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Gendered Racial Microaggressions Predict Post-traumatic Stress Disorder Symptoms and Cognitions among Black Women living with HIV

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Abstract

Objective: Gendered racial microaggression (GRM) experienced by Black women living with HIV (BWLWH) is a potentially important variable for PTSD symptomatology in this population. GRM refers to everyday insults experienced by Black women on the basis of being both Black and female (e.g. comments about Black women’s hair and body). We investigated the associations between GRM, race- and HIV-related discrimination, and trauma symptoms among BWLWH and explored whether gendered racial microaggressions contributed uniquely to trauma symptoms above the contribution of race- and HIV-related discrimination.

Methods: 100 BWLWH in the U.S. completed baseline measures on GRM (frequency and appraisal), racial discrimination, HIV-related discrimination, post-traumatic stress disorder (PTSD) symptoms, and post-traumatic cognitions.

Results: Hierarchical multiple linear regressions controlling for age, education, and income indicated that higher GRM and HIV-related discrimination predicted higher total PTSD symptoms, and higher GRM and racial discrimination predicted higher post-traumatic cognitions. Hierarchical multiple linear regressions with all predictors entered together revealed that only GRM contributed uniquely to both total PTSD symptoms and total post-traumatic cognitions. Analyses between GRM subscales and subscales of PTSD symptoms and post-traumatic cognitions indicated that GRM about beauty/sexual objectification and the strong Black women stereotype contributed uniquely and in interesting ways to PTSD symptoms and post-traumatic cognitions.

Conclusions: Our findings highlight the importance of addressing intersectional adversities such as GRM for BWLWH, as well as recognizing the role that GRM may play in mental health symptoms for Black women. Future research and intervention efforts aimed at improving the well-being of BWLWH should address GRM.

Keywords

Black women; HIV; microaggressions; discrimination; trauma symptoms

Introduction

One of the largest health disparities in HIV is seen at the intersection of gender and race as it pertains to Black women (Centers for Disease Control and Prevention, 2018). Black women represent 12.7% of women in the U.S. yet account for over 60% of women living with HIV and are six times more likely to die from HIV compared to White women (Centers for Disease Control and Prevention, 2018). Trauma and resulting symptoms of post-traumatic stress disorder (PTSD) are key psychosocial factors that have been highlighted as significantly related to both risk for HIV acquisition, poor health indicators once infected (e.g. low medication adherence), and risk for HIV-related morbidity (French et al., 2009; Machtiger, Haberer, Wilson, & Weiss, 2012). Further, the lives of Black women living with HIV (BWLWH) are impacted by adversities including race-related discrimination, HIV-related discrimination, and gendered racial microaggression (Dale, Pierre-Louis, Bogart, O’Cleirigh, & Safren, 2018; Dale & Safren, 2017; Lewis, Mendenhall, Harwood, & Browne Hunt, 2016).

Microaggressions are commonplace every day insults (e.g. jokes, comments) that are meant to demean a marginalized group (Sue, 2010) and gendered racial microaggressions are those experienced by Black women on the basis of being both Black and women (Lewis, Mendenhall, Harwood, & Browne Hunt, 2016; Lewis & Neville, 2015). There is a burgeoning body of literature examining the relationships between racial discrimination and trauma symptoms in the general population (Pieterse, Carter, Evans, & Walter, 2010; Polanco-Roman, Danies, & Anglin, 2016; Wei, Wang, Heppner, & Du, 2012), but there are only a few studies among persons living with HIV that link race-related discrimination and HIV-related discrimination with trauma symptoms (none among BWLWH) (Bogart et al., 2011; Wagner, Bogart, Galvan, Banks, & Klein, 2012). Racial discrimination events assessed were acts such as denial of job and housing (Bogart et al., 2011), which are macroaggressions in comparison to subtle and less overt microaggressions (e.g. jokes). However, no existing literature has examined the associations between gendered racial microaggressions and trauma symptoms among BWLWH or explored whether gendered racial microaggressions contribute to trauma symptoms above what is contributed by discrimination (race- and HIV-related).

There is also a growing field of literature linking experiences of racial discrimination with trauma symptoms. In 2007, Carter argued that racial discrimination results in traumatic symptoms and hence there is need to both recognize and assess *race-based traumatic stress* (Carter, 2007). Since then additional researchers have reported findings in support of the link between racism and trauma symptoms (Pieterse et al., 2010; Polanco-Roman et al., 2016; Wei et al., 2012). For instance, among Black and Asian students, Pieterse et al. (2010) found that racial and ethnic discrimination contributed additional variance to trauma symptoms above the contribution of generic stress.

The literature on racial discrimination and trauma symptoms in the HIV literature, however, is extremely sparse. Wagner and colleagues (2012) found that race-related discrimination, HIV-related discrimination, and gay sexual-orientation discrimination were related to PTSD symptoms among Black men living with HIV and that discrimination mediated the

relationship between PTSD symptoms and HIV medication adherence. Similarly, Myers et al. (2015) both conceptualized and reported findings indicating that experiences of racial discrimination among Black and Latina women account for a part of the *cumulative burden of adversities* they experience and relate to mental health symptoms including PTSD symptoms. Also among a diverse sample of women with HIV, researchers found that HIV-related stigma was associated with PTSD symptoms (Katz & Nevid, 2005). However, we were unable to find any studies specifically among BWLWH in the U.S. that examined the relationships between race-related and HIV-related discriminations and trauma symptoms.

