves to navigate racially stressful moments (Stevenson, 2014).

Familial and Intrapersonal: Racial Identity

Parents and other influential adults are often involved in the healing process for youth given that children's perception and understanding of race is still developing (Quintana, 2007). In promoting racial identity development, parents, teachers, and providers are key components of programs for young children (e.g., Promoting Racial Identity Development in Early Education; University of Pittsburgh School of Education Race & Early Childhood Collaborative, 2016). Racial identity, or the multidimensional and metamorphosing construct comprising the content and process of one's racial beliefs and behaviors (Umaña-Taylor et al., 2014), is a component of each person, whether salient or minor, proximal or distal, or achieved or developing. For youth, the development of racial identity may begin forming in infancy when distinctions in appearance are first observed (Xiao et al., 2014). However, most scholars draw a distinction between the identification young children ascribe to race (e.g., a preference for a doll or picture of racialized characters and the child's own racial identity (e.g., how

they feel about their own inhabitation of this “race”; Ruble, Alvarez, Bachman, & Cameron, 2004; Spencer & Markstrom-Adams, 1990). However, through the exploration rather than achievement of racial identity, even young children can engage in age-appropriate therapeutic strategies (e.g., drawing and music; Malchiodi, 2011) and treatments (e.g., play therapy; Baggerly & Parker, 2005) to navigate RRS. While treatment in childhood may represent healing for burgeoning RRS concerns, the challenges present in adolescence often represent more injurious attacks to Black youth’s well-being, while unresolved childhood RRS remains.

Experiences of Racism-Related Stress in Adolescence

Initially not recognized as a distinct developmental epoch (Petersen, 1988), adolescence (defined here as 12–18 years old) now represents a time of numerous physical and biological (e.g., pubertal onset), psychological (e.g., enhanced cognition), and social (e.g., identity exploration) changes, and serves as both the time-literal and metaphorical bridge between childhood and adulthood. Black adolescents, like the children that become them, face unique experiences. Moreover, disturbing trends, such as the sharp rise in Black teen suicide (Price & Khubchandani, 2019) necessitate understanding relevant risk and protective factors. It is in this context of increased risk and opportunity that the nature of adolescent RRS must be understood. For example, increasing social-cognitive abilities in adolescence influences perceptions of RRS—and the resultant articulation of and response to such stress—in developmentally unprecedented ways (Cooper, Guthrie, Brown, & Metzger, 2011; Quintana & McKown, 2012). Moreover, increasing affiliation with peers and social media may reduce parents’ and caregivers’ ability to buffer adolescents from the effects of RRS. Alternatively, as Priest and colleagues (2013) imply in their systematic review of the impact of racism on health for youth, the robust and consistent negative association between racism and positive health indicators during the high school years may reflect an accumulation of racial stress from childhood. It is important to appreciate that, just as in childhood, RRS experiences are as varied as the contexts youth inhabit (e.g., schools, social interactions, jobs).

Instrumental: Middle and High School

Research indicates that Black American adolescents continue to experience interpersonal RRS from teachers and other personnel in school (e.g., Griffin, Cooper, Metzger, Golden, & White 2017). For instance, in a study conducted by Cogburn, Chavous, and Griffin (2011), 8th grade Black American adolescents endorsed experiences such as feeling that teachers graded or disciplined them more harshly than their peers because of their race, and these experiences were associated with student reports of compromised mental health (e.g., depressive symptoms, self-esteem). In addition to specific interpersonal school experiences, research also suggests that Black American teens are faced with broader school-institutional RRS. Fisher, Wallace, and Fenton (2000) found that African American youth reported racial discrimination as a reason for being more harshly disciplined, having lower grades, and

discouraged from taking advanced courses. Given that adolescents can understand and process school-based RRS more fully than in childhood, their academic esteem may be further damaged as maturation from childhood continues.

