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Che tipo di microaggressioni sperimentano le donne in ambito sanitario? Esaminando tipologie, contesto e identità intersezionali.

What kinds of microaggressions do women experience in the health care setting? Examining typologies, context and intersectional identities

Abstract

Microaggressions are everyday verbal and non-verbal indignities, promoted intentionally or by well-intentioned people towards minority and disadvantaged individuals or groups. Microaggressions are often unconscious, socially normalized and naturalized. This qualitative study intended to examine and understand microaggressions lived by women with different intersectional identities (women of Color, immigrant women, straight women, LGBTQ+ women, functionally diverse women) in the Portuguese healthcare context. Semi-structured interviews were conducted using the Critical Incident Technique. Seventeen self-identified female feminists, activists and/or that were involved with NGOs and organizations actively committed to social causes participated. Content and thematic analysis were used in order to recognize the different microaggressive forms (microinsults, microinvalidations, microassaults) and manifestations (verbal, nonverbal/behavioral, environmental) committed in the healthcare context. The results are discussed in light of diversity training opportunities to raise awareness about subtle forms of discrimination among health care practitioners.

Keywords: Microaggressions, Healthcare System, Women, Minoritarian Identities, Intersectionality.

Abstract

Con il termine microaggressioni si intendono alcune forme di discriminazione verbale e non verbale, attuate consapevolmente o inconsciamente, spesso da parte di soggetti ben intenzionati, e dirette a minoranze o gruppi e/o individui marginalizzati. Le microaggressioni sono spesso socialmente normalizzate e naturalizzate. Il presente studio qualitativo mira ad esaminare e comprendere le microaggressioni vissute da donne con diverse identità intersezionali (donne di colore, migranti, eterosessuali, LGBTQ+, con diversità funzionale) nel contesto del sistema sanitario portoghese. Alcune interviste semi-strutturate sono state condotte attraverso la Tecnica degli Incidenti Critici. Sono state coinvolte diciassette partecipanti di genere femminile che si identificano come femministe, attiviste e/o che sono impegnate con organizzazioni senza scopo di lucro e organizzazioni attive nel contesto di cause sociali. Tecniche di analisi tematica e di contenuto sono state utilizzate allo scopo di identificare le diverse forme di microaggressione (micro-insulti, micro-invalidazioni, micro-attacchi) e i livelli a cui esse si manifestano (verbale, non-verbale/comportamentale, ambientale) nel contesto del sistema sanitario. I risultati vengono qui discussi allo scopo di creare opportunità di formazione per sensibilizzare gli operatori sanitari al riconoscimento e alla comprensione di queste forme di discriminazione sottile.

Keywords*:* Microaggressioni, Sistema sanitario, Donne, Identità Minoritarie, Intersezionalità

1. Microaggressions: a general overview

Microaggressions are "brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile derogatory or negative racial, gender, sexual orientation and religious slights or insults to the target person or group" (Sue, 2010, p. 5). Forms of discrimination as racism, sexism and heterosexism have changed face in the last years (Dovidio & Gaertner, 1996): while obvious manifestations are disappearing, new subtle forms arise. Microaggressions ascend in different context and levels, assuming different forms and being related to different themes (Sue, 2010).

Microaggressions are based on stereotypical beliefs acquired by individuals during their socialization process, and may be committed by everyone, transmitted via interactions with members of dominant social groups, members of other stigmatized groups or individuals with shared stigmatized identities (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Furthermore, these subtle insults are the expression and the reflection of societal mechanism and beliefs regarding privilege, oppression and meritocracy.

On the targets' side, the exposure to microaggressions may lead to severe consequences. At the individual level, microaggressions "have the lifelong insidious effects of silencing, invalidating, and humiliating the identity and/or voices of those who are oppressed" (Sue, 2010, p. 66). Microaggressions have shown to be related with negative effects on both physical and mental health, such as increased susceptibility to illness, increased stress levels (Sue, 2010), lowered self-esteem, increased prevalence of depressive symptoms, lowered levels of psychological well-being, negative emotional intensity, negative perception of one's own identity, etc. (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014). Furthermore, at the systemic and macro level, microaggressions reflect and reproduce societal stereotypes and prejudices, disparities and inequalities, affecting the quality of life and standard of living for stigmatized groups (Sue, 2010).

Research suggest that microaggressions occur at different levels, in different forms, and reflect different themes. Sue (2010) proposed a classification of microaggressions based on three levels of manifestation (verbal, nonverbal/behavioral, environmental) and on three forms (microinsults, microassaults, microinvalidations). Each form of microaggression can occur at any level – or simultaneously at more levels – and contain different themes.

Microaggressions are directed at members of minority, historically oppressed and disadvantaged groups. Different forms of discrimination are the basis of microaggressions: for example, racial microaggressions often contain racist beliefs, gender microaggressions contain sexist beliefs, and sexual orientation microaggression contain heterosexist beliefs (Sue, 2010). In other words, prejudiced and stereotypical beliefs determine the contents and themes of microaggressions.

In the social field, a specific condition is experienced by those who identify with two or more minority groups. The possession of different minoritarian and intersectional identities may expose individuals to microaggressions of different nature (Nadal, et al., 2015; Sue, 2010). Intersectionality is defined as "the interconnected nature of social

categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage" (Oxford University Press, 2019). People with different minoritarian identities do not only experience discrimination based on the separated social groups they belong to, neither experience the sum of these forms of discrimination, but they are subjected to specific forms of oppressions related to the intersection of their identities (Lewis & Neville, 2015) .