There is a similar gap in the literature as it relates to microaggressions, with a limited number of studies noting relationships between microaggressions and trauma symptoms. For instance, Torres and Taknint (2015) found that ethnic microaggressions among Latinos were significantly associated with traumatic stress symptoms and that trauma symptoms mediated the relationship between microaggressions and depressive symptoms. Torres and Taknint (2010) also found that racial microaggressions among African American students in doctoral graduate programs were related to greater stress, but trauma symptoms were not an outcome measure. In addition, Robinson and Rubin (2016) also reported significant associations between homonegative microaggressions and PTSD symptoms among lesbian, gay, bisexual, and heterosexual participants. While we are aware of one manuscript (Moody & Lewis, under review) that reports empirical findings between gendered racial microaggressions and trauma symptoms in a general sample of Black women, there is no existing literature on the relationships between gendered racial microaggressions and trauma symptoms among BWLWH nor literature examining the unique contribution of gendered racial microaggression above race- or HIV-related discrimination. Gendered racial microaggression is particularly important to investigate as it gives an intersectional (Crenshaw, 1991) lens to examine daily microaggressions experienced by Black women on the basis of being “women” and “Black”.

Given the gaps in the literature, our current study is poised to make a rather unique contribution to the literature on microaggressions and trauma symptoms, especially as it pertains to BWLWH. In the current study among BWLWH and histories of trauma, we examined associations between gendered racial microaggression, race-related discrimination, HIV-related discrimination, PTSD symptoms, and post-traumatic cognitions and explored whether gendered racial microaggression made a unique contribution to PTSD symptoms and cognitions above and beyond what race- and HIV-related discrimination contributes. Our findings could provide important insights on the role that everyday gendered racial micro-aggressions play in relation to trauma symptoms and cognitions experienced by BWLWH and the need for interventions to address microaggressions in addition to race- and HIV-related discrimination.

Methods

Participants

BWLWH were recruited in a large urban metropolitan area in the Southeastern United States between October 2017 and May 2018 as part of an intervention development study in the U.S. Study flyers and posters were distributed at community health centers and clinics,

hospitals, community events, and community-based organizations. In addition, study staff regularly visited these organizations, built relationships with their staff, and provided information about this research study. Potential participants were screened for eligibility once they contacted our study staff. Upon completion of the screen women were eligible for an in person baseline assessment if they met the following inclusion criteria (1) English speaking, (2) At least 18 years old, (3) Cis-gender female, (4) Identify as Black and/or African American, (5) History of abuse/trauma, (6) Prescribed antiretroviral therapy (ART) for HIV for at least the last two months, and (7) self-reported detectable viral load within the past year, low ART adherence, and/or missed HIV-related medical visits within the past year.

At the baseline assessment participants completed the informed consent process, used Research Electronic Data Capture (REDCap, a secure web-based application; [Harris et al., 2009]) to complete self-report surveys, and participated in a semi-structured clinical interview. The baseline assessment process occurred over 2 visits across 2 weeks. Participants were given \$50 total (\$25 at visit 1 and \$25 at visit 2) at the baseline assessment for their time and efforts. All study procedures were approved by the Institutional Review Board at the University of Miami. Participants primarily interfaced with a team of Black females (Principal Investigator, two research coordinators, one graduate student, and one research coordinator/recruiter who is also a women living with HIV).

Measures

Self-report Sociodemographic Survey.—This survey asked participants to provide information on their age, education level, country of birth, annual income, employment status, sexual orientation, relationship status, number of children, living situation, religious affiliation, and HIV viral load status (i.e. detectable vs undetectable).

Multiple Discrimination Scale (MDS; Bogart et al., 2011).—Twenty-six items from the Multiple Discrimination Scale (Bogart et al., 2011) were used to capture race-related discrimination and HIV-related discrimination. Thirteen items assess race-related discrimination and the other thirteen parallel items assess HIV-related discrimination. Participants were asked to respond “yes” or “no” to questions about whether in the past year they experienced thirteen different discriminations events such as interpersonal discrimination or institutional discrimination. Sample items include, “In the past year, were you denied a job or did you lose a job because you are Black or African-American?” and “In the past, were you ignored, excluded, or avoided by people close to you because you are HIV positive?” The MDS has shown good reliability (Cronbach’s alphas of .85 for HIV subscale and .83 for race subscale) and construct validity (e.g. associated with mental health symptoms) (Bogart et al., 2011). In the current sample Cronbach’s alpha for the race-related discrimination subscale was .86 and .87 for the HIV-related discrimination subscale.

