






## Article

# The Psychosocial Health of Black/African Americans Compared with People of Other Races/Ethnic Origins during the COVID-19 Pandemic

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**Abstract:** This study compared the psychosocial health between Black/African Americans and other ethnic groups during the COVID-19 pandemic. Using self-report questionnaires, data were collected at three time points from April 2020 to January 2022, controlling for education and employment status. Surprisingly, Black/African American participants consistently reported lower psychological distress compared to their counterparts. However, they initially reported lower quality of life, which improved over time, eventually surpassing that of the other groups by January 2022. These findings suggest resilience among Black/African Americans despite historical marginalization. Socioeconomic factors and historical context may have influenced these disparities, highlighting the need for targeted interventions to support marginalized communities during crises.

**Keywords:** COVID-19; African American; psychosocial well-being



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## 1. Introduction

Colloquially, “20/20 vision” is a term used to describe being able to see clearly. The year 2020 allowed the world to see health disparities in the United States (US) “clearly” using a global lens. A global pandemic was declared three months after the World Health Organization published a public statement to share that a cluster of illnesses had been identified in Wuhan, China, on 5 January 2020. The analysis teams determined rapid transmission rates as they observed the virus spread across provinces within 30 days. This rapid spread of an illness with fatal potential required immediate and intentional responses internationally to protect public health and safety. Individuals across the globe began to feel impacts from an unfamiliar illness that led to a strain on medical resources [1]. Universal recommendations for social isolation, utilization of face coverings, and travel limits were offered by the World Health Organization [1–4]. In the US, individual states had autonomy to develop and implement responses to address the public health emergency, which led to a variety of policies and procedures. In the US, Puerto Rico was the first to mandate the stay-at-home order for everyone at the onset of the pandemic. In contrast to Puerto Rico, New York and Oklahoma only mandated a stay-at-home order for people with a greater risk of serious illness or death. Some states, such as Texas and Massachusetts, only initiated advisory orders and never mandated all persons to stay home [1,2]. Traditional structures

changed drastically as all non-essential movement was restricted for safety. Typical ways of socializing, working, and learning were no longer immediate options. Pandemic-related stressors and psychosocial and physical health tolls became a new source of concern. The economic burden and financial loss experienced early in the pandemic, paired with concern surrounding high infection and mortality rates and reduced immediate social interaction, had a unique and acute population-wide psychosocial impact [5,6]. Although there were global impacts from COVID-19, experiences and outcomes among individuals have been reported as distinctly different [1,7,8].

As individuals attempted to understand the current state of their world being disrupted, adverse mental and behavioral health outcomes were observed in adults in the US, with symptoms of anxiety and depression increasing significantly in the US from April–June 2020 compared to the same period in 2019 [7–10]. Jewell and colleagues reported that their overall results indicated that US residents experienced higher stress, depression, and anxiety symptoms, especially among uninsured or unemployed residents during the pandemic [9]. Higher rates of adverse psychosocial health were reported by women, younger adults, and healthcare workers [7–11].

COVID-19 highlighted prevalent social injustices in the US. Soon after being declared a global health pandemic, the disparities of the negative impacts of COVID-19 on specific populations became evident [9–11]. The ability to evaluate the presence and severity of COVID-19 by observing social demographics such as geographic location, employment status and setting, gender, age, and race provided detailed information on what groups were disproportionately impacted. Race, social–economic class, and gender were immediate indicators of health inequalities. People of color and those with lower educational levels and incomes were disproportionately impacted by COVID-19 infections and fatalities [12,13]. One example of the disparities observed was the rate of Black/African American people dying at 1.4 times the rate of White people across the US, with those rates being even higher in some states, such as Michigan [14]. In Michigan, although Black/African Americans only account for 14% of residents, they represented 21% of COVID-19 deaths by April 2021 [15]. The staggering rate of mortality among Black/African Americans revealed how structural inequities contribute to the vulnerability of communities and individuals. Predisposing conditions like asthma, heart disease, high blood pressure, and diabetes are all linked to severe illness and mortality due to COVID-19, and these conditions are more common among racial and ethnic minorities [16,17].