Interpersonal: Peers

Peer-based RRS has also been identified for Black American adolescents (Seaton & Yip, 2009; Tynes, Giang, Williams, & Thompson, 2008), though the majority of research has not specified whether such peer discrimination is within or outside of the school context. Direct and vicarious RRS via social media and texting is one specific example of the way peer-based RRS may present uniquely in adolescence (Tynes et al., 2008; Tynes, Willis, Stewart, & Hamilton, 2019). While Tynes and colleagues’ work found an association with direct discrimination and negative psychological outcomes, the changing landscape of social media platforms (e.g., auto-play videos, “live stories”) makes even unintentional exposure to vicarious RRS—such as the killing of Black American teens—more likely than ever. Even more startling is that for adolescents, such stories may be shared rapidly among social networks without parent or caregiver knowledge or supervision.

Institutional: Juvenile Justice

Black American teens accosted by state- or community-appointed authorities, as well as those currently detained in juvenile justice facilities, represent another subset of detrimental and potentially fatal RRS experiences (e.g., Guthrie, Cooper, Brown, & Metzger, 2012). Research in criminology from nearly 800 Black teens found that more than a quarter of youth reported police-based discrimination within a year (Stewart, Baumer, Brunson, & Simons, 2009). In-depth qualitative interviews of 40 urban-residing Black male teens provide insight into the nature of these police-based traumatic experiences (e.g., name-calling, profanity, public cavity searches, etc.), which were largely perceived as racially motivated (Brunson & Miller, 2006). These findings are important given that adolescents are more likely than adults or younger children to encounter police and to report negative interactions during such contacts (Taylor, Turner, Esbensen, & Winfree, 2001). Notably, these increased encounters are the result of systemic policies, such as “stop-and-frisk” and “hot-spot policing.” Moreover, the increasing media coverage of this police-inflicted trauma on Black American teens (e.g., Michael Brown’s murder in 2014; the McKinney, Texas, pool party hostile detainment in 2015) has led to concerted research efforts to better understand how such incidents impact them (see Moore, Robinson, & Adedoyin, 2016; April 2016 *Journal of Human Behavior in the Social Environment: Shooting of Unarmed African American Males*).

Institutional: Collective Experiences of RRS

Lastly, adolescence also represents a time of increasing awareness of institutional and collective forms of RRS for Black American youth. For example, Seaton and Yip (2009) found that Black adolescents endorsed discrimination that was both cultural (e.g., not hearing positive things about Black people in the media) and collective/institutional (e.g., not receiving a deserved reward due

to being Black), with the latter being significantly associated with depressive symptoms and low self-esteem. That the increased understanding of historical and contemporary RRS in adolescence coincides with increasing experiences of interpersonal and developmentally relevant institutional (e.g., school and justice systems) RRS is not a coincidence. The impairment to racial identity and self-worth within these racialized spaces may negatively manifest at a time of crucial development to these processes within identity. This nexus of cognitive-affective awareness and lived experience is important to address to avoid deleterious outcomes into adulthood, including internalized racism (Chambers et al., 2004) and other maladaptive outcomes (e.g., self-harm, Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous, & Zimmerman, 2004; compromised health, Brody et al., 2006; Clark & Gochett, 2006).

Coping With Racism-Related Stress in Adolescence

The increasingly sophisticated understanding of racism in adolescence compared to childhood allows Black youth to take more agency in their coping and to improve in their ability to cognitively process RRS. Overall, coping with racial stress is typically encouraged by accurately appraising the stressor, eliminating its source, changing youths' perception of it, and bolstering the internal and external resources needed to cope with it (S. P. Harrell, 2000).

Familial and Intrapersonal: Racial Socialization

Although racial socialization processes begin in childhood, parent's messages focused on cognitive and behavioral coping strategies from their own experiences with RRS may be particularly important for adolescents (e.g., Cooper, Smalls-Glover, Metzger, & Brown, 2015). Communication also may shift from focusing primarily on racial pride to talking about racial barriers and potential responses (Anderson & Stevenson, 2019). In addition, cognitive and behavioral coping strategies allow youth to evaluate the stress caused by racial encounters and modify their reaction through engaging in active coping rather than avoidance. Further, as youth develop, racial socialization messages are transmitted by parents and peers, other influential figures (e.g., teachers, police), and the media (Adams & Stevenson, 2012; Hughes et al., 2006). Specifically, peers have increased influence on the meanings associated with racism, and socialization takes place in social gatherings, neighborhood activities, and school interactions (S. P. Harrell, 2000). Positive pride messages and strategies for coping with racial barriers often result in strengthened racial identity and increased pride, resilience, and coping abilities (Coard, Wallace, Stevenson, & Brotman, 2004; Hardy, 2013).