Gendered Racial Microaggressions Scale for Black Women (Lewis & Neville, 2015).—This 26-item scale captures microaggressions experienced by Black women both on the basis of being Black and women. The scale includes a frequency scale and an appraisal scale as well as four subscales - Assumptions of Beauty and Sexual Objectification Subscale, Silenced and Marginalized Subscale, Strong Black Woman Subscale, and Angry

Black Woman Subscale. Sample items include “Someone accused me of being angry when I was speaking in a calm manner”, “I have been told I am too independent”, and “Someone made a negative comment to me about my skin color / skin tone”. Women are asked to select how often in their lifetime (0=never, 1=less than once a year....5=once a week or more) they experienced a microaggression and to rate how stressful the experience was for them (0= never happened, 1= not at all stressful....5=extremely stressful). The GRMS-BW has shown good validity (Lewis & Neville, 2015) and reliability (Cronbach’s alphas of .93 (appraisal) and .92 (frequency) in the literature. In the present sample Cronbach’s alpha was .95 for appraisal and .92 for frequency.

Post-traumatic Cognition Inventory (PTCI; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999).—The PTCI is a 36-item scale that measures common trauma-related thoughts. Sample items include “The event happened because of the way I acted” and participants respond to all items on a 7-point likert scale (e.g. totally disagree, totally agree). In addition to the overall scale the PTCI has three subscale capturing trauma-related thoughts – Negative Cognitions About the Self, Negative Cognitions About the World, and Self-Blame. The PTCI has shown great reliability (Cronbach’s alpha of .97) and validity in the literature (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). However, researchers have found that women with significant posttraumatic stress symptoms endorsed fewer negative cognitions than men (Herta, Nemes, & Cozman, 2017) and that African Americans scored higher on negative cognitions about the world than White Americans (Williams, Jayawickreme, Sposato, & Foa, 2011). Cronbach’s alpha was .96 in this sample.

Davidson Trauma Scale (DTS; Davidson et al., 1997).—This is a 17-item measure of post-traumatic stress disorder symptoms (PTSD) that fall within three clusters of (i.e. re-experiencing, avoidance/numbing, and hyperarousal). Participants are instructed to “Please identify the trauma or abuse experience that has been the most disturbing for you” and rate their symptoms for the past week. A sample item is “Have you ever had distressing dreams of the event?” Participants respond to each item on 5-point Likert scales capturing both the frequency of each symptom (e.g. 0= not at all, 4= everyday) and the related severity/distress (e.g. 0 = not at all distressing, 4 = extremely distressing). The sum of the frequency and severity scores for the total scale and subscales were used in analyses. DTS is a widely used measure of PTSD symptoms with evidence of excellent reliability (Cronbach’s alphas of .99) and validity in existing literature (Davidson et al., 1997). No gender differences have been observed on the DTS (Davidson, Tharwani, & Connor, 2002). Cronbach’s alpha was .94 in the present sample.

Analyses

All statistical analyses were conducted with SPSS version 24. All 100 participants who completed baseline assessments were included in analyses. First, to assess how predictors of race-related discrimination, HIV-related discrimination, and gendered racial microaggression (frequency and appraisal) were each related to outcomes of PTSD symptoms (total scores and subscale scores) and post-traumatic cognitions (total scores and subscale scores), hierarchical linear regressions controlling for covariates of age, education, and income were run. One predictor and one outcome were entered separately each time. Second, hierarchical

multiple linear regressions controlling for covariates were run with all the predictors of interest entered together to examine the unique effects of the predictors on each outcome. Third, hierarchical multiple linear regressions controlling for covariates were conducted to examine which gendered racial microaggression subscales (entered together) contributed unique variance to total scores and subscale scores of PTSD symptoms and post-traumatic cognitions.

Results

Socio-demographics and Clinical Characteristics

Table 1 presents participants' socio-demographics and descriptive statistics on study surveys for 100 BWLWH. In short, participants' average age was 49 (range = 22 – 67), 62% had an annual income of less than \$12,000, 63.5% finished high school or above, 71% were renting an apartment or home, and 61% were on disability. The traumatic events that women reported as most disturbing on the Davidson Trauma Scale included sexual assault/abuse (26%), physical assault/abuse (13%), both sexual and physical abuse/assault (5%), intimate partner violence (14%), death of a loved one (21%), HIV diagnosis (5%), and other (16%).

Multivariable Associations of Discrimination, Microaggressions, and Trauma Symptoms and Cognitions (Table 2)

Higher race-related discrimination significantly predicted higher total post-traumatic cognitions ($\beta=.25$, $p<.05$), but was not associated with total PTSD symptoms ($\beta=.21$, $p=ns$). Similarly, higher HIV related discrimination significantly predicted higher total PTSD symptoms ($\beta=.27$, $p<.05$), but not total post-traumatic cognitions ($\beta=.16$, $p=ns$). However, higher gendered racial micro-aggressions (frequency and appraisal) significantly predicted both higher total PTSD symptoms (frequency: $\beta=.32$, $p<.01$; appraisal: $\beta=.34$, $p<.01$) and higher total post-traumatic cognitions (frequency: $\beta=.40$, $p<.001$; appraisal: $\beta=.40$, $p<.001$).