Two months after COVID-19 was declared a global pandemic, the murder of a Black man, George Floyd, by a White law enforcement officer was captured on video and shared internationally through various forms of media on 25 May 2020. The image of a sworn officer of the law kneeling on the neck of a citizen was seen worldwide and called for attention and action to address systemic issues, with particular attention focused on government law developers and enforcers. The image and situation quickly became aligned with theories about why systems cannot be trusted to care for the health and wellness of Black and African American citizens, and the term “double pandemic” surfaced to describe the public health impacts of racism and COVID-19 [17,18]. COVID-19 and systemic race-based oppression created a dual pandemic that has been evidenced to lead to poor health outcomes that disproportionately impact people who identify as Black or African American [12,13,19]. The American Psychological Association (APA) reported that there is a link between the mental health issues of Black/African Americans and COVID-19 due to the trauma experienced during the global pandemic [12]. While Black/African Americans have been disproportionately affected with regards to mortality rates due to COVID-19 [15], it is unclear whether the disproportionate health outcomes among Black/African Americans also extended to include psychosocial outcomes. In addition, it is unclear whether any such differences in psychosocial health have been stable over time or have varied across the different stages of the pandemic.

Examining psychosocial health among Black/African Americans in the US in comparison to other groups is important for providing a better understanding of the well-being of Black/African Americans in American society during the COVID-19 pandemic.

### *Study Aim*

This study aimed to examine the psychosocial health of Black/African American adults, in comparison to adults of other ethnic identities, during the COVID-19 pandemic at three different periods of time between 2020 and 2022.

## **2. Materials and Methods**

A repeated cross-sectional design was utilized to observe group differences in psychosocial health throughout the first two years of the global pandemic. Convenience sampling was used. This study reports the results from surveys openly disseminated at three different time points during the COVID-19 pandemic. The electronic surveys were available for the general public's participation in the early phase (April 2020), mid-point (November 2020), and two years after the initial onset of the pandemic (January 2022). In the US, Qualtrics was utilized to collect data from participants. There was no reimbursement to participants, and completing the survey took approximately 10 min. A landing site for the survey was established and shared through personal and professional networks using electronic communication (i.e., text messaging, email, etc.) and social media platforms (i.e., Facebook, Twitter, etc.).

To be included in the study, participants had to be 18 years or older, be able to read English, live in the US, and have access to an electronic device and the internet.

### *2.1. Measures*

#### *2.1.1. Sociodemographic Characteristics*

The sociodemographic data collected included age groups (18–29 years, 30–39 years, 40–49 years, 50–59 years, 60 years and above); gender identity (male, female); racial identity (Black or African American, White, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or other); highest completed education level (high school or lower versus bachelor's degree or higher); and employment status (full-time or part-time employment, or no employment). Racial identity was subsequently re-coded into Black/African American versus other. In the possible case of participants selecting more than one racial identity, participants were treated as Black/African Americans in the analyses if this was one of the selected identities.

#### *2.1.2. Psychosocial Health Variables*

To examine psychosocial health among the participants, the general health questionnaire 12 (GHQ-12), psychosocial well-being (PSW), Cantril's self-anchoring ladder (CL), and loneliness scale were utilized as self-report measures.

The general health questionnaire 12 (GHQ-12) is widely used as a self-report measure of mental health and has been used in multiple studies and shown to be reliable when considering health outcomes in various settings [20–22]. Six items of the GHQ-12 are phrased positively (e.g., "able to enjoy day-to-day activities") and six negatively (e.g., "felt constantly under strain"). The positive items were reverse coded prior to the analysis. The respondent indicated the degree to which the item content has been experienced during the two preceding weeks, using four response categories ("less than usual" (0), "as usual" (1), "more than usual" (2) or "much more than usual" (3)). The final score ranges from 0–36, with higher scores indicating higher psychological distress. Across the three time points, the Cronbach's  $\alpha$  ranged from 0.88 to 0.91.

Psychosocial well-being (PSW) assesses an individual's psychological experience of health and wellness and consists of ten items. The measure includes five positive and five negative statements, with the item scores ranging between 1 (=highest) and 5 (=lowest) [23], with the validity tests in the questionnaire showing a significance level  $< 0.05$  [11]. After

recording, higher PSW scores indicated lower psychosocial well-being. Across the time points, the Cronbach's  $\alpha$  ranged from 0.89 to 0.91.

Cantril's self-anchoring ladder (CL) is a self-administered overall Quality of Life (QoL) questionnaire with one question, "How is your life?", asking the person to rate his or her present experience of life on a scale anchored by their own identified values [24]. The measure is often used when comparing satisfaction with life between groups and populations and has been observed to have reasonable reliability and good validity and stability [24–28]. Higher scores indicate higher quality of life.