Individual Coping

Active coping through employing the social support of peers, families, and community leaders promotes emotional well-being and buffers the impact of RRS on health (S. P. Harrell, 2000). Importantly, RRS is characterized by a power differential that often involves consequences that may make certain cathartic coping strategies detrimental (S. P. Harrell, 2000). For example, in a

racially hostile classroom environment, taking opposing actions (e.g., standing up for oneself or "talking back" to a teacher, administrator, or peer) could result in youth gaining a reputation as a troublemaker, receiving disproportionate disciplinary actions, and/or having a negatively impacted academic career. Conversely, choosing not to utilize approach-oriented coping or ignoring negative racial encounters has negative implications for the mental health and well-being of adolescents (Stevenson, 2008). Thus, additional research on problem-focused and emotionally beneficial strategies is sorely needed.

Racially Attuned Collective Coping

Adolescents also utilize approach-oriented coping behaviors encouraged by intragroup support in response to RRS. These include acts of collectivism such as joining boycotts and protests, civic engagement and demonstrations, and membership and participation in racial group organizations with their peers (Cooper et al., 2014; S. P. Harrell, 2000). Through collective coping, other Black Americans aid in the healing process by providing modeling, understanding, mentorship, and a more connected sense of community, resilience and resistance. Other behavioral strategies for reducing RRS include intergroup support, or the validation of RRS by members of other ethnic groups (Hardy, 2013; S. P. Harrell, 2000), a critical identity-related achievement for adolescents transitioning into adulthood.

Experiences of Racism-Related Stress in Adulthood

RRS manifests in myriad ways throughout the expanse of adulthood (defined here as 19 years old and older), metaphorically carrying over the effects from childhood and adolescence. Moreover, the vastness of adulthood means adults will transition through many social roles (e.g., student, employee, retiree) obviating the consideration of age-patterned exposures. In addition, Black American adults are likely to experience significant relational (e.g., marriage, parent-child), financial, and possibly health status changes (Estrada-Martínez, Caldwell, Bauermeister, & Zimmerman, 2012; Serido, Shim, & Tang, 2013). These multiple transitions influence the nature of, frequency of, exposure to, and resources to cope with RRS (Gee et al., 2012; Metzger, Cooper, Ritchwood, Onyeuku, & Griffin, 2017). Indeed, contemporary figures show that Black Americans live, on average, 3.4 fewer years than White Americans (Centers for Disease Control and Prevention, 2016). Given that changing sociohistorical and political contexts create cohort effects across adult groups, RRS can also occur at individual, institutional, and cultural levels (Jones, 1997). For example, because overt racism was previously socially acceptable in the United States, the early life experiences of older Black Americans may have exposed them to more blatant racism, while younger adults may be more accustomed to subtle, insidious forms of racism (Salvatore & Shelton, 2007). However, the recent rebranding of the White Supremacy movement and racialized political rhetoric demonstrate that blatant racism is still a familiar experience. As such, the places in which most adults experience troublesome RRS are contexts in which they spend the majority of their time, including at work, in relationships, and increasingly, in relation to medical treatment.

Instrumental: Employment/Career

As individuals transition from adolescence into adulthood, they take on new social roles, responsibilities, and obligations, many of which are influenced or created by race and racism (e.g., college, military, employment; Gee et al., 2012). These paths may be influenced by personal choice or race-related processes such as unequal access to early quality education (Santiago-Rivera, Adames, Chavez-Duenas, & Benson-Flores, 2016), college financial aid packages, socioeconomic status, family obligations, experiences with the justice system (Hudson et al., 2016), or disproportionate enlistment of ethnic minorities in the military (Parker, Cillufo, & Stepler, 2017). As individuals progress through adulthood, their social roles may change; thus, a midcareer Black American with an established reputation compared to an early career peer may have more collateral with which to address RRS in the workplace (Cose, 2011). Retirees may experience exclusion from or isolation in retirement communities that are almost homogeneously White middle- to upper-class citizens (McHugh & Larson-Keagy, 2005). The interaction of status changes across and within roles and racial identity impact how an individual experiences and copes with RRS.