Higher race-related discrimination significantly predicted PTSD hyperarousal ($\beta=.27$, $p<.05$), negative cognitions about the world ($\beta=.27$, $p<.05$), and self-blame ($\beta=.26$, $p<.05$). Higher HIV-related discrimination significantly predicted PTSD avoidance/numbing ($\beta=.25$, $p<.05$). Higher gendered related microaggressions significantly predicted PTSD avoidance/numbing (frequency: $\beta=.30$, $p<.01$; appraisal: $\beta=.27$, $p<.05$), PTSD hyperarousal (frequency: $\beta=.38$, $p<.01$; appraisal: $\beta=.48$, $p<.001$), negative cognitions about the self (frequency: $\beta=.32$, $p<.01$; appraisal: $\beta=.39$, $p<.001$), negative cognitions about the world (frequency: $\beta=.41$, $p<.001$; appraisal: $\beta=.38$, $p<.01$), and self-blame (frequency: $\beta=.36$, $p<.01$; appraisal: $\beta=.26$, $p<.05$). There were no significant associations between (a) racial discrimination, PTSD re-experiencing, PTSD avoidance/numbing, negative cognitions about the self, and self-blame (b) HIV-related discrimination, PTSD re-experiencing, PTSD hyperarousal, negative cognitions about the self, negative cognitions about the world, and self-blame, and (c) gendered racial microaggression (frequency and appraisal) and PTSD re-experiencing.

Multivariable Associations of Predictors Entered Together to Predict and PTSD symptoms and Post-traumatic Cognitions (Table 3)

Only gendered racial microaggression (appraisal: $\beta=.28$, $p<.05$; frequency: $\beta=.27$, $p=.05$) made a unique contribution to the prediction of total PTSD symptoms. Neither racial discrimination nor HIV-related discrimination remained significantly associated with total PTSD symptoms in the multivariable model. Similarly in predicting total post-traumatic cognitions, only gendered racial microaggression (frequency: $\beta=.41$, $p<.01$; appraisal: $\beta=.37$, $p<.01$) made a unique contribution, but not racial discrimination or HIV-related discrimination.

Gendered racial microaggression made unique contributions to PTSD hyperarousal symptoms (appraisal: $\beta=.43$, $p<.001$; frequency: $\beta=.34$, $p<.05$) and PTSD avoidance/numbing symptoms (frequency: $\beta=.27$, $p<.05$). Further, gendered racial microaggression uniquely contributed to negative cognitions about the self (appraisal: $\beta=.37$, $p<.01$; frequency: $\beta=.33$, $p<.05$), negative cognitions about the world (frequency: $\beta=.43$, $p<.01$; appraisal: $\beta=.34$, $p<.01$), and self-blame (frequency: $\beta=.36$, $p<.05$). Race-related discrimination did not contribute uniquely to any subscales of PTSD symptoms or post-traumatic cognitions, HIV-related discrimination did not contribute uniquely to either subscales of PTSD or post-traumatic cognition, gendered racial microaggression frequency did not contribute uniquely to PTSD re-experiencing, and gendered racial microaggression appraisals did not contribute uniquely to subscales of PTSD re-experiencing, PTSD avoidance/numbing, or self-blame.

Multivariable Associations Examining Associations between the Subscales of Gendered racial Microaggressions and PTSD symptoms and Post-traumatic Cognitions

Given that gendered racial microaggression both in terms of frequency and appraisal made unique contributions to total PTSD symptoms and post-traumatic cognitions as well as their respective subscales, additional analyses were conducted to examine which subscales of gendered racial microaggression (i.e. Assumptions of Beauty and Sexual Objectification Subscale, Silenced and Marginalized Subscale, Strong Black Woman Subscale, and Angry Black Woman Subscale) in particular explained unique variance in both total scores and subscale scores of PTSD and post-traumatic cognition symptoms.

Findings (see Table 4) indicated that beauty and sexual objectification microaggression frequency (1) contributed uniquely and was significantly and positively related to total PTSD symptoms (frequency: $\beta=.48$, $p<.01$) and (2) was on the borderline for significantly contributing to total post-traumatic cognitions (frequency: $\beta=.32$, $p=.05$). Strong Black woman microaggression frequency was also on the borderline for significantly contributing to total PTSD symptoms, but inversely (frequency: $\beta = -.23$, $p=.05$). In addition, the beauty/sexual objectification and strong Black woman microaggression subscales contributed uniquely to some subscales of PTSD symptoms and post-traumatic cognitions. Beauty and sexual objectification microaggression (frequency and/or appraisal) contributed uniquely and was positively related to PTSD symptoms of re-experiencing (frequency: $\beta=.42$, $p<.05$), PTSD symptoms of avoidance/numbing (frequency: $\beta=.46$, $p<.01$), PTSD symptoms of hyperarousal (frequency: $\beta=.36$, $p<.05$), and negative cognitions about the self (appraisal:

$\beta=.38, p<.05$). Strong Black woman microaggression frequency contributed uniquely and was inversely related to PTSD symptoms of re-experiencing (frequency: $\beta = -.27, p<.05$) and negative cognitions about the self (frequency: $\beta = -.24, p<.05$). Strong Black woman microaggression appraisals also contributed uniquely to negative cognitions about the world, but positively (appraisal: $\beta=.36, p<.05$).