The de Jong Gierveld loneliness scale consists of six statements that respondents rate from 0 (totally disagree) to 4 (totally agree). The scale measures two aspects of loneliness, "emotional loneliness" and "social loneliness", but it can also be used as a measure of overall loneliness [29]. This study used all the items to form an overall measure of loneliness, with higher scores indicating higher levels of loneliness. Across the three time points, the Cronbach's  $\alpha$  ranged from 0.77 to 0.83.

## 2.2. Data Analysis

SPSS software version 29.01 was utilized to analyze the data. Participants who selected Black or African American as their racial identity were grouped together and labeled as Black/African American. Participants who selected White or other racial identities were grouped together and labeled as other. Participants with missing data on their racial identity were excluded from all the analyses, while participants with missing data on their sociodemographic and/or psychosocial variables were excluded casewise (analysis-by-analysis). For each time point, racial identity was cross-tabulated with the sociodemographic factors: age group, gender, education level, marital status, and employment status, and the Chi-squared test was used to identify group differences. Variables indicating group differences at  $p = 0.10$  or lower were carried over to be used as covariates in the linear regression analyses conducted in the next step. The associations between racial identity and each of the psychosocial outcomes (psychological distress, quality of life, psychosocial well-being, and loneliness) were assessed at each time point using linear regression analysis. In the regression analyses, we adjusted for sociodemographic variables that were identified in the previous step as having a bivariate association with racial identity at each time point. Statistical significance was set at  $p < 0.05$ . Unadjusted beta values indicate the magnitude of the difference between Black/African Americans compared to participants with other ethnic identities, adjusted for the relevant covariates, and the 95% confidence intervals (CI) indicate the intervals for which group differences are established with 95% certainty.

The variance inflation factor (VIF) was used to examine multicollinearity. For all the analyses, all the VIFs were between 1.01 and 1.09, indicating that there was no problematic multicollinearity between the employed predictor variables. Multivariate normality was approximated, as assessed by visual inspection of the residuals' distribution and by assessing the minimum and maximum values of the standardized residuals. Across the analyses, the standardized residuals were found to be between  $-3.60$  and  $3.54$ , thus slightly exceeding the recommended range  $(-3, 3)$ . To examine the homoscedasticity, we inspected the scatterplots with the standardized predicted values plotted against the standardized residuals. No patterns were observed, indicating that the regression models appeared to function well across the different levels of the dependent variables. Based on this information, we considered the data appropriate for linear regression analysis.

## 2.3. Ethics

Ethical approval was granted by the University of Michigan Institutional Review Board for Health Sciences and Behavioral Sciences (IRB HSBS) and the study was designated as exempt (HUM00180296). The data collected in this study were anonymous.

### 3. Results

#### 3.1. Sociodemographic Characteristics

In the first survey, 74 participants (5.3%) identified as Black/African American out of a total of 1319. In the second survey, 75 participants (3.5%) out of a total of 2130 identified as Black/African American, while in the third survey, 45 participants (4.9%) out of a total of 915 identified as Black/African American. The sociodemographic characteristics of the two sample subgroups at each time point are displayed in Table 1. Significant group differences are shown for marital status (time 1), education level and marital status (time 2), and age, gender, and marital status (time 3).

**Table 1.** Sociodemographic characteristics of Black/African American participants versus participants with other racial identities at three time points during the COVID-19 pandemic.

Time	Characteristics	Black/African American <i>n</i> (%)	Others <i>n</i> (%)	<i>p</i>
1	Age Group			0.09
	18–29	14 (18.9)	227 (17.3)	
	30–39	18 (24.3)	227 (17.3)	
	40–49	18 (24.3)	223 (17.0)	
	50–59	8 (10.8)	235 (17.9)	
	60+	16 (21.6)	401 (30.5)	
	Gender			
	Male	11 (14.9)	313 (24.3)	0.06
	Female	63 (85.1)	973 (75.7)	
	Education Level			
	High school or lower	18 (24.3)	279 (21.2)	0.52
	Higher education	56 (75.7)	1040 (78.8)	
	Marital Status			
	Spouse or partner	36 (63.2)	831 (77.7)	0.01
No spouse or partner	21 (36.8)	238 (22.3)		
Employment				
Employed	47 (64.4)	832 (63.1)	0.82	
Not employed	26 (35.6)	487 (36.9)		
2	Age Group			0.27
	18–29	14 (21.9)	392 (21.9)	
	30–39	14 (21.9)	463 (25.9)	
	40–49	13 (20.3)	279 (15.6)	
	50–59	11 (17.2)	187 (10.5)	
	60+	12 (18.8)	466 (26.1)	
	Gender			
	Male	16 (21.9)	479 (24.6)	0.60
	Female	57 (78.1)	1469 (75.4)	
	Educational Level			
	High school or lower	28 (37.3)	514 (25.5)	0.02
	Higher education	47 (62.7)	1501 (74.5)	
	Marital Status			
	Spouse or partner	32 (42.7)	1230 (59.9)	0.003