Interpersonal: Roles and Relationships

Adulthood brings with it new and changing peer, romantic, and familial relationships, all of which have the potential to be influenced by RRS. In parent-child relationships, evidence shows that Black American mothers' childhood and adulthood RRS are directly and indirectly related to postpartum depressive symptoms (Heldreth et al., 2016). Such findings may have important implications for the quality of the mother-child relationship that can develop in the context of such symptoms. Additionally, Black American adults may experience and propagate vicarious RRS through a friend, romantic partner, or family member (Dominguez et al., 2008). For example, for online relationships, social media may increase the potential for vicarious RRS (Tynes, Rose, & Markoe, 2013), just as it does in adolescence, and, increasingly, childhood. Given that approximately 35% of individuals 65 years old and older use social networking sites (Perrin, 2015), it is probable that older adults observe or experience RRS online, and more work is needed to understand their interpretations and experiences of such incidents. Notably, these examples highlight the importance of linked-lives considerations for the impact of RRS, and the parenting-specific findings point to the role of transgenerational effects of such stressors over time (Gee et al., 2012).

Institutional: Medical Care

Robust research elucidates the deleterious impact of racism on the physical and mental health of Black American adults (see Williams & Mohammed, 2009 for review). RRS affects health primarily via an individual's appraisal of environmental stimuli as racist and the subsequent physiological and psychological responses to RRS (Clark et al., 1999). Such repeated responses may contribute to health-impairing behaviors over time. For example, due to race-related atrocities perpetrated by the medical field (e.g., forced sterilization of Black women, Tuskegee, Alabama, syphilis

experiments), many Black Americans mistrust health providers (Washington, 2006). In one study, their mistrust partially accounted for the relationship between RRS and lower medication adherence among those with hypertension (Cuffee et al., 2013).

Further, institutional forms of RRS can also influence Black American adults' health. For example, evidence shows that physicians are less likely to prescribe opioids to African American patients compared to White patients presenting to an emergency room with physical pain symptoms (Pletcher, Kertesz, Kohn, & Gonzales, 2008). Further, a recent study showed that half of medical students and residents in their sample held biased beliefs such as "Black people's skin is thicker than White people's skin," assessed Black mock patients' pain as lower than White mock patients, and subsequently made less accurate treatment recommendations for Black compared to White mock patients (Hoffman, Trawalter, Axt, & Oliver, 2016). In the mental health field, Black Americans may underutilize psychotherapy or have less satisfactory experiences due to race- and racism-related factors such as financial and access barriers, mistrust of providers, microaggressions directly from therapists, and less cultural competency of White providers (Constantine, 2007). Given that Black psychologists only make up 5.3% of the psychology workforce (American Psychological Association Center for Workforce Studies, 2015), and that even fewer are licensed practicing therapists, it is also less likely that patients desiring to process RRS with a psychologist of their same racial background will have such an opportunity.

Coping With Racism-Related Stress in Adulthood

Barring significant health problems, cognitive issues, or imprisonment, most adults will enter early adulthood with much more autonomy than they have experienced in previous developmental periods. This autonomy increases the level of agency Black adults have in first appraising and then coping with and healing from RRS. Although much of the literature assessing RRS coping strategies has focused on the content of coping (e.g., problem- vs. emotion-focused, approach vs. avoidance, social support; Brondolo, Halen, Pencille, Beatty, & Contrada, 2009), alternative conceptualizations have been posited regarding the function that individual-level coping serves (e.g., to protect oneself, to challenge RRS) for interpersonal racism (Mellor, 2004).