Recent studies stressed the need to consider microaggressions towards people with intersectional identities as a specific phenomenon, using multisystemic and multidimensional approaches (Samuels & Ross-Sheriff, 2008). For example, Nadal et. al (2015) demonstrated that microaggressions towards people with intersectional identities contain themes that are new to the classic literature about microaggressions and, based on the intersectional notion of "gendered racism" Lewis and Neville (2015) proposed a Microaggressions Scale for Black Women.

Microaggressions may occur in many contexts and by different committers (Sue, 2010). An environment of particular interest is the healthcare context, specifically in relation to microaggressions committed by health providers towards patients. In this context, the relation health provider-patient is characterized by a strong interdependence, in which, patients tend to be in a vulnerable state when seeking medical provision and health providers occupy a position of social power and authority (Saha, Beach, & Cooper, 2008; Cruz, Rodriguez, & Mastropaolo, 2019). This power disparity may be strengthened or overlap with other disparities related to the social relationship between dominant and minority groups. According to Vissandjée and colleagues (2001), the power differential between patient and physician may be reinforced with women because of sexist beliefs related to their health issues. Many studies (Cruz, Rodriguez, & Mastropaolo, 2019; Almond, 2017; Hobson, 2001; Franks, Fiscella, & Meldrum, 2005; Feagin & Bennefield, 2014) showed the presence of different forms of microaggressions in the healthcare context.

Some studies used specific scales – such as the Microaggressions Health Care Scale (MHCS) (Cruz, Rodriguez, & Mastropaolo, 2019) and the Racial Microaggressions in Medical Practice Scale (RMMPS) (Almond, 2017) – to understand the perpetration and impact of racial microaggressions in the healthcare context. Findings show that ethnic minorities face a high number of microaggressions, especially in cross-racial interactions, and that there is a strong correlation between the experience of microaggressions and the

occurrence of anxiety and depressive symptoms (Walls, Gonzalez, Gladney, & Onello, 2015; Almond, 2017; Cruz, Rodriguez, & Mastropaolo, 2019). Snyder, Wand and Truitt (2018) found that health providers often make mistaken assumptions about patients' ethnic identity (mistaken identity), family kinship (mistaken relationships) and income class or degree of education (pervasive stereotypes) based on their skin color or physical attributes, that providers often make inappropriate questions about patients' ethnicity (entitled examiners), that patients often suffer from intersectional forms of microaggressions (intersectionality) and encounter difficulties in identifying with one exclusive ethnic category between those mentioned in clinical forms (fixed forms).

Disparities between women and men in healthcare treatment begin at the research level: women's health issues are less investigated than men's ones, women are less included in trials for medicines and in medical research samplings (Travis, Howerton, & Szymanski, 2012). Women are believed to be highly emotional and anxious, and this often leads to the assumption that they are too hypochondriac and unreliable in their health issues (Halas, 1979). Expectations of pain are also related to gender roles: women are commonly considered less able to endure pain and more willing to report it (Robinson, et al., 2001). Obstetric violence is considered by some authors a form of gender violence, for being a gendered phenomenon related to the objectification of pregnant women and the paternalization of mothers (Shabot, 2016). Smith-Oka (2015) conceptualized obstetric violence as a new form of microaggressions, called "corporeal microaggressions": providers justify verbal indignities and violent physical treatment and interventions as a necessary reaction to the perceived non-cooperation and non-compliance of pregnant women during consultations and childbirth.

Health providers often assume that their patients are heterosexual (Morrison, 2012; Platzer & James, 2000; Marques, Nogueira, & de Oliveira, 2015) and may have reactions of surprise, curiosity, judgment and avoidance, when their patients disclose their sexual identity (Dean, Victor, & Guidry-Grimes, 2016; Lee & Kanji, 2017). LGBTQI+ patients may encounter various forms of overt and subtle discrimination in the healthcare context: providers are often unprepared to treat homosexual, transgender and intersexual patients and their knowledge is often based on heterosexual beliefs. Furthermore, same-sex couples are likely to not be recognized as family members during visiting hours (Lee & Kanji, 2017). Lesbian mothers can be considered a vulnerable category, being likely to experience forms of heterosexist invalidation (e.g. the belief same-sex couples are unnatural, uncapable of parenting) and exclusion (e.g. non-biological or co-mothers are

often excluded from care), expression of overt homophobia and disgust, refusal of services (Dahl, Fylkesnes, Sørlie, & Malterud, 2013; Gregg, 2018). According to a study about LGBTQI+ microaggressions in healthcare (Smith & Turell, 2017), homosexual, bisexual and transgender patients identified microaggressions in non-welcoming environments and in providers' heteronormative assumptions, discomfort with sexual health conversations, lack of knowledge of LGBTQI+ health needs and unfamiliarity with appropriate terms of address, inappropriate targeting of sexual health needs.

People with functional diversity are also likely to experience negative ableist attitudes in the healthcare context. The lack of sensitivity of health professionals, the lack of appropriate health provision, the building of a hostile environment and the use of discriminatory, unappropriated or highly technical language, are some of the factors responsible for shaping ableist discrimination in the healthcare context (Scullion, 1999). Dehumanization and abuse of people with functional diversity emerge in the invalidation of their physical condition, in the invasion of their privacy, in the excessive curiosity for their personal condition or in forcing them into humiliating situations (Swain & French, 2001).