Discussion

In a sample of BWLWH with histories of trauma, average trauma symptom and cognition scores were consistent with previous literature (Davidson et al., 2002; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) and we found new and significant findings among gendered racial microaggression, race-related discrimination, HIV-related discrimination, PTSD symptoms, and post-traumatic cognitions that add to the literature. Specifically we found that higher gendered racial microaggression and HIV-related discrimination were significantly associated with higher total PTSD symptoms, and higher gendered racial microaggression and racial discrimination were significantly associated with higher total post-traumatic cognitions. The findings between race- and HIV-related discrimination and PTSD symptoms and cognitions add to the small body of literature (Bogart et al., 2011; Wagner et al., 2012) (which includes no studies on Black women) noting associations between discrimination and PTSD symptoms among people living with HIV. However, among Black women no prior study has reported significant findings between gendered racial microaggressions and both PTSD symptoms and post-traumatic cognitions. These findings are not only novel, but important because they highlight the need to both study and understand how intersectional everyday slights for Black women (i.e. gendered racial microaggressions) relate to trauma symptoms and cognitions. These are particularly important for BWLWH as PTSD symptoms have been shown to relate to negative HIV health outcomes and behaviors (Machtiger, Haberer, et al., 2012). Though subtle, the daily and pervasive nature of microaggressions have macro-level impact and make them necessary to examine in addition to overt acts of discrimination. This is consistent with a previous publication (Donovan et al., 2013) noting that racial microaggressions predicted higher depressive symptoms and made a unique contribution above overt racial discrimination.

Our additional findings showed that gendered racial microaggression, race-related discrimination, and HIV-related discrimination were related to the various subscales of PTSD symptoms and post-traumatic cognitions in interesting ways. Race-related discrimination related to PTSD hyperarousal symptoms, negative cognitions about the world, and self-blame. Black women with HIV may be vigilant/jumpy due to experiences of racial discrimination and in an effort to prevent future encounters, may think negatively about the world as a result of being treated differently based on their race, and may also blame themselves due to internalized oppression (Dale & Merren, 2018) and common practices of their discrimination experiences being questioned, minimized, and invalidated (Eliezer & Major, 2012; Gulker, Mark, & Monteith, 2013; Kaiser & Miller, 2001). HIV-related discrimination was associated with PTSD symptoms of avoidance/numbing, suggesting that BWLWH may avoid conversations, people, and places that remind them of HIV-related discrimination. This particular cluster of symptoms may be useful for women living with HIV given that one's HIV status is not a visible identity. Women may also try to

avoid thoughts of HIV-discrimination in an effort to reclaim their daily lives beyond their HIV positive status. Gendered racial microaggressions were significantly related to higher PTSD symptoms and post-traumatic cognitions in all subscales except one (PTSD re-experiencing). Higher gendered racial microaggressions predicted higher PTSD hyperarousal, PTSD avoidance/numbing, negative cognitions about the self, negative cognitions about the world, and self-blame. This indicates that gendered racial microaggressions may relate to BWLWH being vigilant/jumpy, avoiding people, places, and conversations related to microaggression experiences, as well as having negative thoughts about oneself and the world, and blaming oneself. These multiple associations echo the negative impact of gendered racial microaggressions on PTSD symptoms experienced by BWLWH and suggest a call for additional research and intervention efforts.

Further, when gendered racial microaggression, race-related discrimination, and HIV-related discrimination were entered together in models only gendered racial microaggression contributed uniquely to total PTSD symptoms, total post-traumatic cognitions and most of their various subscales. In particular, two of the four types of gendered racial microaggression (assumptions of beauty/sexual objectification, silenced and marginalized, strong Black woman, and angry Black woman) may contribute uniquely to PTSD symptoms and post-traumatic cognitions. Beauty and sexual objectification microaggressions contributed uniquely to PTSD hyperarousal, PTSD avoidance/numbing, and negative cognitions about the self, with higher beauty and sexual objectification microaggressions relating to higher PTSD symptoms of hyperarousal and avoidance/numbing and higher negative cognitions about the self. The beauty/sexual objectification microaggressions may cause BWLWH to feel uneasy/jumpy and be vigilant, avoid certain people, places, and conversations, and think negatively about themselves. In addition, for BWLWH with various trauma histories such sexual abuse/rape, beauty/sexual objectification microaggressions may trigger and exacerbate PTSD symptoms linked to those traumas. These findings are consistent with findings by Miles-McLean and colleagues (Miles-McLean et al., 2015) who found that sexual objectification was associated with trauma symptoms both for women with and without histories of sexual trauma and that for women with sexual trauma histories sexual objectification was also associated with feeling ashamed of one's body.