Individual Coping

Individuals must cope with several forms of RRS (e.g., working hard to prove competence in a field that does not historically train or employ Black Americans). Individual qualities (e.g., racial pride and identity), which are posited to provide buffering effects against RRS are also related to adaptive health outcomes among Black adults. For instance, Black men in St. Louis, Missouri, reported that they coped with stress, including RRS, via health promoting behaviors (e.g., exercise), social support, and engaging in religious practices (e.g., prayer; Hudson et al., 2016). These men also identified maladaptive coping methods including health-impairing behaviors (e.g., consuming alcohol). More knowledge is needed to understand the mechanisms by which individuals pursue health-promotive versus health-impairing coping patterns in response to RRS (e.g., Metzger et al., 2018).

Racially Attuned Collective Coping

Targets of RRS may also utilize collective coping strategies to respond to institutional RRS (e.g., The 2014 Ferguson protests; Galovski et al., 2016). While less is known about these methods, they may encompass both healing and resistance components (e.g., Psychosocial Model of Racism and Resistance; Neville & Pieterse, 2009). Like individual strategies, collective healing strategies can be informal or formal. Informally, adults may utilize social media to collectively grieve RRS news stories or have discussions at Senior Center talk groups. Formally, Black American adults may participate in Emotional Emancipation (EE) Circles (Association of Black Psychologists), which are self-help support groups across the country for Black Americans to process a multitude of effects related to Black inferiority and the devaluing of Black lives. EE Circles also provide space allowing Black Americans to tell an empowering (rather than disempowering) narrative of African ancestry, revitalize their sense of self and relationships with other Black Americans, and learn and practice emotional well-being collectively and individually (Grills, Aird, & Rowe, 2016). Although such initiatives are certainly encouraging, more research is needed to gauge the effectiveness of EE Circles in reducing stress stemming from RRS.

In terms of resistance methods, Black American adults may participate in protesting racism at institutional and cultural levels. Perhaps one significant difference between participating in resistance methods in adulthood compared to adolescence is increased responsibility (e.g., families, careers, financial obligations) which translates into higher risks (e.g., loss of job/income, being charged as an adult if arrested). Still, protesting can be an empowering form of resisting RRS, though these acts can be taxing on an individual's emotions (Galovski et al., 2016) and on the larger community (Ballantyne, 2006). Thus, support within the context of resistance is needed. Community-level coping responses can be powerful given that coping should not be confined to only individual therapy avenues (Vera & Speight, 2003). Taken with the aforementioned barriers to individual treatment for Black Americans, community-level intervention should be a significant area of RRS research focus.

Recommendations and Future Directions

In the previous sections, we have identified the ways RRS can present in the multiple ecological contexts of Black Americans across the life span. These include neighborhoods, schools, the workplace, the juvenile justice system, relationships, social roles, and media, to name a few. Importantly, we recognize this is a nonexhaustive listing of institutions that may influence RRS across the life span, but chose to provide institutions that in some cases have received great attention in the literature, while elevating those that have been discussed with less fervor. The omission of any given institution should not imply its lack of importance, but rather challenging decisions due to space considerations. In addition, we illuminated what coping and healing might look like across the childhood, adolescent, and adulthood developmental periods, as socioemotional and cognitive abilities change, access to resources and services change, and the cascading effects of RRS necessitate increasingly intentional coping strategies. We now consider some recommendations and future directions that are important for mov-

ing forward a life-course perspective on the interplay between RRS and healing among Black Americans.

That RRS has yet to receive formal clinical recognition presents definitional, diagnostic, and treatment-related challenges. We are hopeful that the continued exploration in the research literature and diagnostic standards will rectify this issue (see Williams, Metzger, Leins, & DeLapp, 2018). Once racial stress and trauma is empirically and clinically recognized, it will be vital for scholars, counselors, and other clinicians to integrate the multiple terms associated with RRS (e.g., racism, race-based traumatic stress, racial discrimination, RRS), to provide clarity in the field. A scholarly glossary building on the work of Jones (1997); Carlson (1997); Carter (2007); S. P. Harrell (2000); Bryant and O'Campo (2005), and others would be instructive. Moreover, Carter and Forsyth (2009) question the use of the term "disorder" in the case of RRS, suggesting that psychological "injury" is more appropriate. Pathologizing natural responses to one's environment, that is, stress reactions to discrimination that are endemic in the United States, may be an inaccurate classification of a "disorder." While highlighting the importance of clinicians to combat stigma that comes with psychological diagnoses and the use of the term "disorder," we posit here, that diagnosing racial trauma will aid in the development of more comprehensive case conceptualizations and treatment plans that are culturally informed (Williams et al., 2018). Regarding definitions of healing processes, our work here has centered the importance of appraisal and coping. However, we know that while adaptive coping strategies in the context of a racial incident connotes healing, healing is intentionally described as a process given its ongoing nature. Understanding an individual's subjective view of the racially stressful event and the challenges of determining if an event was indeed evidence of racism shows the importance of the skillset it takes to accurately appraise a stressor (e.g., Anderson & Stevenson, 2019; Carter & Sant-Barket, 2015). As such, it is important to further define and understand the mechanism through which continued coping efforts lead to healing and health.