Individuals' awareness is not consensual, especially when expressed in subtle forms as microaggressions. The literature about prejudice and discrimination suggests that all individuals may learn and acquire stereotypes and biases during their socialization process (Dovidio & Gaertner, 1996). As explained by the psychological dilemma of "invisibility of unintentional bias" (Sue, 2010), not only committers, but also receivers of microaggressions may be unaware of the discrimination in course. The Microaggression Process Model (Sue, 2010) suggests that receivers of microaggressions make a sever effort to understand the intentionality, motivation and content of a microaggression. The body of research about feminist identity development (Downing & Roush, 1985), Black identity development (Cross, 1978), and homosexual identity development (Cass, 1979), suggests that resources and the ability to interpret microaggressive incidents are related to specific phases of the minoritarian identities development. For example, the Feminist Identity Development Model proposed by Downing and Roush (1985), identifies five stages through which women develop an actively committed identity: passive acceptance, revelation, embeddedness/emanation, synthesis, active commitment. According to the Model these phases are not linear, can be experienced cyclically and often more than one time, but most women do not experience the last two phases (Downing & Roush, 1985). Models of Black and homosexual identity development (Cross, 1978; Cass, 1979) are

conceptually similar to the Model of Feminist Identity Development, suggesting that awareness of discrimination does not arises in all individuals and that it is related with active social commitment.

A specific study has been conducted to explore and understand women's reactions to microaggressions (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013). Women were found to process and react to microaggressions on different levels: emotional, behavioral and cognitive. Emotional reactions may be based on internalized or externalized emotions. Behavioral reactions were classified on a continuum, ranging from passivity to confrontation. Finally, the cognitive processes involved in the reaction to microaggressions were related to resiliency, acceptance and resistance.

Women's reactions and even their awareness of microaggressions may be related to their levels of feminist identity according to Capodilupo et al. (2010). In a study about the manifestation of gender microaggressions, women who seemed to maintain more feminist ideologies than others were also those that seemed more likely to recognize microaggressions and to understand the psychological impact that these subtle incidents had. On the other side, participants with lower levels of feminist identity were those who presented higher unawareness and acceptance of microaggressions in their lives (Capodilupo, et al., 2010). Emotional and behavioral reactions may also be related to individual levels of feminist identity: women with higher awareness of microaggressions might be more inclined to experience externalized emotions (e.g. anger) (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013), and to react in assertive ways (e.g. confronting). Assertive reactions may have the function of terminating the committer's behavior or educating him or her about discrimination (Capodilupo, et al., 2010).

Microaggressions committed in the healthcare context have received increasing attention during the last decade, revealing how social disparities are embedded not only in overt manifestations of discrimination, but also in more subtle and invisible forms, which have an equally harmful potential. In this context, the power disparity between patients and providers exacerbates the already existing disparities between socially powerful and disadvantaged groups, increasing potential for discrimination. Patients belonging to minority and disadvantaged groups may experience a wide range of microaggressions, such as forms of invalidation and subtle insults or even these two forms in a combined fashion. The purpose of this study was to conduct a qualitative analysis in order to identify, analyze and understand microaggressive incidents towards different groups of women in the healthcare context. The study aimed at creating a new association

between the literature about sexism, heterosexism, racism and ableism in the healthcare context and the definition, taxonomy of microaggressions.

The use of the Critical Incident Technique (Flanagan, 1954; Chell & Pittaway, 1998; Edvardsson & Roos, 2001; Spencer-Oatey, 2013), which contextualize microaggressions and render its subtle nature more visible, and the specific attention paid to intersectional microaggressive experiences may also represent a major contribution of this study. Due to the subtleness of microaggressions, this study will focus on women with a developed feminist identity, as they were already proved to be more sensitive to subtle forms of discrimination (Capodilupo et al., 2010; Downing & Roush, 1985).

2. Methodology

2.1. Participants

A total of 21 interviews (four for the pilot study, seventeen for data collection) was conducted between March and May 2019. The sample was composed of women belonging to different social minorities in Portugal.

Snowball sampling (Robinson, 2014) was chosen as a strategy to reach and recruit participants, starting by some contacts that the research team already had. Participants were contacted by email or social media with a short message presenting the study, the inclusion criteria and asking if they were willing to participate. Inclusion criteria (Robinson, 2014) consisted of: self-identification with women population, self-identification as a feminist and/or an activist and/or engagement with NGOs and organizations actively committed to social causes. According to Downing and Rush's Model (1985), the identification as "feminist" and the active commitment in social causes are indicators of a developed feminist identity. At the end of each interview, participants were asked if they knew anyone that would fit into the sampling criteria and willing to participate. The principle of saturation (Saunders, et al., 2018) was reached after interviewing 17 participants. Four groups of analysis were created based on participants' minoritarian identities:

1. Perceived as ethnic majority ingroup member, heterosexual women;
2. Perceived as ethnic minority outgroup member, heterosexual women;
3. Perceived as ethnic majority ingroup member, LGB women;
4. Functionally diverse, perceived as ethnic minority outgroup member, heterosexual women.

With "perceived as ethnic ingroup/outgroup" we intended to group women based on those visible characteristics that could induce an enactor of microaggressions to think that they belonged to the Portuguese population (ethnic majority ingroup) or to perceive them as foreigners (skin color, migrant status, accent; ethnic minority outgroup). The initial study included a fifth group: perceived as ethnic minority outgroup member, LGBTQ+ women. However, it was very difficult to enter in contact with this population, and even those who were contacted declined to participate.

