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Gendered Racial Microaggressions Associated with Depression Diagnosis among Black Women Living with HIV

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Abstract Black women are disproportionately impacted by HIV and depression has been linked to negative HIV outcomes. Little attention has been given to social/structural factors that may drive depression among Black women living with HIV (BWLWH), including discrimination and gendered racial microaggressions (GRM). One hundred BWLWH completed measures on GRM, race- and HIV-related discrimination, and depressive symptoms, as well as a clinical interview for major depressive episode (MDE). GRM and race- and HIV-related discrimination were significantly associated with depressive symptoms and increased likelihood of MDE, but only GRM contributed uniquely in associations with both. Interventions targeting depression among BWLWH should address GRM and race- and HIV-related discrimination.

Keywords Black women · HIV · Microaggressions · Discrimination · Depression

Introduction

In the USA, 1 in 54 Black women is living with HIV compared with 1 in 941 White women and the lives of Black women living with HIV are impacted by mental health struggles such as depression [1–3] and social and structural adversities including racial discrimination, HIV-related discrimination, and gendered racial microaggressions [4–7]. Depression has been significantly linked to negative health outcomes and behaviors among people living with HIV including higher mortality and morbidity and lower medication adherence [1, 8]. Gendered racial microaggressions are subtle daily insults that Black women experience on the basis of being both Black and women (e.g., comments about their body and voice) [6, 9]. Existing literature has found associations between HIV- and race-related discrimination and depressive symptoms; [10, 11] however, no one has examined the relationships between gendered racial microaggressions and depressive symptoms among Black women living with HIV. Such an examination is particularly relevant for Black women living with HIV given the role of depression in their health and well-being. Further, investigating the relationships between gendered racial microaggressions and depression in conjunction with race- and HIV-related discrimination (macro acts) may provide information about whether gendered racial microaggressions make unique contributions to depressive symptoms above and beyond the contributions of race- and HIV-related discrimination.

Microaggressions are subtle yet frequent behaviors and comments that insult a marginalized individual/group [12]. Being both Black and women, Black women experience microaggressions at the intersection of both race and gender [13–15] that may differ from those experienced by someone of a different gender and/or race. For Black women, examples of microaggressions [6, 14] may include being accused of being angry

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despite speaking in a calm manner, hearing negative comments about one's hair when worn naturally, receiving negative comments about one's body (e.g., butt, hips) or facial features (e.g., lips, nose), having one's comments ignored during a discussion, and being tokenized in a professional setting (e.g., highlighted as the one Black woman to show the business's effort at hiring diverse people). Due to the subtle nature of microaggressions, they are likely to occur on a frequent basis and be reported by a majority of Black women. For instance, Lewis and Neville [6] found that among 259 Black women, 87 to 92% reported experiencing microaggressions based on race and gender. Given the subtlety of microaggressions, they are referred to as "micro" in comparison to "macro" acts of discrimination (based on one's marginalized identities) such as denial of housing and employment, unfair treatment by law enforcement, property damage, and physical assault [10]. However, microaggressions may still have a substantial impact on the well-being and mental health of individuals. For instance, microaggressions were reported as "worse" than macro racial discrimination in a qualitative study among highly educated Black women [16]. Both macro discrimination acts and microaggressions are linked to depressive symptoms in various samples [17–19], but microaggressions remain understudied among BWLWH [9].

Studies across various race/ethnic groups have linked racial discrimination with symptoms of depression [20–22] and existing research has reported significant associations between HIV-related discrimination (/perceived or enacted stigma) and depressive symptoms among individuals living with HIV [10, 11, 17]. For instance, among Black American women and men, a national longitudinal study found that reports of racial discrimination at an earlier time point was related to high levels of psychological distress (included some symptoms of depression in the past month) at a later time point [23]. Similarly, among African-American women living with HIV, Vyavaharkar and colleagues [11] found that perceived HIV stigma was associated with depressive symptoms.