**Table 1.** *Cont.*

Time	Characteristics	Black/African American n (%)	Others n (%)	<i>p</i>
	No spouse or partner	43 (57.3)	825 (40.1)	
	Employment			
	Employed	49 (66.2)	1330 (67.1)	0.87
	Not employed	25 (33.8)	652 (32.9)	
3	Age Group			
	18–29	14 (31.1)	167 (19.2)	0.002
	30–39	11 (24.4)	285 (32.8)	
	40–49	8 (17.8)	296 (34.0)	
	50–59	4 (8.9)	72 (8.3)	
	60+	8 (17.8)	50 (5.7)	
	Gender			
	Male	15 (34.9)	179 (22.0)	<0.05
	Female	28 (65.1)	636 (78.0)	
	Education Level			
	High school or lower	13 (28.9)	182 (20.9)	0.20
	Higher education	32 (71.1)	688 (79.1)	
	Marital Status			
	Spouse or partner	20 (44.4)	593 (68.2)	<0.001
	No spouse or partner	25 (55.6)	277 (31.8)	
	Employment			
	Employed	30 (66.7)	661 (76.0)	0.16
	Not employed	15 (33.3)	209 (24.0)	

Note. Statistical tests are Chi-square. The category “Other” for racial/ethnic identities includes participants who did not select Black/African American.

### 3.2. Differences at the Three Time Points

The results of the linear regression analyses of the differences between Black/African Americans and participants with other ethnic identities are shown in four subsequent tables pertaining to psychological distress (Table 2), quality of life (Table 3), psychosocial well-being (Table 4), and loneliness (Table 5). Black/African Americans had lower psychological distress than other participants at all three time points, but the difference was more pronounced in the early phase (beta estimates: T1 =  $-3.64, p < 0.001$ ; T2 =  $-1.91, p = 0.01$ ; T3 =  $-1.86, p < 0.05$ ) (Table 2). Black/African Americans had poorer QoL at T1 (estimate:  $-0.83, p < 0.01$ ) and T2 (estimate:  $-0.81, p < 0.01$ ), but higher QoL at T3 (estimate:  $1.00, p < 0.01$ ), compared to the other participants (Table 3). The differences in psychosocial well-being (PSW) were not significant at T1, but Black/African Americans had higher psychosocial well-being (indicated by lower PSW ratings) at T2 (estimate:  $-0.23, p < 0.05$ ) and T3 (estimate:  $-0.40, p = 0.001$ ) (Table 4). Finally, a borderline trend toward lower loneliness among Black/African Americans at T1 became significant at T2 (estimate:  $-1.31, p < 0.05$ ), but no significant differences in loneliness were found at T3 (Table 5).

**Table 2.** Associations between racial identity and psychological distress at three time points during the COVID-19 pandemic, adjusted for relevant sociodemographic variables.

Time	Independent Variables	Beta (95% CI)	p
1	Age	-1.08 (-1.33--0.84)	<0.001
	Gender	1.28 (0.46-2.10)	0.002
	Marital status	-0.29 (-1.13-0.56)	0.51
	Racial identity	-3.64 (-5.21--2.07)	0.001
	R <sup>2</sup> = 0.095 (adjusted R <sup>2</sup> = 0.092)		F = 28.03
2	Education level	0.65 (0.01-1.29)	<0.05
	Marital status	-0.80 (-1.38--0.23)	0.006
	Racial identity	-1.91 (-3.42--0.40)	0.01
	R <sup>2</sup> = 0.009 (adjusted R <sup>2</sup> = 0.007)		F = 5.61
3	Age	-0.82 (-1.19--0.46)	<0.001
	Gender	1.48 (0.55-2.42)	0.002
	Marital status	-1.36 (-2.21--0.51)	0.002
	Racial identity	-1.86 (-3.66--0.05)	<0.05
	R <sup>2</sup> = 0.053 (adjusted R <sup>2</sup> = 0.048)		F = 11.85

Note. Linear regression analysis showing the associations between racial identity (Black/African American = 1, other racial identity = 0) and psychological distress (GHQ-12 ratings; higher ratings indicate more distress), adjusted for relevant sociodemographic variables at each time point.