Participants' age ranged from 23 to 59 years (*M* = 38). Sixteen of them identified with feminine gender, one participant identified with non-binary gender. All participants had Portuguese nationality, three of them also had a second nationality. All participants identified as activists and/or feminists. Fourteen of them defined themselves as "formal activists" (meaning that they usually engage in activities with associations, organizations and other entities that openly work with activism), while three of them defined themselves as " non-formal activists" (intending activism as an "every-day contribution" through interpersonal relations, work activities, research activities, etc.).

2.2 Data Collection

2.2.1 The Critical Incident Technique

This study was conducted through interviews based on the Critical Incident Technique (CIT). The CIT has been defined by Chell (1998) as "a qualitative interview procedure, which facilitates the investigation of significant occurrences (events, incidents, process or issues), identified by the respondent, the way they are managed, and the outcomes in terms of perceived effects. The objective is to gain an understanding of the incident from the perspective of the individual, taking into account cognitive, affective and behavioral elements" (Chell & Pittaway, 1998). This technique aims to retrieve some specific critical (i.e. that is considered "extreme" and/or that deviates significantly from what is normal or expected) incidents (i.e. observable activities that are sufficiently complete in themselves to permit inferences and predictions to be made about the person performing the act) from participants' memory (Spencer-Oatey, 2013).

2.2.2. Procedures

The development of a semi-structured interview relied on previous literature about microaggressions and discrimination in the healthcare context, as well as on the Flanagan's guidelines (1954) and other studies about the CIT. The structure of the guide

was also coherent with the one proposed by Capodilupo et al. (2010). It included an introduction, containing the definition of microaggressions, and subsequently participants were asked to remember situations of microaggressions directly experienced by them in the healthcare context or by others.

Open-ended questions were followed, investigating the type of health provider that did the microaggression, where it occurred, which were the participants' feelings during the incident, if the committer apologized, and so on. These questions aimed at obtaining as much details as possible (Gremler, 2004) and at facilitating the remembrance of the situation of microaggression (Edvardsson & Roos, 2001) and was repeated for each incident described. At the end, questions about the sociodemographic traits were asked.

All participants received the introduction to the interview, with the definition of microaggressions, shortly after the interview was scheduled. Out of 17 interviews, 12 were conducted face-to-face, three were conducted on video-call and two by telephone. The average number of critical incidents elicited did not differ across interview settings, and most of the incidents described occurred in similar contexts.

The interviews proceeded accordingly to the interview guide. At the end, participants were thanked for their availability and received a debriefing sheet containing the contacts of the research team and the major references relevant for the study. All interviews were conducted in Portuguese, audio-recorded, and transcribed verbatim. Quotes reported in this study are the result of an accurate translation from Portuguese to English.

2.2.3. Data Analysis

Content analysis techniques were adopted for the data analysis. The term "content analysis" refers to a general approach characterized by systematic coding and categorizing, employed to explore large amounts of information and to determine trends and patterns within the investigated phenomenon. This type of analysis is highly descriptive and aims to quantify and code data according to systematic categories, using frequencies to find significant meanings within the information available (Vaismoradi, Turunen, & Bondas, 2013).

The data analysis was conducted on NVivo. Before starting the analysis, an NVivo case was created for each participant. During the interviews, some participants reported situations that were experienced by other people (situations they witnessed or were told by acquaintances, friends or family members) with different social identities. This is why each person that experienced a microaggression was coded as a different NVivo case. In

the analysis phase, NVivo cases constituted the actual sample of the study (28 cases). NVivo cases were classified in groups, according to social identities (Table 1).

Case classifications	N. of NVivo cases
Perceived as majority ingroup member, Heterosexual women	10
Perceived as majority ingroup member, LGB women	7
Perceived as minority outgroup member, heterosexual women	8
Functionally diverse, perceived as majority ingroup member, heterosexual women	3
Total	**28**

Table 1. Classification of NVivo cases based on participants' minoritarian identities

A mixed approach of directed and conventional content analysis was used (Hsieh & Shannon, 2005). At first, the taxonomy of microaggressions proposed by Sue (2010) was used to code the different forms and levels of manifestations of the collected microaggressive. Categories for forms of microaggressions were described as follows:

- Microinvalidations: this category included the denial of someone's reality (what you feel is not true, denial of individual or social discriminatory attitudes, myth of meritocracy, dismissive-condescending attitudes, etc. (Sue, 2010); summary and superficial medical examination, lack of attention and empathy to the patient, insensitivity, denial of patients' pain or feelings.
- Microinsults: unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that demean a person's heritage or identity (Sue, 2010). Look of distrust or suspicion, avoidance, sexist comments, assuming that the other is heterosexual, treating someone as "abnormal", are some of the contents of this category.
- Microassaults: conscious, deliberate, purposeful, biased offenses, intended to threaten, humiliate, intimidate, hurt or make feel unwanted (Sue, 2010).
- Mixed microinvalidations + microinsults: this fourth category was created in the coding phase to provide a category for those microaggressions that were both a microinvalidation and a microinsult.

Verbal, non-verbal/behavioral and environmental levels of manifestation (Sue, 2010) were combined with the above described four microaggressive forms, generating 12

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different typologies of microaggressions. In a second moment, categories were created in order to categorize the different information related to each microaggressive incidents.