There is also a growing body of literature on the relationships between microaggressions and depressive symptoms in various marginalized groups that have noted that higher microaggressions are linked to higher psychological distress or depressive symptoms [18, 19, 24]. A publication in the current sample of Black women living with HIV found that gendered racial microaggressions predicted trauma symptoms [9]. However, we were only able to locate three published articles examining microaggressions and depressive symptoms or psychological distress among Black women specifically. In a sample of undergraduate Black women, Donovan and colleagues [25] found that racial microaggressions predicted higher depressive symptoms and made a unique contribution above overt racial discrimination. Lewis and Neville [6] found that higher gendered racial microaggressions were related to higher psychological distress (no specific measure of depressive symptoms used) in a general sample of Black women. A more recent publication by these scholars [26] also found that among Black women, higher gendered racial microaggressions were associated with higher disengagement coping (e.g., denial and self-blame) which was then associated with higher depressive symptoms.

While the literature in general samples are growing, there is very sparse literature examining how multiple types of discrimination (i.e., race- and HIV-related) relate to depression among Black individuals living with HIV and particularly Black women living with HIV. Bogart and colleagues [10] found that macro acts of discrimination (e.g., being denied a job) based on race-, HIV-, and sexual orientation–related discrimination were associated with depressive symptoms; however, this study was conducted among Black men who have sex with men. Given the marginalization of women based on their gender, it is necessary to understand how for BWLWH their experiences of multiple discrimination may be associated with mental health symptoms. For Black women living with HIV, we only found one study conducted in Canada in a sample of African, Caribbean, and Black women, and results indicated that racial discrimination, gender discrimination, and HIV-related stigma were all significantly related to depressive symptoms [17]. However, neither of these two studies investigated microaggression as a predictor or clinical diagnosis of depression as an outcome; instead, these two studies utilized a self-report measure of depressive symptoms. Thus, no existing literature has investigated the relationship between gendered racial microaggressions and the clinical diagnosis of depression among Black women living with HIV.

To address the noted gaps, the current study examines the associations between gendered racial microaggressions, race- and HIV-related discrimination, and depressive symptoms and the clinical diagnosis of

depression among Black women living with HIV. This study may add valuable information to the existing literature given (1) the limited number of studies examining microaggressions and depressive symptoms in the general population of Black women in the USA, (2) the absence of any studies that have examined microaggressions in relation to clinical diagnosis of depression among Black women, (3) no existing literature that has looked at microaggressions in relationship to depressive symptoms and clinical diagnosis of depression among Black women living with HIV, and (4) the inclusion of measures of both macro race- and HIV-related discrimination and microaggressions in the current study, which allows for exploring any unique contribution of microaggressions and macro acts of discrimination to depressive symptoms and clinical diagnosis among Black women living with HIV. Findings may provide insights on the role of microaggressions and discrimination in depression among Black women living with HIV and implications for areas to address in future research and intervention efforts.

Methods

Participants

From October 2017 through August 2018, Black women living with HIV in Miami, FL, and surrounding areas were recruited for participation in a behavioral medicine intervention development trial. Data for the present study were thereby collected as a part of the larger behavioral medicine intervention development study. Recruitment efforts consisted of distributing flyers and posters at community clinics and health centers, hospitals, community events, and community-based organizations. Study staff members also conducted active outreach and recruitment by attending community outreach events and visiting clinics/organizations and building relationships with staff. Once interested participants contacted study staff, a phone screen was conducted to determine if she met the criteria to be scheduled for an in-person baseline assessment. To be scheduled for a baseline assessment, participants had to meet the following inclusion criteria: (1) identify as Black and/or African-American, (2) 18 years of age or older, (3) cisgender female, (4) English-speaking, (5) prescribed ART for at least the last 2 months, (6) history of abuse/trauma (i.e., responding "yes" to "During your lifetime have your experienced trauma or abuse?"), and (7) based on self-report the potential of low ART adherence, detectable viral load within the past year, and/or missed HIV-related medical visits within the past year.

During baseline assessment visits, participants gave written informed consent, completed self-report instruments using the Research Electronic Data Capture (REDCap, a secure web-based application; Harris et al. 2009) [27], and participated in a semi-structured clinical interview. Participants were given $50 total as reimbursement for their time and efforts during baseline assessments. The Institutional Review Board of the University of Miami approved all study measures and procedures. All study procedures were carried out by a team of majority Black women including the study principal investigator and in study rooms decorated to be culturally affirming and welcoming.