**Table 3.** Associations between racial identity and quality of life at three time points during the COVID-19 pandemic, adjusted for relevant sociodemographic variables.

Time	Independent Variables	Beta (95% CI)	p
1	Age	-0.33 (-0.42--0.24)	0.05
	Gender	-0.01 (-0.31-0.28)	0.93
	Marital status	-0.57 (-0.88--0.26)	<0.001
	Racial identity	-0.83 (-1.39--0.27)	0.004
	R <sup>2</sup> = 0.076 (adjusted R <sup>2</sup> = 0.073)		F = 22.29
2	Education level	-0.08 (-0.32-0.16)	0.52
	Marital status	-0.61 (-0.82--0.40)	0.001
	Racial identity	-0.81 (-1.37--0.25)	0.005
	R <sup>2</sup> = 0.020 (adjusted R <sup>2</sup> = 0.019)		F = 12.38
3	Age	0.17 (0.04-0.30)	0.009
	Gender	-0.28 (-0.61-0.05)	0.09
	Marital status	0.76 (0.46-1.06)	<0.001
	Racial identity	1.00 (0.37-1.63)	0.002
	R <sup>2</sup> = 0.052 (adjusted R <sup>2</sup> = 0.047)		F = 11.65

Note. Linear regression analysis showing the associations between racial identity (Black African American = 1, other racial identity = 0) and quality of life (Cantril's ladder ratings; higher ratings indicate higher quality of life), adjusted for relevant sociodemographic variables at each time point.

**Table 4.** Associations between racial identity and psychosocial well-being at three time points during the COVID-19 pandemic, adjusted for relevant sociodemographic variables.

Time	Independent Variables	Beta (95% CI)	p
1	Age	-0.06 (-0.07--0.04)	0.001
	Gender	0.04 (-0.01-0.09)	0.08
	Marital status	0.04 (-0.01-0.09)	0.09
	Racial identity	-0.06 (-0.15-0.03)	0.20
	R <sup>2</sup> = 0.061 (adjusted R <sup>2</sup> = 0.057)		F = 17.57
2	Education level	-0.00 (-0.08-0.08)	>0.99
	Marital status	-0.26 (-0.34--0.18)	<0.001
	Racial identity	-0.23 (-0.44--0.01)	0.04
	R <sup>2</sup> = 0.023 (adjusted R <sup>2</sup> = 0.021)		F = 14.17
3	Age	-0.13 (-0.17--0.08)	<0.001
	Gender	0.17 (0.05-0.30)	0.007
	Marital status	-0.40 (-0.51--0.29)	<0.001
	Racial identity	-0.40 (-0.64--0.15)	0.001
	R <sup>2</sup> = 0.103 (adjusted R <sup>2</sup> = 0.099)		F = 24.49

Note. Linear regression analysis showing the associations between racial identity (Black African American = 1, other racial identity = 0) and psychosocial well-being (PSW-10 ratings, higher ratings indicate lower well-being), adjusted for relevant sociodemographic variables at each time point.

**Table 5.** Associations between racial identity and loneliness at three time points during the COVID-19 pandemic, adjusted for relevant sociodemographic variables.

Time	Independent Variables	Beta (95% CI)	p
1	Age	-0.63 (-0.82--0.44)	<0.001
	Gender	-0.31 (-0.94-0.32)	0.33
	Marital status	-1.55 (-2.21--0.90)	<0.001
	Racial identity	-1.24 (-2.47-0.00)	0.05
	R <sup>2</sup> = 0.077 (adjusted R <sup>2</sup> = 0.073)		F = 22.13
2	Education level	-0.40 (-0.91-0.12)	0.13
	Marital status	-1.31 (-1.78--0.85)	<0.001
	Racial identity	-1.31 (-2.55--0.08)	0.04
	R <sup>2</sup> = 0.020 (adjusted R <sup>2</sup> = 0.018)		F = 12.22
3	Age	-0.19 (-0.50-0.12)	0.24
	Gender	0.39 (-0.41-1.18)	0.34
	Marital status	-1.72 (-2.44--1.00)	<0.001
	Racial identity	-0.66 (-2.19-0.87)	0.40
	R <sup>2</sup> = 0.030 (adjusted R <sup>2</sup> = 0.025)		F = 6.60

Note. Linear regression analysis showing the associations between racial identity (Black/African American = 1, other racial identity = 0) and loneliness (loneliness scale ratings; higher ratings indicate higher levels of loneliness), adjusted for relevant sociodemographic variables at each time point.