The chosen unit of coding consisted of segments of conversation that represented a single message or a distinguishable feature relevant for each created node. The length of these units was various and determined by the coder herself every time (Kurasaki, 2000).

All interviews were digitally recorded and transcribed verbatim (with identifying information removed), while peer debriefing was frequently performed during the study. Triangulation of researchers was employed to verify codes and coding procedures, that were reviewed and discussed within the research team (Coutinho, 2008). Intercoder reliability was provided by the creation of an Agreement Matrix and the calculation of the Intercoder Agreement coefficient, Cohen's Kappa (Kurasaki, 2000). A colleague of the research team reviewed the 20% of all collected data, randomly selected, and stated her agreement (or disagreement) on each code. Results for Cohen's Kappa were $\kappa = 0.874$.

This study was conducted according to the ethical principles of Psychology. At the beginning of the interviews, all participants were asked to read and sign an informed consent, which ensured that the participation to the study was voluntary, anonymous and confidential, that collected information would be only analyzed collectively.

3. Results

3.1. Typologies of microaggressions

Descriptive patterns of results and tendencies were interpreted accordingly to the taxonomy proposed by Sue (2010), as described above.

a) Women are highly likely to experience microaggressions in the healthcare context

Of the total of 17 participants, 14 participants were able to report microaggressions experienced in first person, two participants were able to report microaggressions experienced by people they knew and only one participant reported to have never experienced, witnessed nor heard about a microaggression in the health care context. Participants reported a total of 53 situations of microaggressions.

b) <u>Nonverbal/behavioral microinvalidations</u> represented 25% of microaggressions among the entire sample

Nonverbal/behavioral (17) and verbal (11) microinvalidations resulted as the most frequent typologies of microaggressions, followed by mixed verbal microinvalidations/microinsults (8) and verbal microassaults (7) (Table 2).

[Example of non-verbal/behavioral microinvalidation] This happens many times, regardless of being or not in health situations. [...] I remember being a at the entrance [of the emergency], to check in, (maybe it was the day of childbirth, I don't remember), there was a couple and they were being attended, and there was no one else to be attended, only me. […] And they were attended, and when I advanced, the nurse decided at that time to staple all the papers she had and go to the doctor or whoever was in the other room. […] And I felt uncomfortable and said: ‹‹we are in a situation of pain, in a delicate situation, I do not understand why you abandoned me here, there is no one else!›› [IP 2, age 34]

Typology of microaggressions	Frequencies
Nonverbal/behavioral microinvalidations	**17**
Verbal microinvalidations	**11**
Verbal microinvalidations + microinsults	8
Verbal microassaults	7
Nonverbal/behavioral microassaults	4
Environmental microinvalidations	4
Nonverbal/behavioral microinvalidations + microinsults	4
Nonverbal/behavioral microinsults	3
Verbal microinsults	2
Environmental microinsults	2
Environmental microassaults	0
Environmental microinvalidations + microinvalidations	0
Total	**62**

Table 2. Absolute frequencies of reported typologies of microaggressions

c) Women with different intersectional identities (M fN= 2,23) tend to experience more microaggressions than those perceived as ethnic ingroup, heterosexual women (fN= 1.2)

Perceived as ethnic majority ingroup member, *heterosexual women* reported a total of 12 microaggressive incidents (fN = 1.2). *Perceived as* ethnic majority ingroup member, *LGB women* reported 24 microaggressive incidents (fN = 3.4). *Perceived as* minority

outgroup member, *heterosexual women* reported 10 microaggressive incidents (fN = 1.9). Finally, *perceived as* ethnic majority ingroup, *heterosexual women with functional diversity* reported 10 incidents (fN = 3.6) (Table 3).

	Perceived as ethnic minority ingroup, Functionally diverse, heterosexual women	Perceived as ethnic minority outgroup, heterosexual women	Perceived as ethnic majority ingroup, LGB women	Perceived as ethnic majority ingroup, heterosexual women
N. of cases per group	3	8	7	10
N. of microaggressions per group	11	15	24	12
Relative frequencies (microaggressions per case)	**3.6**	**1.9**	**3.4**	**1.2**

Table 3. Frequencies of reported microaggressions organized per group

d) Different groups of women experience different typologies of Microaggressions

All groups reported a relatively high number of behavioral microinvalidations. However, *functionally diverse, perceived as ethnic ingroup heterosexual women* show the tendency to report a higher number of verbal microinvalidations (fN=1.30). *Perceived as ethnic outgroup, LGB* minority members tended to be targeted by verbal microinvalidations (fN=0.85) and verbal microassaults (fN=0.60).

[Example of verbal microassault] […] Since a friend commented that it happened to her. She's younger than me. And she told me what happened to her. And that's that terrible thing, when you are having the baby, you are in labor... There is the comment, I think by female nurses: ‹‹You liked to do it, now it costs you to have it.›› [IP 4, 46]

3.2 Specific medical areas or physical sections of healthcare facilities

Table 4 shows that most of the reported microaggressions occurred in the medical areas of maternity or obstetrics (13) and gynecology (8).