Measures

Self-Report Sociodemographic Survey

This measure asked participants to provide information on their age, education level, sexual orientation, annual income, employment status, relationship status, number of children, country of birth, living situation, religious affiliation, and years since HIV diagnosis.

Multiple Discrimination Scale [10]

Race-related discrimination and HIV-related discrimination were measured using twenty-six items from the Multiple Discrimination Scale (Laura M. Bogart et al. 2011). Thirteen items captured race-related discrimination and thirteen parallel items captured HIV-related discrimination. Participants were asked to respond "yes" or "no" to whether in the past year, they experienced thirteen different discrimination events. Two sample items are "In the past year, were you denied a job or did you lose a job because you are HIV positive?" and "In the past year, were you denied a place to live or did you lose a place to live because you are Black or African-American?" Total scores on each subscale (race or HIV) ranged from 0 to 13. This scale has shown good construct validity (e.g., associated with mental health symptoms) [10, 28, 29] and reliability (race subscale $\alpha = .83$ and HIV subscale $\alpha = .85$) [10]. In the current sample, Cronbach's alpha for the HIV-related

discrimination subscale and the race-related discrimination subscale were .87 and .86, respectively.

Gendered Racial Microaggressions Scale for Black Women [6]

The 26-item GRMS-BW captures microaggressions experienced by Black women both on the basis of being Black and women. Participants choose how often (i.e., frequency) in their lifetime they experienced a particular microaggression (0 = never, 1 = less than once a year….5 = once a week or more) and how stressful (i.e., appraisal) the experience was for them (0 = never happened, 1 = not at all stressful….5 = extremely stressful). Total scores range from 0 to 26 on the frequency and appraisal scales and are derived by averaging across the participants' responses to all items. In addition to information on the frequency and stress appraisal for microaggressions, the GRMS-BW has four subscales: Assumptions of Beauty and Sexual Objectification Subscale (11 items), Silenced and Marginalized Subscale (7 items), Strong Black Woman Stereotype Subscale (5 items), and Angry Black Woman Subscale (3 items). Assumptions of Beauty and Sexual Objectification Subscale capture assumptions/stereotypes about attractiveness, style, and standards of beauty and a sample item for this subscale is "Someone made a negative comment to me about my skin color / skin tone." Silencing and Marginalized Subscale assesses how women are silenced in professional settings and a sample item is "My comments have been ignored in a discussion in a work, school, or other professional setting". Strong Black Woman Subscale captures expectations that Black women are "strong" and too assertive/independent and a sample item is "I have been told I am too independent". Angry Black Woman Subscale includes stereotypical expectations that Black women are angry such as "Someone accused me of being angry when I was speaking in a calm manner". This GRMS-BW has evidence of good validity and reliability (frequency $\alpha = .92$; appraisal $\alpha = .93$) in existing literature [6] and great reliability in the present sample (frequency $\alpha = .92$; appraisal $\alpha = .95$).

Center for Epidemiologic Studies Depression Scale [30, 31]

The Center for Epidemiologic Studies Depression Scale is a self-report measure that captures current affective depressive symptoms with 20 items. Sample items include "I felt lonely" and "I had crying spells" and participants respond on a 4-point Likert scale (0 = rarely or none of the time, 1 = some or little of the time, 2 = moderately or much of the time, and 3 = most or almost all of the time). The Center for Epidemiologic Studies Depression Scale has been widely used in studies of women with HIV [32]. Total scores range from 0 to 60 and cutoff scores of > 16 and > 23 have been used in the literature to indicate probable clinical depression [30]. It has shown great reliability ($\alpha = .85$ to .90) and validity (e.g., predicts mortality among women with HIV) in existing studies [31, 33] and good reliability ($\alpha = .88$) in the current sample.

Mini-International Neuropsychiatric Interview (M.I.N.I.) for DSM 5 [34, 35]

The MINI was used in a clinical interview to assess for current Major Depressive Episodes. The MINI is an established and widely used short semi-structured clinical interview [35]. It has shown evidence of concurrent validity with an established, yet longer structured, clinical interview [35].