#### 4. Discussion

Findings have been reported to highlight the implications of COVID-19 across the world [4,11]. A cross-country comparative survey with respondents from Norway, the USA, the UK and Australia showed that 50–74% of respondents reported high levels of



distress [11]. Due to the unique context of race in the US, most studies focused on country of citizenship or ethnicity. Previous studies in the US have shown that unique challenges have been experienced by Black/African Americans during COVID-19 [1,30–32]. This study aimed to compare the differences in psychosocial health between Black/African Americans and participants with other ethnic backgrounds between 2020 and 2022. Unlike the reports shared by the American Psychological Association, the Black/African American respondents in this study shared having lower psychological distress at each time point compared to their counterparts. Social economic status and self-reporting based on the individual perception of distress may contribute to the differences among participants in this study.

It is possible that the better psychosocial health among Black/African Americans is due to the higher socioeconomic status of the Black/African American participants. While the analyses controlled for education level and employment status where appropriate, we did not ask for information about income levels, occupational group, or other indicators of socioeconomic status in any of the three surveys. Prior studies have shown that better mental health is associated with people of higher socioeconomic status [33,34]. Thus, if the study reached a selected group of Black/African Americans with higher socioeconomic statuses and, comparatively, individuals of other ethnic identities with lower socioeconomic status, such differences may contribute to explaining the group differences in psychological distress in favor of those identifying as Black/African Americans.

Using self-report questionnaires may also contribute to the differences seen in this study. The questionnaires used rely on the perceptions of the participants, and there may be differences in perceptions of stressful events between people of different ethnic backgrounds. A difference in the perception of stress has been observed by Vines and colleagues when they studied the stress levels between Black/African American and White women. Although there were not differences between the number of stressful events experienced by the Black/African American and White women, the White respondents reported higher levels of stress than the Black/African American women concerning similar or same events (2009).

While the Black/African American participants had consistently lower levels of psychological distress than the participants with other ethnic identities, they also had lower levels of quality of life than their counterparts on the two first measurement occasions. As better mental health is generally associated with higher quality of life [35], these combined results for the early stages of the pandemic are seemingly a paradox. Black/African Americans did report lower levels of quality of life than the other groups from mid-late 2020, and that may have been attributed to the general public learning about disparities among mortality rates and to other national crises that involved racial conflicts. Lower levels of quality of life for incidents that may appear to be preventable may also speak to the experiences of a group that has experienced historical marginalization and oppression. This prompts consideration of how Black/African Americans in the US have experienced historical marginalization and oppression, which may have resulted in higher levels of resilience and a sense of strength in unity than other racial and ethnic groups [36,37]. It is worth noting that the murder of George Floyd, which may have had a particular influence on the responses, took place shortly after the first survey was distributed. Therefore, a positive sense of mental health might co-exist with the lower levels of quality of life, which can likely arise from Black/African Americans' experiences of marginalization, discrimination, and oppression.

Although media reports have shared that Black/African Americans are reporting disproportionate challenges and disruptions to their psychosocial health due to being impacted by the “double pandemic”, this study identified Black/African American respondents as having lower levels of psychological distress than other groups [32,38–42].

## 5. Limitations

A convenience sample was recruited via social media, rendering the results difficult to generalize to the study population of adults in the USA. The fact that the study was led by universities may have contributed to the higher levels of participants with higher levels of education and employment. At each time point of data collection, more than 50% of participants reported having completed higher educational levels and at least 60% of participants reported being employed. Since this is not representative of the general population, the results of the study should be treated with caution. Caution should also be exercised due to the small sample of Black/African Americans obtained at each of the measurement occasions.

This study did not follow the participants at each time period, so the responses are based on different participants with different intersections of identities. Although this study did not follow specific participants, survey fatigue from various sources may have impacted both the response rates and responses given.

Additional environmental factors, such as policy changes or support from public authorities (i.e., stimulus payments, supplemental unemployment insurance, vaccination availability, elections, etc.) during the survey administration, may also have impacted the responses related to distress, quality of life, and psychosocial health.

## 6. Conclusions

In this study, Black/African American participants reported being less psychologically distressed compared with other racial groups at three different time points between April 2020 and January 2022. Although Black/African Americans reported having significantly lower levels of quality of life than other racial/ethnic groups at the early onset (April/May 2020) and midpoint (November 2020), Black/African American respondents had significantly higher quality of life than their counterparts at the two-year time point (January 2022). It may be beneficial to explore the factors that led to lower levels of quality of life.

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