Areas/sectors	Frequencies
Maternity or Obstetrics	**13**
Gynecology	**8**
Non-specified areas or sectors	7
Emergency	5
Waiting rooms and reception	3
Family doctors	3
Dermatology	2
Ophthalmology	1
Clinical analysis and exams	1
Otorhinolaryngology	1
Forensic medicine	1
Physiotherapy	1

Table 4. Absolute frequencies for specific medical area or physical sections of healthcare facilities

3.3. Microaggressive contents

During the interviews, participants were asked if they were able to recognize which contents or stereotypes were behind the microaggression they experienced, or if they could guess the reason of the committer's attitude. For 33 out of 53 situations of microaggressions described, participants were able to recognize the content behind the microaggression. According to participants' opinions, most microaggressive contents were related to sexist (13), homophobic or heterosexist (2), racist or xenophobic (3) and ableist (2) beliefs.

It is a completely sexist type of aggression, that is, she can make a judgment about my sexual behavior, being that for her sleeping with many men is something evil. And it is completely... Yes, that was an aggression. [IP 10, 49]

Another category of contents was defined "intersectional" (6) referring to microaggressive beliefs or attitudes related to intersectional identities:

And in this situation, yes, I felt invisible. And yes, I believed that it was because of being a woman and being young. I believed that if I were a man, or if I were someone older, I would have had another type of attention. And, also, because we're Indian, isn't it? And in this case, I felt much the matter of racism... [IP 8, 35]

It is interesting to notice that participants also described some forms of microaggressions (7) that apparently were not related to societal stereotypes or discriminatory attitudes, but to practitioners' perceived attitude of arrogance, detachment, lack of empathy, and superficiality.

3.4. Emotional reactions

When asked about their feelings and thoughts at the moment of the microaggressive incidents, participants described feelings of anger (9) and powerlessness and vulnerability (7).

The first thing I always feel is anger. In these two cases I did not feel humiliated, I did not feel embarrassed, I think I felt angry because it also implied a little my... The cost of consultation, and lack of sensitivity, and also the fact that reality did not correspond to the expectation that I had about what a professional should have done. Yes, the anger. [IP 2,34]

Other feelings included shame (3), feeling of being minimized (3), feeling of injustice (3), self-directed anger (2), feeling of being objectified (1) and sadness (1).

It was immediately a feeling of injustice, like: "what are you doing here?" This is not fair, no one can treat me like this." [IP 9, 45]

3.5. Behavioral reactions

When asked about their reactions at the moment of the microaggressive incident, participants affirmed that many times they were able to directly (14) or indirectly (3) answer to the committers. Others affirmed that some microaggressive incidents (9) left them without reaction.

And there I instantly lose my patience: "Why are you talking about using hot towels? What is that?" […] So, I forced them to come forward, to explain, "but what is this?" I am not the kind of person that stays quiet. Also, I work in an area that is a bit connected to health... so I am always like: "What is this for? Why did you give me this?" [IP 3, 59]

And then [I felt] also upset with myself because I didn't have the ability to react at the time. I didn't react, and I should have reacted. [IP 7, 38]

3.6. Recalling the incident

The question "Have you ever thought about the incident again, after it happened?", was positively answered 14 times, and negatively answered four times.

I: Have you ever thought about this event again, after it happened?
P: Yes, whenever I talk about good practices or whenever I talk about going to the doctor, or whenever I think [about it], the image comes back to me… I remember the doctor's figure, not feeling safe inside. [IP 16, 29]

I: Have you ever thought about this event again, after it happened?
P: No, only now, trying to remember things, I tried to remember some situations in the health context, and I remembered it, but I hadn't thought about it again. [IP 15, 31]

3.7. Social sharing of the incident

Of all incidents in which social sharing was mentioned, 16 were shared by participants, three were not shared. Targets of social sharing were mainly friends, romantic partners and family members. Furthermore, 13 incidents, when shared, triggered a supportive reaction, while three triggered dismissive reactions.

So yes, I shared it with my family, and I was very angry. First, I was alone in there with her [my grandmother], so when I told them what had happened, what the two of us had lived, I told them how it happened. But actually, at that moment the most important thing for everyone was my grandmother's health." [IP 8, 35]

I: And which feedbacks did you receive?
P: Yes, there it is. I don't remember exactly. But they probably told me that I overreact. This could be a microaggression, too. [IP 2, 34]

3.8. Change in the relationship with or perception about the health provider

Participants were asked if the microaggressive incident affected their relationship with the health provider, the perception they had of him/her or of the healthcare facility.
Only when relating about two microaggressive incidents, participants stated that what happened did not change their perception of or relation with the health provider.

Yes, I continue [to go to the same gynecologist]. It changed. Yes, it changed [the relationship with the doctor]. […] I compensate this lack of sensitivity with the fact that he is a good professional. In other words, I say to myself "ah, but if I have to find another doctor and start everything from the beginning, I prefer to pass through these things than passing through a new relationship". But I continue to find him insensitive to these things. […] it costs to start a new relationship, at least for me it costs a lot." [IP 2, 34]

For five incidents, participants reported that it did change.

So, as these situations have a strong impact [on me], I try to distract myself a bit from what happened, but obviously my confidence, my openness... They quickly change. My way of being in that room, with that person, takes another shape... [IP 8, age 35]

In other eight occasions, participants stated that they decided to never return to the same health provider or healthcare facility.

I never went back there. I really didn't like it. And I've been there several times. But this was... [IP 6, 23]

3.9. Consequences of microaggressions on patients' health

Participant were asked if health provider' microaggressive attitudes had or may have had any practical consequences for their health. According to the collected answers, 14 incidents had or may have had consequences for targets' health (e.g. errors in the diagnosis or in the prescription of medicines), 11 incidents did not have any consequence and 6 incidents did not have any practical consequence but affected them unconsciously.