Analyses

SPSS version 24 was used to conduct all statistical analyses. All women who completed baseline assessments were included in analyses. Based on a correlation of .41 between gendered racial microaggression and psychological distress/depressive symptoms in an existing study among a general sample of Black women [26], we estimated 99% power in a sample of 100 Black women living with HIV. Hierarchical multiple linear and logistic regressions controlling for age, education, and income were conducted to examine the associations between race-related discrimination, HIV-related discrimination, gendered racial microaggressions (frequency and appraisal), and depressive symptoms and diagnosis. Frequency and appraisal subscales of the gendered racial microaggression scale/subscales were entered separately in all analyses because of high collinearity. We suspected that there would be evidence of high collinearity because both the frequency and appraisal subscales were based on identical items and our intuitions were confirmed by high variance inflation factors.

Results

Sociodemographic Characteristics

Among the 100 Black women living with HIV, average age was 49 (range = 22–67), 62% reported an annual income of less than $12,000, 63.5% completed high school/GED, 46.5% were single, 75.2% were exclusively heterosexual, 82.2% were parents of children, 71.3% rented a home or apartment, and 54.5% lived alone. In terms of depression, 24% met criteria for a current Major Depressive Episode, and average score for depressive symptoms on the Center for Epidemiologic Studies Depression Scale was 21.41 (range = 0–50).

Multivariable Associations of Depressive Symptoms and Diagnosis by Microaggressions and Discrimination

Hierarchical multiple linear regressions were run to examine the relationships between the predictors (race-related discrimination, HIV-related discrimination, and gendered racial microaggression [frequency or appraisal]) and the outcome of depressive symptoms. We entered covariates of age, education, and income in block one, one predictor in block two, and one outcome as the dependent variable. Results presented in Table 1 indicated that higher racial discrimination ($\beta = .21$, $p < .05$), HIV-related discrimination ($\beta = .21$, $p < .05$), and gendered racial microaggressions (frequency: $\beta = .39$, $p < .001$; appraisal: $\beta = .54$, $p < .001$) were significantly associated with higher depressive symptoms.

There were similar results from hierarchical multiple logistic regressions controlling for covariates, with major depressive episode as the outcome, and predictors of race-related discrimination, HIV-related discrimination, and gendered racial microaggression (frequency or appraisal). As shown in Table 2, racial discrimination (OR = 1.20, $p < .05$), HIV-related discrimination (OR = 1.27, $p < .05$), and gendered racial microaggression (frequency: OR = 2.34, $p < .01$; appraisal: OR = 3.15, $p < .001$) were associated with higher likelihoods of being diagnosed with current major depressive episode.

Multivariable Associations of Depression by Microaggressions and Discrimination Entered Together

We conducted additional hierarchical linear and logistic regressions to determine whether any of the predictors made unique contributions (above the other predictors) to depressive symptoms and major depressive episode. We entered all the predictors together (race-related discrimination, HIV-related discrimination, and total gendered racial microaggression [frequency or appraisal]) with covariates (age, education, and income) and outcomes of depressive symptoms (in linear regressions) and major depressive episode (in logistic regressions). Linear regression findings presented in Table 3 indicated that only gendered racial microaggression contributed uniquely in associations with depressive symptoms (frequency: $\beta = .39$, $p < .01$; appraisal: $\beta = .54$, $p < .001$). Similarly, findings from the logistic regression (see Table 4) indicated that only gendered racial microaggressions contributed uniquely in increasing the likelihood of being diagnosed with major depressive episode (frequency: OR = 2.28, $p < .05$; appraisal: OR = 2.93, $p < .01$).