Strong Black women microaggressions also contributed uniquely to some symptoms of PTSD and post-traumatic cognitions, but not entirely as expected. Higher strong Black women microaggressions related to lower PTSD re-experiencing symptoms and lower negative cognitions of the self, but higher negative cognitions about the world. While strong Black women microaggressions are negative (i.e. "I have been told I am too independent") they may trigger positive self-evaluations by BWLWH (i.e. "I am independent") hence relate to lower negative cognitions of the self (Romero, 2000). Also BWLWH reporting experiences of strong Black women microaggressions may embrace the strong Black women stereotype in their own lives as a source of strength/motivation that helps them to heal from trauma thereby reporting lower PTSD symptoms of re-experiencing (Abrams, Maxwell, Pope, & Belgrave, 2014; Dale, Pierre-Louis, Bogart, O'Cleirigh, & Safren, 2018). On the other hand, the negative impact of the strong Black women microaggressions is still evidenced by higher strong Black women microaggressions relating to negative cognitions about the world.

Limitations

While we present novel findings on the relationships between microaggressions, discrimination, and trauma symptoms among BWLWH, there are a few limitations to note. First, the data were collected among BWLWH in the United States and therefore findings may not be as generalizable to women in other geographic locations. Second, this was a cross-sectional study design and as such we are unable to draw causal conclusions. Third, all the surveys were self-report measures, which inherently are subject to social desirability and recall biases. Despite these limitations our findings make contribution to the literature and broaden our understanding of the associations between gendered racial microaggression, race- and HIV-related discrimination, PTSD symptoms, and post-traumatic cognitions among BWLWH.

Implications

Our findings that higher gendered racial microaggressions and higher race- and HIV-related discriminations relate to higher PTSD symptoms and post-traumatic cognitions, with gendered racial microaggressions contributing uniquely have three important implications. One, large scale research studies on these variables are needed to further enhance our knowledge and be equipped to improve the lives of BWLWH. Two, intervention efforts for BWLWH need to address gendered racial microaggressions in addition to race- and HIV-related discriminations. Three, daily gendered racial microaggressions (especially beauty/sexual objectification and strong Black women types) warrant special attention as we seek to understand and address trauma symptoms among BWLWH. Beauty and sexual objectification microaggressions especially need to be thwarted via public education, awareness, and policies. While strong Black women microaggressions showed positive associations with trauma symptoms, this does not lend support to their ongoing perpetration. Instead additional attention and research is needed on the internal coping and interpretation that Black women may make of these strong Black women microaggressions that may in turn render positive effects. However, intervention efforts may benefit from emphasizing humanizing narratives of Black women's strength that incorporate struggle, vulnerability, help seeking, and self-care (Dale, Pierre-Louis, Bogart, O' Cleirigh, & Safren, 2018).

Conclusion

In sum, the literature had not previously investigated the associations between gendered racial microaggressions and trauma symptoms among Black women living with HIV or explored whether gendered racial microaggressions contributed above and beyond what discrimination (race- and HIV-related) contributed to trauma symptoms. Our analyses revealed that while higher gendered racial microaggressions and race- and HIV-related discrimination were associated with higher trauma symptoms, gendered racial microaggressions contributed uniquely to both PTSD symptoms and post-traumatic cognitions. In particular, higher beauty/sexual objectification microaggressions related to higher PTSD symptoms and negative thoughts about the self, while higher strong Black women microaggressions related to higher negative thoughts about the world, but lower PTSD symptoms and negative thoughts about the self. Additional research is needed to examine the role of gendered racial microaggressions in the lives of BWLWH and

interventions aimed at improving the well-being of BWLWH and/or reducing trauma symptoms need to address gendered racial microaggressions. Further, greater recognition is needed for the importance of intersectional everyday slights in the lives of BWLWH and the macro-impact of microaggressions.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Clinical Impact Statement

Gendered racial microaggressions are intersectional everyday slights and insults (e.g. jokes, comments) that Black women experience on the basis of being both Black and women. Our study among Black women living with HIV and histories of trauma found that gendered racial microaggression predicts trauma symptoms more than race- and HIV-related discrimination. This emphasizes the importance of intersectional everyday slights in the lives of Black women living with HIV and the major impact of microaggressions on their mental health. Clinicians need to consider and address the role of microaggressions in trauma symptoms.

Table 1.