I: In this situation, the attitude of the health professional created, or could have created practical implications and/or for your health?

P: Yes, because if I had left, if I did not insist on seeing another doctor, she would have discharged me [from the hospital] [IP 11, 33]

When it happens again, I anticipate the event - if I'm in the line and I'm going to be attended, I'm already waiting for that behavior. [IP 2, 34]

3.10. Apologies from health providers

According to participants, most health providers and enactors of microaggressions did not perceive their attitude was microaggressive, nor apologized (13).

However, in some cases committers seemed to understand, changed their attitudes but did not apologized (3). In other cases, enactors of microaggressions apologized, probably in response to targets' behavioral reactions or under the threat of receiving charges, but their attitude did not change (3).

I: At some point did health professionals realize that they had assumed a wrong attitude and/or apologized?
P: Yes, they were apologizing, saying that it was not their intention, yes... […] There wasn't exactly a change of attitude. They said "Yes, yes, let's try" but then nothing changed. [IP 11, 33]

Out of the total of collected answers for this node, only one reported the apology and consequent change of attitude of a health provider. Furthermore, in some situations, representatives of the health care facilities or other practitioners apologized for the attitude of their colleagues (2).

I: At any time, did any of the health professionals realize that they had assumed a wrong attitude and apologized?
P: This pediatrician has come to apologize for her colleague's attitude. But he didn't, she came. [IP 9, 45]

3.11. Participants that never experienced microaggressions

Conformingly with the above described procedures to ensure trustworthiness and study quality, results for negative cases (Coutinho, 2008) are here presented. Out of 17 participants in the study, one stated that she never experienced, never witnessed nor heard about any microaggression in the healthcare context, and two participants referred that

they never experienced it in first person, but they witnessed to or heard about it from intimates.

I: So, in the context of the text that has been presented to you, can you remember any situation of microaggression?
P: No. Never... I've never had an experience, or that reminds me... That could be considered a microaggression. No, no, no.
I: Do you know anyone who has been through this?
P: I don't think so either. [IP 5, 48]

3.12. General questions about microaggressions

At the end of the interview, participants answered three questions about their general perception of microaggressions:

- All participants identified commonality of microaggressions. Awareness of the commonality of microaggressions was also displayed by those that never experienced or witnessed to a microaggressive incident.

I: Do you believe that these microaggressions are common?
P: Yes. I believe that they are so common in the area of health as in any other area of our lives, because we are people, health professionals are people like all of us, they do not have a specific training for gender equality, as almost no human contact area has such trainings, so there are stereotypes that are perpetuated in any dimension. [IP 11, 33]

- Fifteen out of 17 participants identified the negative impact of microaggressions on their targets. The remaining two believed that the impact of microaggressions depends on the targets' context, emotional state, personality and other factors.

I: Do you believe that these microaggressions have a negative impact?
P: Yes. Even because they're not normally seen as an aggression, so whenever we try to question them, people say: ‹‹but it was nothing, it's just a joke, it's not a big deal, it's in your head.›› So, there is a feeling of impotence. Do I have to take this? Does it have to be normal? Am I going to feel this way, bad, for the rest of my life? [IP 13, 26]

- Most participants (14) believed that microaggressions are an underestimated issue, and that tools of sensitization and training should be provided to all health

professionals. Other participants (3) referred to other good practices, such as the improvement of the justice system or the insertion of Psychology classes since the first years of university.

Our health professionals here in Portugal do not receive enough training. That is, I think there should be more training, with an inclusive language against heteronormativity, more inclusive to different sexualities, and that could mainly focus on the greater knowledge of how to treat the human being that is in front of them, also in psychological terms, not to treat the other as an object. I think there is little training and that it is super possible to implement these things, as I already met health professionals that had an approach more…. Not of assuming things for you, but of making careful questions… and we could have this approach from doctors, but unfortunately here is not common. [IP 6, 23]

4. Discussion

Results show that women are highly likely to experience microaggressions in the healthcare context. Women with different intersectional identities (perceived as ethnic outgroup, LGB, functionally diverse) were found to experience a greater amount of microaggressions than perceived as ethnic ingroup heterosexual women. Furthermore, this study illustrates, through the application of Sue's (2010) taxonomy to the data, that different groups of women experience different typologies of microaggressions.

Within this framework, an important finding is represented by the relatively high number of microaggressions that were reported to happen in the medical specialties of gynecology, obstetrics and in relation to maternity. We found that almost half of the reported microaggressive incidents was related to these areas. An important question arises from these results: why sexist microaggressions seem to occur mainly in medical areas that are exclusively related to women's health? These areas should be shaped around women's physical, psychological and social needs. One possible explanation is related to women's perception of discrimination. Someone would suggest that gynecology and obstetrics are as sexist as any other medical specialties, but that in these areas women feel more vulnerable – because they are socialized to see themselves in terms of reproductive potential (Halas, 1979), and these sectors are related to reproductive health – and are consequently more sensitive to microaggressions. However, in the last decades many studies have focused on sexist attitudes specifically present in gynecology and obstetrics (Halas, 1979; Elder, Humphreys, & Laskowski, 1988). Elder, Humphreys & Laskowski

(1988) analyzed gynecology textbooks used in medical schools between 1978 and 1983 and found sexist patterns that may have affected doctors since university. A similar study had been previously conducted by Scully and Bart (1978), that analyzed gynecology textbooks from 1943 to 1972. Both studies found that textbooks' contents perpetrated paternalistic and derogatory stereotypes related to traditional gender roles (e.g. women's function should be related to childbearing, child caretaking, homemaking and husband pleasing) and to stereotypical views of female personality. Even if the second study (Elder, Humphreys, & Laskowski, 1988) highlighted a decrease of stereotypical contents along time, this change resulted to be incomplete. A physician that graduated in 1980, today would be still practicing. It is not difficult to imagine that he or she might have studied one of these textbooks.

