Journal of Counseling Psychology
2017, Vol. 64, No. 5, 475–486

0022-0167/17/$12.00 http://dx.doi.org/10.1037/cou0000231

Applying Intersectionality to Explore the Relations Between Gendered Racism and Health Among Black Women

Jioni A. Lewis, Marlene G. Williams, Erica J. Peppers, and Cecile A. Gadson
University of Tennessee, Knoxville

The purpose of this study was to apply an intersectionality framework to explore the influence of gendered racism (i.e., intersection of racism and sexism) on health outcomes. Specifically, we applied intersectionality to extend a biopsychosocial model of racism to highlight the psychosocial variables that mediate and moderate the influence of gendered racial microaggressions (i.e., subtle gendered racism) on health outcomes. In addition, we tested aspects of this conceptual model by exploring the influence of gendered racial microaggressions on the mental and physical health of Black women. In addition, we explored the mediating role of coping strategies and the moderating role of gendered racial identity centrality. Participants were 231 Black women who completed an online survey. Results from regression analyses indicated that gendered racial microaggressions significantly predicted both self-reported mental and physical health outcomes. In addition, results from mediation analyses indicated that disengagement coping significantly mediated the link between gendered racial microaggressions and negative mental and physical health. In addition, a moderated mediation effect was found, such that individuals who reported a greater frequency of gendered racial microaggressions and reported lower levels of gendered racial identity centrality tended to use greater disengagement coping, which in turn, was negatively associated with mental and physical health outcomes. Findings of this study suggest that gendered racial identity centrality can serve a buffering role against the negative mental and physical health effects of gendered racism for Black women.

Public Significance Statement
This study found that Black American women who experienced a greater frequency of gendered racism and reported lower levels of gendered racial identity centrality, tended to use greater disengagement coping strategies, which in turn, was associated with poorer mental and physical health. Thus, higher levels of gendered racial identity centrality can serve a buffering role against the negative mental and physical health effects of gendered racism for Black American women.

Keywords: gendered racism, microaggressions, sexism, stress, coping

Although theoretical and empirical research on the influence of perceived racism on the mental and physical health of African Americans is well established in the literature (Paradies, 2006; Pascoe & Smart Richman, 2009; Pieterse, Todd, Neville, & Carter, 2012), there is still a dearth of research that focuses on the role of gendered racism, or the intersection of racism and sexism, on the health of African American women. Much of the extant literature conceptualizes perceived racism as a stressor that has the potential to influence the physiological stress response, which in turn, can impact health outcomes (Clark, Anderson, Clark, & Williams, 1999). However, absent from the literature is the explication of the role of the intersections of perceived racism and sexism, or gendered racism, on health. In this study, we applied intersectionality theory to extend Clark et al.'s (1999) biopsychosocial model of perceived racism by proposing mediating and moderating variables that influence the role of gendered racism on health outcomes among Black women. First, we briefly review the literature on perceived racism and health. Then, we highlight intersectionality theory and gendered racism. We also highlight the role of coping strategies and gendered racial identity centrality as important mediators and moderators in the link between gendered racism and health outcomes.

Perceived Racism and Health

There is a large body of theoretical and empirical research that has found that perceived racism negatively affects both mental and physical health outcomes (Clark et al., 1999; Paradies, 2006; Pascoe & Smart Richman, 2009; Pieterse et al., 2012). For example, Clark et al.'s (1999) biopsychosocial model of racism pro-

Editor's Note. Carlos Santos served as the action editor for this article.—TT

Jioni A. Lewis, Marlene G. Williams, Erica J. Peppers, and Cecile A. Gadson, Department of Psychology, University of Tennessee, Knoxville.

Preliminary results from this study were presented at the American Psychological Association 10th Biennial National Multicultural Conference and Summit, January 2017, Portland, OR.