Hierarchical linear and logistic multivariable regressions controlling for covariates were run to determine which gendered racial microaggression subscales (entered together) made unique contributions in associations with depressive symptom and major depressive episode. Results showed that Assumptions of Beauty and Sexual Objectification Subscale, Angry Black Woman Subscale, and Strong Black Woman Subscale contributed uniquely in associations with depressive

Table 1 Hierarchical linear regressions of depressive symptoms by microaggressions and discrimination

Predictor variables	*B*	Standard error	Standardized coefficients beta	*p*
Race-related discrimination	.893	.420	.211	.036
HIV-related discrimination	1.186	.571	.206	.041
Gendered racial microaggression-F	4.718	1.149	.385	< .000
Gendered racial microaggression-A	5.931	.959	.539	< .000

A, appraisal; *F*, frequency

Table 2 Hierarchical logistic regressions of depression diagnosis by microaggressions and discrimination

Predictor variables	Exp (*B*)	95% CI		*p*
		Lower	Upper	
Race-related discrimination	1.20	1.003	1.444	.047
HIV-related discrimination	1.27	1.005	1.614	.045
Gendered racial microaggression-F	2.34	1.318	4.134	.004
Gendered racial microaggression-A	3.15	1.660	5.976	< .000

A, appraisal; *F*, frequency

symptoms. Assumptions of Beauty and Sexual Objectification Subscale (frequency: $\beta = .26$, $p =$ ns at .07; appraisal: $\beta = .59$, $p < .05$) and Angry Black Woman Subscale (frequency: $\beta = .31$, $p < .01$; appraisal: $\beta = .28$, $p =$ ns at .05) were associated with higher depressive symptoms while the Strong Black Woman Subscale was associated with lower depressive symptoms (frequency: $\beta = -.34$, $p < .01$; appraisal: $\beta = -.28$, $p =$ ns at .15). Similarly, the Assumptions of Beauty and Sexual Objectification Subscale and the Strong Black Woman Subscale contributed uniquely to the likelihood of major depressive episode. The Assumptions of Beauty and Sexual Objectification Subscale was associated with increased likelihood of major depressive episode (frequency: OR = 4.27, $p < .01$; appraisal: OR = 3.00, $p =$ ns at .08) and the Strong Black Woman Subscale was associated with decreased likelihood of major depressive episode (frequency: OR = .39, $p < .01$; appraisal: OR = .42, $p =$ ns at .19).

Table 3 Hierarchical linear regression of depressive symptoms by microaggressions and discrimination

	B	Standard error	Standardized coefficients beta	*t*	*p*
Age	− .275	.097	− .270	− 2.841	.006
Education	.475	1.017	.045	.467	.642
Income	− .175	.244	− .069	− .718	.474
Race-related discrimination	− .311	.541	− .075	− .575	.567
HIV-related discrimination	.262	.688	.046	.381	.704
Gendered racial microaggression-F	4.759	1.488	.393	3.198	.002
Age	− .187	.089	− .186	− 2.102	.039
Education	.644	.922	.061	.698	.487
Income	− .022	.230	− .008	− .096	.924
Race-related discrimination	− .080	.453	− .019	− .177	.860
HIV-related discrimination	.100	.634	.017	.157	.876
Gendered racial microaggression-A	5.945	1.068	.540	5.566	< .001
Age	− .201	.092	− .195	− 2.184	.032
Education	.470	.946	.044	.496	.621
Income	.033	.228	.013	.145	.885
Assumptions of Beauty and Sexual Objectification Subscale-F	3.026	1.632	.260	1.854	.067
Silenced and Marginalized Subscale-F	1.317	1.541	.126	.855	.395
Strong Black Woman Subscale-F	− 2.902	.868	− .339	− 3.344	.001
Angry Black Woman Subscale-F	2.307	.818	.312	2.821	.006
Age	− .020	.128	− .021	− .158	.876
Education	.696	1.437	.063	.484	.631
Income	.150	.335	.058	.449	.656
Assumptions of Beauty and Sexual Objectification Subscale-A	5.341	2.020	.588	2.644	.012
Silenced and Marginalized Subscale-A	1.142	1.449	.128	.789	.435
Strong Black Woman Subscale-A	− 3.158	2.146	− .282	− 1.472	.149
Angry Black Woman Subscale-A	2.727	1.356	.276	2.012	.051

Table 4 Hierarchical logistic regression of depression diagnosis by microaggressions and discrimination (predictors entered together)