Inextricably linked to definition is measurement. As discussed, the research is scant with respect to assessing RRS at the developmental bookends (i.e., childhood and elderhood). The continued need for developmentally appropriate assessment and measurement of RRS cannot be understated (see Williams et al., 2018), in addition to advanced methodologies which explore RRS and coping (e.g., qualitative, longitudinal, observational, and virtual reality; Brody et al., 2006; C.J.P. Harrell et al., 2011; Lowe, Okubo, & Reilly, 2012; Smith-Bynum, Anderson, Davis, Franco, & English, 2016). Cognitive and expressive limitations should not be an excuse to not better understand how RRS expresses in these time points, particularly given the potential vulnerability of the youngest and most senior Black Americans. In fact, there have been anecdotal experiences by the clinical authors of this text in which young children have cited political, contemporary, and episodic content displayed from the media. Data from these informal contexts indicates that youth as young as five can recount the murder of Trayvon Martin from watching the news and label the experience as "racism." Simply because we lack adequate measurement of youth voice in empirical studies does not imply that young children are not experiencing the effects of RRS and do not need healing from these occurrences. In addition to better assessing RRS at certain developmental periods, an empirical longitudinal

approach to measuring RRS is necessary to better understand how stress and trauma at earlier developmental periods compounds as individuals mature. It is also important to appreciate the vast paths that Black Americans take: given that college is only one of several early adulthood options yet a convenient sampling location for many studies, researchers must explore paths that differ in experience (e.g., within the community) but are still united by the common reality of exposure to RRS. Lastly, in addition to being contemporarily relevant (e.g., an appreciation for the role of social media and technology), measures should be created that are simultaneously rigorous and efficient to enhance their use in both basic and applied research and clinical settings.

Therapy in the RRS Coping Process

As a collective of clinically trained scholars, it is important to highlight several important reflections practitioners should bear in mind. While it is helpful to consider traditional methods of treatment, considering the nascence of the RRS literature, simply adapting treatments that were developed for well-researched differential disorders may not suffice in the case of RRS. Its development and maintenance remains unclear, thus requiring careful and individualized thought based on individual presentation and subjectively reported experiences across all settings. This lack of clarity should manifest in treatment settings, with therapists allowing more undefined space for patients to create and process their own appraisals, as well as inform clinicians of their own culturally salient coping strategies. Considering the multitude of contexts in which targets of RRS have experienced discrimination, creating a safe, emotionally facilitative space should be a priority for counselors and therapists, even if they belong to racial groups that have committed the very discriminatory acts that propelled clients into therapy (Bartoli, Bentley-Edwards, García, Michael, & Ervin, 2015). Regardless of the attending clinician's racial background, developing a trusting relationship lies in the transparency of disclosing one's understanding of and experiences with race-related matters, even if limited. Thus, processing discriminatory events may help targets of RRS develop new, more effective coping skills for future discriminatory acts (Resick, Monson, & Chard, 2006). Along these lines, preliminary research has demonstrated that higher levels of trait-mindfulness are associated with decreased anxious arousal in response to racial discrimination in nonclinical Black populations (Graham, West, & Roemer, 2013), suggesting mindfulness meditation might be a beneficial coping tool in the case of RRS. Further, the identification and carrying out of valued behaviors (e.g., advocacy efforts, self-care, spending time with family), are generally effective for a wide range of challenges to mental health (Dimidjian, Martell, Addis, Herman-Dunn, & Barlow, 2008).