Sociodemographics and Clinical Characteristics of Black Women Living with HIV

Characteristic		Mean (SD, range) or n (%)*
Age		49.25 (10.89, 22–67)
Income	Less than \$5,000	36 (35.6%)
	\$5,000 – \$11,999	27 (26.7%)
	\$12,000 – \$15,999	7 (6.9%)
	\$16,000 – \$24,999	4 (4%)
	\$25,000 – \$34,999	2 (2%)
	\$35,000 – \$49,999	0 (0%)
	\$50,000 and greater	3 (3%)
	Choose not to answer or Don't know	21 (21%)
	Missing	0 (0%)
Education	Eighth grade or Lower	5 (5%)
	Some high school	31 (30.7%)
	High school graduate/GED	34 (33.7%)
	Some college	24 (23.8%)
	College graduate	5 (5%)
	Some graduate school	1 (1%)
	Missing	0 (0%)
Employment Status	Full-time Work	5 (5%)
	Part-time Work	6 (5.9%)
	Full or Part-time School	4 (4%)
	Neither Working or in School	18 (17.8%)
	On Disability	62 (61.4%)
	Other	6 (5.9%)
	Missing	0 (0%)
Housing Arrangement	Renting home or apartment	72 (71.3%)
	Owned by you or someone else in household	10 (9.9%)
	Publicly subsidized housing	9 (8.9%)
	A friend or relative's home/apartment	5 (5%)
	Homeless: sleeping in a shelter	1 (1%)
	Homeless: sleeping on the street, beach, car	1 (1%)
	Missing	2 (2%)
Living Situation	Lives with Self	55 (54.5%)
	Partner/spouse	19 (18.8%)
	Roommates	5 (5%)
	Children	25 (24.8%)

Characteristic	Mean (<i>SD, range</i>) or n (%)*	
	Group Home or Residential Treatment	1 (1%)
	Other	21 (20.8%)
	Missing	0 (0%)
Place of Birth	U.S. Born	98 (97%)
	Non-U.S. Born	2 (2%)
Parents of Children		83 (82.2%)
	Missing	1 (1%)
Number of Children of Parents of Children		2.78 (1.562, 1–9)
	Missing	0 (0%)
Religion	Christian	26 (25.7%)
	Catholic	4 (4%)
	Baptist	53 (52.5%)
	None	7 (6.9%)
	Other	8 (7.9%)
Relationship Status	Married	14 (13.9%)
	Cohabiting relationship, unmarried	14 (13.9%)
	Non-cohabiting relationship	13 (12.9%)
	Single	47 (46.5%)
	Divorced/Separated	7 (6.9%)
	Widow or Loss of Partner	3 (3%)
	Missing	2 (2%)
Sexual Orientation	Exclusively Heterosexual	76 (75.2%)
	Heterosexual, some Homosexual Experience	9 (8.9%)
	Bisexual	6 (5.9%)
	Exclusively Homosexual	4 (4%)
	Choose not to answer	1 (1%)
	Missing	4 (4%)
Gendered racial microaggressions (Frequency)		24.03 (20.27)
Gendered racial microaggressions (Appraisal)		24.07 (22.68)
Race-related Discrimination		1.83 (2.62)
HIV-related Discrimination		1.02 (1.89)
PTSD symptoms		43.64 (28.54)
Post-traumatic cognitions		76.80 (43.81)

Table 2.

Hierarchical Linear Regression of Microaggressions, Discrimination, and Trauma Symptoms and Cognitions Entered Separately

Dependent Variables		B	Standard Error	Standardized Coefficients Beta	t	p
Total PTSD symptoms	HIV-related Discrimination	4.033	1.660	.267	2.429	.018
	Race-related Discrimination	2.317	1.213	.212	1.907	.061
	Gendered racial microaggression-A	9.943	3.184	.344	3.123	.003
	Gendered racial microaggression-F	10.251	3.379	.323	3.034	.003
PTSD re-experiencing	HIV-related Discrimination	1.241	.628	.226	1.976	.052
	Race-related Discrimination	.397	.463	.100	.857	.394
	Gendered racial microaggression-A	1.786	1.251	.169	1.427	.158
	Gendered racial microaggression-F	1.757	1.324	.152	1.327	.189
PTSD avoidance/numbing	HIV-related Discrimination	1.647	.701	.251	2.350	.022
	Race-related Discrimination	.859	.515	.181	1.669	.099
	Gendered racial microaggression-A	3.417	1.371	.271	2.491	.015
	Gendered racial microaggression-F	4.191	1.428	.304	2.935	.004
PTSD hyperarousal	HIV-related Discrimination	1.180	.620	.217	1.904	.061
	Race-related Discrimination	1.061	.441	.270	2.408	.019
	Gendered racial microaggression-A	4.950	1.101	.476	4.497	.000
	Gendered racial microaggression-F	4.300	1.218	.377	3.530	.001
Total Post-traumatic Cognitions	HIV-related Discrimination	3.666	2.569	.158	1.427	.158
	Race-related Discrimination	4.257	1.811	.254	2.350	.021
	Gendered racial microaggression-A	17.887	4.696	.403	3.809	.000
	Gendered racial microaggression-F	19.529	4.939	.402	3.954	.000
Negative Self	HIV-related Discrimination	.101	.081	.138	1.248	.216
	Race-related Discrimination	.109	.058	.206	1.892	.062
	Gendered racial microaggression-A	.548	.148	.393	3.708	.000
	Gendered racial microaggression-F	.497	.160	.324	3.096	.003
Negative World	HIV-related Discrimination	.077	.083	.106	.919	.361
	Race-related Discrimination	.143	.058	.274	2.460	.016
	Gendered racial microaggression-A	.524	.154	.378	3.399	.001
	Gendered racial microaggression-F	.622	.160	.409	3.895	.000
Self-blame	HIV-related Discrimination	.081	.079	.118	1.014	.314
	Race-related Discrimination	.130	.056	.262	2.327	.023
	Gendered racial microaggression-A	.341	.153	.260	2.226	.029

Dependent Variables	B	Standard Error	Standardized Coefficients Beta	t	p
Gendered racial microaggression-F	.524	.156	.364	3.369	.001

Note: A = Appraisal scale of the GRM. F= Frequency subscale of the GRM. Covariates of age, income, and education were entered in all analyses.