Emotional and behavioral reactions reported by participants, underlying the prevalence of externalized emotions, such as anger, and direct confrontation (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013) appeared in contrast with the classic literature on microaggressions, according to which targets are commonly found to experience feelings of powerlessness and are often unable to confront their microaggressor (Sue, 2010). However, these findings might be related to participants' highly developed feminist identity, as already found by Capodilupo and colleagues (2008). Similarly, results related to the emotional implications of microaggressions, such as the frequent recalling of microaggressive incidents, or the high degree to which some participants appeared to share the incident – this last finding is, again, in contrast with the established literature – might be explained in the light of the Model of Social Sharing of Emotions (Rimé, 2009). For example, incidents that were recalled several times where those characterized by higher emotional intensity, and thus triggered a higher need of sharing.

In the present study, participants reported that many providers did not apologize, neither changed their attitude after the microaggressive incident. This may find support in both microaggressions and sexism theories: on the one side, providers may have been well-intentioned and may have not realized that they were committing a microaggression (Sue, 2010); on the other side, providers may have not felt the need to apologize because of sexist beliefs related to women's inferiority (Glick & Fiske, 2001).

A final point of discussion should be made around the identification of good practices that may contribute to reduce the amount and intensity of microaggressions committed against women in the healthcare context. Participants in this study identified as good practices the implementation of training and sensitization programmes, oriented to raising

providers' awareness about social minorities and disadvantaged groups, but also to increase their application of patient-centered approaches. Scholars pointed out the particular and urgent need for trainings about women health issues (Vissandjée, M., Dupéré, & Abdool, 2001), LGBTQI+ people health issues (Smith & Turell, 2017) and cultural competency trainings to fight racialized medicine (Feagin & Bennefield, 2014). Other good practices may include bringing the directly interested people (minorities) at the top of the decision-making processes and at the middle of the conversation (Feagin & Bennefield, 2014), increasing the number of providers for underrepresented social minorities, creating specific guidelines, implementing the use of community health workers (non-medical personnel that can help patients navigating in the healthcare system) and focusing future research on the monitorization of providers' progresses (Nelson, 2002).

4.1 Limitations

The present research has some methodological limitations. The four groups of participants based on their minoritarian identities, were not numerically equal and the sample size was small for each minoritarian group. The group of heterosexuals perceived as ethnic majority ingroup women was more numerous than other groups. In this context, the results of this study cannot be interpreted as conclusive in relation to the patterns illustrated by the use of relative frequencies.

Another methodological weakness of this theoretical framework lays in the application of Sue's (2010) taxonomy. First, many incidents appeared to be simultaneously microinvalidations and microinsults, at the point that we needed to create a fourth category in order to code them correctly. Second, there is some confusion in the literature about the concept of "microassault". As suggested by Lilienfeld (2017), microassaults seem to conceptually overlap with the "old-fashioned" forms of discriminations, usually defined "blatant" or "overt" (Pettigrew & Meertens, 1995), entering in contradiction with the classical definition of microaggressions.

4.2 Suggestions for future research

This study was based on the assumption that women with a more developed feminist identity would be those that would more easily recognize microaggressions (Capodilupo, et al., 2010). For this reason, we chose to interview women that identified as feminist or activists, and that were actively cooperating with NGOs and other socially committed

organizations. The results seem to confirm our assumption given the relatively high number of microaggressive incidents that were reported. In the introduction, we proposed that the different levels of feminist identity might be related with different emotional and behavioral reactions (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013) which was not possible to verify in this study. The relationship between the Developmental Model of Feminist Identity (Downing & Roush, 1985), targets' awareness of microaggressions and their emotional, behavioral and cognitive reactions need to be studied in future research. Also, it might be useful to establish a reliable connection between targets' emotional reactions to microaggressions and the above-described theories of Psychology of Emotions (Rimé, 2009).

Furthermore, the interviews conducted during this study were based on the Critical Incident Technique (Flanagan, 1954), which allows to retrieve specific incidents from participants' memory. Critical incidents also appear in the intercultural training literature as a useful tool to raise awareness and enhance cultural competence (Spencer-Oatey, 2013). In this context, the incidents retrieved in the interviews may be used in the future to create training tools aimed at raising health providers' awareness in relation to microaggressions.

In closing, future research should develop a scale to measure gender microaggressions in the healthcare context, inspired by already existing scales, such as the Racial and Ethnic Microaggressions Scale (Nadal K. L., 2011), the LGBT People of Color Microaggressions Scale (Balsam, Molina, Beadnell, Simoni, & Walters, 2011), the Gendered Racial Microaggressions Scale for Black Women (Lewis & Neville, 2015) and on other studies that measure microaggressions in different context, such as in counseling relationships (Constantine, 2007).

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