Therapists and mental health programming also have a unique opportunity to encourage coping with RRS. Some interventions developed for Black American adolescents for reducing public health problems (e.g., interpersonal violence, pregnancy) focus on increasing racial identity while teaching problem-solving skills (Belgrave et al., 2004; Ngwe, Liu, Flay, Segawa, & Aban, 2004). In addition to identifying, processing, and validating racial stress and trauma (Hardy, 2013), clinicians have utilized diverse types of behavioral (e.g., collective coping, social support, engaging in

racial socialization with others) and cognitive (e.g., relaxation, storytelling) strategies (S. P. Harrell, 2000; Stevenson, 2003, 2014). Identifying and discussing RRS perceptions, experiences, attitudes, and coping styles improves therapeutic alliance and clients' engagement in treatment. In turn, behavioral coping strategies strengthen relevant sociocultural variables (e.g., racial identity, empowerment) that improve clients' ability to cope with stressors as they seek to heal from past racial encounters and resist the challenges of future encounters.

A Note on Nontherapy Related, Strengths-Based Coping

Participating in therapies and interventions constructed and applied by representatives of American medical systems (e.g., psychologists, physicians, public health experts, etc.) suggests the notion that RRS can only be addressed by those outside of the community. Although we certainly advise empirically driven interventions, there is much mistrust and stigma against the utilization of such services among Black Americans, as well as inherent bias against Black American worldviews woven within the conception of American medical systems themselves (see Tuskegee syphilis study). Considering these factors, we collectively advise strengths-based approaches, that is, those suffering from RRS might reengage in value-driven, culturally salient healing practices. Because of the heterogeneity of the Black community, this suggestion highly depends on context. For example, an older Black woman who relied heavily on spiritual coping throughout her life, but stopped coping following the 2016 election due to RRS and accompanying depressive symptoms, might find complete healing through reengaging in a reliable coping mechanism (attending weekly church services, joining bible study groups). When we consider a Black male in his early twenties struggling with anxiety and anger resulting from a newfound mistrust in American systems as he reaches new stages of his racial identity, he might find healing through taking community action (e.g., joining organizations such as #BlackLivesMatter, local grassroots initiatives, etc.). Further, his healing might come in the form of previously disowned value-driven behaviors, such as engaging in artistic practices, reading African American literature to validate his experiences, or engaging in physical activity.

Black Americans have always had cultural autonomy outside of American medical systems, and healing from RRS is no different. However, the style of coping highly depends on intrapersonal value systems and what activities might produce positive affect individually (e.g., activism via community organizing vs. academic writing, listening to rap music vs. soul music). For person-centered suggestions, healing from RRS can be framed as a reclaiming of one's sense of autonomy, cultural saliency, and freedom of choice, regardless of suggestions made by White-led medical systems.

Finally, we highlight a few other practice-related future directions. With regard to childhood, it is important to develop language and tools to help children heal from the wounds of RRS. We advocate for the few existing therapeutic preventive interventions for children and their families (i.e., BPSS; Engaging, Managing, and Bonding Through Race; Promoting Racial Identity Development in Early Education; Bakari Project; Parham, 2007; Preventing Long-term Anger and Aggression in Youth (PLAAY), Steven-

son, 2003) as they serve as exemplars of developmentally relevant approaches (see Table 1). We encourage other innovative options, including the use and creation of developmentally and culturally relevant media (e.g., books, cartoons). For both adolescence and adulthood, there is a need for more clinical research (e.g., randomized control trials) to compare different treatment modalities for managing RRS, as well as efforts to explore how to infuse cultural

and contextual-relevance into mainstream therapeutic approaches. Finally, given the real and present need for racial trauma healing, we charge the field to be more vigilant in marrying research and theory with practice. In a time when the very notion that #BlackLivesMatter is being questioned and feverishly rallied against, we cannot wait for research agendas to be wholly completed before making concrete practice recommendations (see Jones & Neblett, 2016, 2017).