	95% CI			
	Exp (*B*)	Lower	Upper	*p*
Age	.99	0.950	1.045	.882
Education	1.06	0.623	1.836	.808
Income	1.22	1.001	1.486	.048
Race-related discrimination	.97	0.747	1.269	.844
HIV-related discrimination	1.06	0.777	1.456	.701
Gendered racial microaggression-F	2.27	1.071	4.842	.033
Age	1.00	0.960	1.060	.727
Education	1.03	0.595	1.804	.900
Income	1.29	1.031	1.636	.026
Race-related discrimination	1.01	0.789	1.317	.885
HIV-related discrimination	1.06	0.773	1.457	.714
Gendered racial microaggression-A	2.93	1.465	5.866	.002
Age	1.01	0.961	1.064	.670
Education	.96	0.536	1.745	.912
Income	1.38	1.065	1.813	.015
Assumptions of Beauty and Sexual Objectification Subscale-F	4.26	1.510	12.053	.006
Silenced and Marginalized Subscale-F	.97	0.416	2.264	.945
Strong Black Woman Subscale-F	.39	0.199	0.767	.006
Angry Black Woman Subscale-F	1.41	0.828	2.403	.206
Age	1.02	0.960	1.095	.457
Education	1.14	0.506	2.597	.744
Income	1.34	0.951	1.907	.094
Assumptions of Beauty and Sexual Objectification Subscale-A	3.00	0.866	10.400	.083
Silenced and Marginalized Subscale-A	1.50	0.638	3.546	.351
Strong Black Woman Subscale-A	.42	0.119	1.519	.188
Angry Black Woman Subscale-A	1.21	0.568	2.614	.613

A, appraisal; *F*, frequency

Discussion

Among Black women living with HIV, we found that gendered racial microaggressions, racial discrimination, and HIV-related discrimination were significantly associated with higher depressive symptoms and increased likelihood of major depressive episode. Further, gendered racial microaggression contributed uniquely in associations with depressive symptoms and major depressive episode above and beyond the contributions of race- and HIV-related discrimination. Prior findings in this sample noted similar findings between microaggressions and trauma symptoms [9] with gendered racial microaggressions contributing uniquely to trauma symptoms above and beyond race- and HIV-related discrimination. However, no prior study among Black women living with HIV has examined the relationship between gendered racial microaggressions and depressive symptoms and the clinical diagnosis of depression. While one prior study linked discrimination (race- and HIV-related) with depressive symptoms among Black women living with HIV in Canada, [17] it did not examine actual clinical diagnosis of depression as an outcome. Our findings therefore make new contributions to the literature for Black women living with HIV.

There may be several underlying explanations as to why gendered racial microaggressions, racial discrimination, and HIV-related discrimination were all significantly associated to higher depressive symptoms and diagnosis. Depression is a constellation of symptoms including sadness, lack of interest, feelings of low self-worth, irritability, and disrupted appetite and sleep. Experiences of gendered racial microaggression and racial and HIV-related discrimination are negating experiences in which Black women living with HIV are treated differently and put down based on their gender, race, and HIV status. Being treated "less than" whether it is explicit or subtle (in the case of microaggressions) may result in the various symptoms of depression (i.e., feelings of sadness, low self-worth). Further theories with extensive supportive evidence about how depressions functions [36] indicates that depression is sustained and exacerbated by negative thoughts about the self, others, and world. For Black women living with HIV, microaggressions and discrimination may trigger, sustain, and exacerbate negative thoughts about themselves (as they internalize the oppression), others (e.g. such as those who perpetrate the acts or are complicit in their actions), and the society we live in that serves as the context in which these marginalizing experiences are happening. In addition, women with depression may zone in on negative aspects of experiences [36] and thereby may be more likely to note microaggressions.