Correspondence concerning this article should be addressed to Jioni A. Lewis, Department of Psychology, University of Tennessee, Austin Peay Building, Knoxville, TN 37996. E-mail: jalewis@utk.edu

poses that the perception of racism as a stressor is influenced by both demographic and psychological variables. In addition, Clark et al. (1999) highlight the role of mediating and moderating variables, such as coping strategies and physiological stress responses, in impacting the role of perceived racism on health outcomes. Several meta-analyses and systematic reviews have consistently found that perceived racism and discrimination is positively associated with greater psychological distress and poor physical health outcomes (Paradies, 2006; Pascoe & Smart Richman, 2009; Pieterse et al., 2012). For example, in a meta-analysis, Pascoe and Smart Richman (2009) found a negative association between perceived discrimination and mental health across 105 studies. In addition, Pieterse et al. (2012) conducted a meta-analysis focused on African American adults and found that perceived racism was negatively associated with mental health across 66 studies.

In terms of physical health, previous research has found that the stress of racism can impact higher physiological responses to stress, which can impact the immune system and cardiovascular functioning, which in turn can have a negative effect on health-related outcomes (Williams & Williams-Morris, 2000). In an African American community sample, Williams, Neighbors, and Jackson (2003) found that racism and discrimination was associated with poorer physical health. Several studies have also indicated that although perceived racism has a negative impact on both mental and physical health, the association may be stronger for mental health than for physical health (Paradies, 2006; Pascoe & Smart Richman, 2009). Although Clark et al. (1999) theorize about specific demographic variables that might influence perceived racism, absent from their model is any information about the intersections between gender and racism, or more specifically the intersection of racism and sexism.

Intersectionality Theory and Black Feminism

The concept of intersectionality has its roots in Black feminist theory (Cole, 2009; Collins, 1990). There is a rich interdisciplinary history that highlights the unique experiences that Black women face at the intersection of racism and sexism (e.g., Beal, 1970; Collins, 1990). Some of the earliest articulations of Black feminism and intersectionality date back to the mid-to-late 19th century when Sojourner Truth, an abolitionist and women's rights activist, famously gave a speech at the 1851 Ohio Women's Rights Convention highlighting the unique position of Black women in the fight for the right to vote at a time when White women tried to exclude Black women from the women's suffrage movement. Several activists, educators, scholars, and writers contributed to the development of Black feminist scholarship, which served as the foundation for research on intersectionality (Collins, 2000). Kimberlé Williams Crenshaw (1989) coined the term *intersectionality* in her work as a Black feminist and critical race legal scholar when she articulated the unique position of Black women in antidiscrimination law, which often excluded Black women at the intersection of racial and gender discrimination. Sociologist, Patricia Hill Collins (1990), articulated U.S. Black feminist thought as a critical social theory focused on challenging the hegemonic paradigms and epistemologies of knowledge production that exclude and marginalize Black women through the matrix of domination.

Although early articulations of intersectionality have been focused on systems-level processes given its history in critical race and legal studies, scholars in the field of psychology have applied intersectionality to individual-level variables, such as exploring the ways that interlocking forms of oppression simultaneously influence a person's life experiences (Cole, 2009). There is some debate in the field of psychology about the best way to explore intersecting identities and forms of oppression. Historically, researchers have utilized various approaches to study discrimination, including single-axis (e.g., race only or gender only), comparative (e.g., comparing Black women with White women or Black women with Black men), additive (e.g., measuring racism and sexism separately and then adding them together; Racism + Sexism), interactional/multiplicative (e.g., measuring racism and sexism separately and then creating a statistical interaction term; Racism × Sexism), and intersectional (measuring the unique intersection of the simultaneous experience of racism and sexism; Cole, 2009; Lewis & Grzanka, 2016; Shields, 2008; Thomas, Witherspoon, & Speight, 2008). Intersectionality scholars (Bowleg & Bauer, 2016; Crenshaw, 1989) posit that the simultaneous experience of both racism and sexism is greater than the sum of its parts. We agree with researchers who have argued that the intersectional approach is preferred, because it is the only approach that explores the experiences of racism and sexism simultaneously without trying to separate them (e.g., Bowleg, 2008; Bowleg & Bauer, 2016; Thomas et al., 2008). Thus, we apply an intersectional approach in the current study to more accurately capture interlocking forms of racism and sexism experienced by Black women.