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Table 3.

Hierarchical Linear Regression of Microaggressions, Discrimination, and Trauma Symptoms and Cognitions Entered Together

Dependent Variables		B	Standard Error	Standardized Coefficients Beta	t	p
Total PTSD symptoms	Age	-.205	.281	-.078	-.729	.468
	Education	3.782	3.030	.136	1.248	.216
	Income	-4.528	2.207	-.221	-2.052	.044
	Race-related Discrimination	-.484	1.620	-.044	-.299	.766
	HIV-related Discrimination	2.325	2.064	.154	1.127	.264
	Gendered racial microaggression-F	8.668	4.393	.274	1.973	.052
	Gendered racial microaggression-A	8.129	3.486	.281	2.332	.023
PTSD re-experiencing	Age	.031	.109	.032	.282	.779
	Education	.239	1.177	.024	.203	.840
	Income	-1.340	.857	-.180	-1.563	.122
	Race-related Discrimination	-.360	.629	-.090	-.572	.569
	HIV-related Discrimination	1.276	.802	.232	1.592	.116
	Gendered racial microaggression-F	1.053	1.707	.091	.617	.539
	Gendered racial microaggression-A	1.240	1.366	.118	.908	.367
PTSD avoidance/numbing	Age	-.128	.119	-.112	-1.075	.286
	Education	2.045	1.279	.168	1.598	.115
	Income	-2.693	.932	-.302	-2.890	.005
	Race-related Discrimination	-.364	.684	-.077	-.532	.596
	HIV-related Discrimination	1.033	.871	.157	1.186	.240
	Gendered racial microaggression-F	3.748	1.855	.271	2.020	.047
	Gendered racial microaggression-A	2.620	1.499	.208	1.748	.085
PTSD hyperarousal	Age	-.108	.102	-.114	-1.054	.296
	Education	1.519	1.101	.151	1.380	.172
	Income	-.606	.802	-.082	-.757	.452
	Race-related Discrimination	.222	.588	.057	.377	.707
	HIV-related Discrimination	.074	.750	.014	.098	.922
	Gendered racial microaggression-F	3.834	1.596	.336	2.403	.019
	Gendered racial microaggression-A	4.505	1.216	.433	3.706	.000
Total Post-traumatic Cognitions	Age	-.722	.414	-.179	-1.744	.086

Dependent Variables		B	Standard Error	Standardized Coefficients Beta	t	p
	Education	1.014	4.458	.024	.227	.821
	Income	-7.405	3.247	-.236	-2.281	.026
	Race-related Discrimination	.797	2.383	0.48	.334	.739
	HIV-related Discrimination	-1.823	3.036	-.079	-.601	.550
	Gendered racial microaggression-F	20.039	6.463	.412	3.101	.003
	Gendered racial microaggression-A	16.198	5.172	.365	3.132	.003
Negative Self	Age	-.024	.013	-.192	-1.802	.076
	Education	.031	.145	.023	.212	.833
	Income	-.246	.106	-.249	-2.326	.023
	Race-related Discrimination	.017	.078	.033	.225	.823
	HIV-related Discrimination	-.035	.099	-.048	-.352	.726
	Gendered racial microaggression-F	.503	.210	.328	2.389	.020
	Gendered racial microaggression-A	.520	.164	.373	3.176	.002
Negative World	Age	-.008	.013	-.064	-.610	.544
	Education	.022	.143	.017	.157	.875
	Income	-.175	.104	-.178	-1.681	.097
	Race-related Discrimination	.060	.076	.115	.786	.434
	HIV-related Discrimination	-.129	.097	-.179	-1.331	.188
	Gendered racial microaggression-F	.652	.207	.429	3.154	.002
	Gendered racial microaggression-A	.473	.168	.341	2.817	.006
Self-blame	Age	-.014	.013	-.116	-1.063	.292
	Education	.065	.140	.051	.463	.645
	Income	-.103	.102	-.111	-1.014	.314
	Race-related Discrimination	.059	.075	.120	.794	.430
	HIV-related Discrimination	-.092	.095	-.135	-.969	.336
	Gendered racial microaggression-F	.517	.203	.359	2.552	.013
	Gendered racial microaggression-A	.263	.167	.200	1.574	.120

Note: A = Appraisal scale of the GRM. F= Frequency subscale of the GRM. The A and F subscales of the GRM were entered separately in these multivariable analyses, however the findings for the A subscale was added to this table for ease of presentation.