While both discrimination experiences and microaggressions were related to higher symptoms of depression and diagnosis, only gendered racial microaggressions contributed uniquely in associations with depressive symptoms and diagnosis when all

predictors were in the same model. Despite being subtle in expression, gendered racial microaggressions may be associated more to depression for Black women living with HIV because of the daily and pervasive nature of microaggressions [16]. Further, it appears that certain subtypes of gendered racial microaggressions are more likely to be associated with depressive symptoms and diagnosis. Gendered racial microaggressions around Beauty and Sexual Objectification and the Angry Black Woman stereotype contributed uniquely in the associations with higher depressive symptoms and clinical diagnosis of depression. As a Black woman being objectified based on one's physical features or being assumed to be sexually promiscuous may result in depressive symptoms such as feelings of sadness, low self-worth, and irritability/anger. Similarly, experiences such as being "accused of being angry when speaking in a calm manner" may cause depressive symptoms such as sadness and withdrawal. Interestingly, the gendered racial microaggressions concerning the Strong Black Woman stereotype contributed uniquely and related to lower depressive symptoms and likelihood of major depressive episode. Though microaggressions are negative, in reaction to the Strong Black Women microaggressions, Black women living with HIV may use a positive reframing/coping response (i.e., "you have that right, I am a strong Black woman") that may result in positive emotions and feeling good about oneself. If Black women living with HIV utilize a positive reframe when confronted with the Strong Black Women microaggressions, lower depressive symptoms and diagnosis would be consistent with the Cognitive Behavioral Therapy literature showing that the reframing/restructuring of negative thoughts decreases depressive symptoms [37]. Some Black women may embrace the narrative of Black women being strong overall [38], and when confronted by the Strong Black Women microaggressions, they may lean into the positive aspects of that narrative of strength. Further, Black women living with HIV who utilize that narrative of strength may be able to cope through adversities adaptively thereby decreasing the likelihood of depressive symptoms/diagnosis. This pattern of gendered racial microaggressions related to the Strong Black Woman stereotype contributing uniquely but counterintuitively to mental health symptoms was also observed in our previous work examining gendered racial microaggressions and trauma symptoms [9].

The interpretation and generalization of our study findings may be limited by a few factors. First, due to the enrollment criteria of the intervention study from which this baseline data was collected, our sample consisted solely of Black women living with HIV who resided in the Southeast United States and reported experiencing a traumatic event in their lifetime. Second, our analyses may not have accounted for other psychosocial (e.g., caretaker burden), medical (e.g., comorbid health conditions), and structural stressors and confounding factors experienced by women in the sample. Third, due to our cross-sectional study design, we are able to conclude that microaggressions are significantly associated with depression, but we are unable to make causal inferences. Fourth, the measures on discrimination (race- and HIV-related), gendered racial microaggressions, and depressive symptoms (from the Center for Epidemiologic Studies Depression Scale) were all self-report measures and are subject to social desirability bias. However, semi-structured clinical interviews used to diagnose major depressive episodes were conducted by trained PhD level and master's level clinicians and the findings from the clinical interviews were consistent with findings from the Center for Epidemiologic Studies Depression Scale. Also, despite these noted limitations, our findings provide novel information on the significant association between gendered racial microaggressions and depressive symptoms and diagnosis among Black women living with HIV, which may inform further research and intervention efforts. Experiences of racial and HIV-related discrimination are important to investigate and address for Black women living with HIV in order to decrease depression, which continue to be linked to mortality and morbidity among people living with HIV. Further, despite both the word "micro" aggression and the often-subtle nature of gendered racial microaggressions, they are associated uniquely and significantly to depressive symptoms and diagnosis among Black women living with HIV and must be further investigated in large-scale studies among Black women living with HIV and addressed in interventions to decrease depression among Black women living with HIV.

In summary, while depression remains linked to negative health outcomes and morbidity among women living with HIV and Black women represent the largest portion of women living with HIV in the USA, there has been no prior research on how daily gendered racial microaggressions and racial discrimination relates to depressive symptoms and the clinical diagnosis of depression among Black women living with HIV. Our

findings showed that racial discrimination, HIV-related discrimination, and gendered racial microaggressions were related to higher depressive symptoms and increased likelihood of being diagnosed with major depressive episode and that gendered racial microaggressions contributed uniquely in associations with depressive symptoms and clinical diagnosis above the contributions of race- and HIV-related discrimination. This highlights that (a) discrimination and microaggressions need to be addressed in order to tackle depression among Black women living with HIV and (b) despite its name microaggression is a salient and important issue in the lives of Black women living with HIV that should be investigated further.

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Compliance with Ethical Standards

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