Table 1. *Selected Interventions for Coping With Racism-Related Stress*

Intervention	Content	Mechanism/Target	Citations/Evidence
Bakari Project	Six areas of mastery (self-awareness/spirituality, history, relationship, skill development, leadership, community service, validation) across 4 years of thematic intervention (rites of passage, mentoring, personal leadership development, apprenticeship college preparation). Originally designed with male groups, but has also been used with mixed-gender groups.	Model assumes that adulthood is defined by mastery rather than age. Emphasizes African-centered principles and constructs.	Parham, 2007; Parham, White, & Ajamu, 2015
BPSS	Cultural adaptation of the Parenting the Strong-Willed Child (Forehand & Long, 2002); 12 sessions (2-hr each) of parent training for parents of 5- and 6-year-olds. Developing parenting strategies around four content areas (e.g., social exclusion, academic achievement, racism, and prejudices).	Familial processes; racial socialization/improve aspects of parenting (monitoring, positive parenting, harsh discipline, use of proactive racial socialization) associated with conduct issues, social and cultural competence in youth.	RCT: Intervention parents engaged in more racial socialization, positive parenting, and less harsh discipline (Coard et al., 2007). Intervention children showed fewer conduct problems, more responsibility, and less cooperation (Coard et al., 2007).
EMBRace	Five 90-min sessions; Intervention for parent-youth dyads (youth ages 10–14 years). Developing skills for three areas: racial socialization content, racial coping, and delivery.	Racial socialization to reduce stressful and traumatic experiences/self-reported coping strategies.	Parents and youth reported improvements in coping strategies (Anderson, McKenny, et al., 2018).
PLAAY	Developing coping skills and anger management through athletic activities; empowering African American parents of boys to engage in cultural socialization.	Psychoeducational and group therapy component. Primary goal is to discuss the meanings, realities, and consequences of being young, Black, and male.	Among a subset of 90 randomly assigned boys, PLAAY students showed significant effects of the intervention on a number of rejection sensitivity variables (Stevenson, 2003).
PRIDE	Conducted a scan to identify how to support positive racial identity development in very young Black children (ages 3–8). Proposed increasing community awareness about race and early childhood; identified the need for curriculum, training, and materials for parents, teachers, and schools to support them engaging in positive racial identity development of very young children; called to action researchers, practitioners, policy makers.	PRIDE pillars include parenting (parent-child curriculum), the arts, education, professional development, and furthering scholarship.	Made specific recommendations based on the findings of the scan. University of Pittsburgh School of Education Race and Early Childhood Collaborative (2016).

Note. BPSS = Black Parenting Strengths and Strategies; EMBRace = Engaging, Managing, and Bonding Through Race; PLAAY = Preventing Long-term Anger and Aggression in Youth; PRIDE = Promoting Racial Identity Development in Early Education; RCT = randomized clinical trial.

Conclusion

“What Goes on Four Feet in the Morning, Two Feet at Noon, and Three Feet in the Evening?”

The famous “Riddle of the Sphinx” coarsely describes the stages of human development. The passing of the day in this riddle—signifying the life span—is coupled with a seemingly impossible change in the ambulatory ability of the riddle’s answer—a person. However, careful and creative thinking allows us to envision the two hands of a baby serving as “feet” for crawling, and the assistance of a walking cane serving as a third “foot” for an elder. And yet, even with the hope borne from the two-term presidency of the first president of African descent, racism has proven to be an even more “impossible” riddle for Black people in this country. As seen in the persistent and deleterious impacts of RRS across the life span, racism similarly operates from “morning” until “night,” or from “crib to coffin” (Gee et al., 2012). And, just as Oedipus’ ability to rid himself of the vice grip of the Sphinx required intentional and creative thinking, healing from RRS requires not only a keen understanding of how that stress manifests across the life span, but also a commitment to alleviating its noxious effects. This work serves to build upon the extant knowledge base, ushering a new set of research and practice that has at its core the mental, physical, and emotional well-being of Black Americans at every stage. Although the riddle may be complex, the solution is not simply to remain puzzled and defeated. Resolution requires proper assessment, documentation, and application to solve what certainly seems to be America’s most pressing and persistent riddle: how can we heal from our racial wounds to have a healthy nation for all?

Keywords: Black Americans; racism-related stress; racial coping; life-course perspective

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