Gendered Racism

Gendered racism refers to the simultaneous experience of both racism and sexism (Essed, 1991). The majority of quantitative research in psychology on gendered racism experienced by Black women has found that these intersecting forms of oppression are related to negative mental health, such as greater psychological distress (Lewis & Neville, 2015; Thomas et al., 2008; Woods, Buchanan, & Settles, 2009). One issue that has contributed to the dearth of research on gendered racism has been limited measures to explore this intersectional phenomenon. Previous studies have adapted existing measures of everyday sexism for use with Black women (e.g., Klonoff & Landrine, 1995; Thomas et al., 2008), which may not capture the unique intersectional experience of interlocking racial and gender oppression. Lewis and Neville (2015) developed an intersectional measure to assess gendered racial microaggressions (i.e., subtle forms of gendered racism). Their findings indicated that greater experiences of gendered racial microaggressions were positively related to racial microaggressions, perceived sexist events, and psychological distress in a sample of adult Black women. As one of the first intersectional measures to assess subtle gendered racism, this scale has the ability to uncover the influence of gendered racism on health for Black women.

A Potential Mediator: Coping With Gendered Racism

Clark et al.'s (1999) biopsychosocial model was adapted from Lazarus and Folkman's (1984) transactional model of stress and coping. In their model, coping responses are considered to mediate the relations between perceived racism and psychological and

physiological stress responses. In addition, Harrell's (2000) multidimensional conceptualization of racism-related stress highlighted sociocultural characteristics, such as racial and gender identity that can influence the racism-related stress and coping process. Previous theoretical and empirical research suggests that coping with interpersonal racism is an important variable involved in the stress and coping process for people of color (Brondolo, van Helen, Pencille, Beatty, & Contrada, 2009). However, within the traditional stress and coping literature, many coping measures do not consider the contextual and culturally specific ways that people of color may respond to race-based stress (Utsey, Adams, & Bolden, 2000). To measure culturally specific coping strategies, researchers have either developed measures specifically for African American populations, such as the Africultural Coping Systems Inventory (Utsey et al., 2000), or they have adapted existing measures, such as adapting the Coping With Problems Experienced Inventory (COPE; Carver, Scheier, & Weintraub, 1989). For example, Greer (2007) developed a four-factor higher order model for the COPE, which included spirituality, interconnectedness/social support, problem-oriented/engagement coping, and disengagement coping based on theoretical conceptualizations and empirical findings on coping behaviors of African Americans.

Previous research focused on Black women's coping strategies has found that there are a variety of ways that Black women cope with the unique stress of intersecting forms of oppression. Qualitative research has found that Black women generally engage in four types of coping strategies, such as active/engagement strategies (i.e., cognitive and behavioral efforts to deal with the situation; approach coping; resistance strategies), social support/interconnectness (i.e., seeking support from friends and family), religion and spirituality (prayer or ritual-centered coping), and disengagement/avoidance strategies (i.e., not doing anything to resolve the situation; denial and desensitization; Everett, Hall, & Hamilton-Mason, 2010; Lewis, Mendenhall, Harwood, & Browne Huntt, 2013; Shorter-Gooden, 2004). Thomas et al. (2008) conducted a quantitative study to explore the mediating role of culturally specific coping strategies on the relations between gendered racism and psychological distress among African American women. They found that using cognitive/emotional debriefing (i.e., coping with stress by avoiding thinking about the situation) partially mediated the relations between gendered racism and psychological distress, such that greater experiences with gendered racism were positively related to the use of cognitive emotional debriefing, which in turn, contributed to higher distress.

A Potential Moderator: Gendered Racial Identity Centrality

There is a large body of research that has explored whether racial identity serves as a buffer against the negative effects of perceived racism. Several studies using the Multidimensional Inventory of Black Identity (MIBI; Sellers, Rowley, Chavous, Shelton, & Smith, 1997) have found racial centrality to buffer the negative effect of perceived racism on psychological distress (e.g., Seaton, 2009; Sellers et al., 2003). However, some studies have found that racial centrality exacerbates the negative effects of racism on psychological distress (Burrow & Ong, 2010). In addition, a meta-analysis of the link between perceived discrimination and health found mixed results for the effect of identity centrality, such that some studies found no effect, a buffering effect, or an exacerbating effect (Pascoe & Smart Richman, 2009). However, there is a dearth of research that explores the potential moderating role of *gendered racial identity centrality* on the gendered racism-health link, due to lack of measures to assess intersectional aspects of identity.

Gendered racial identity centrality refers to how central the intersection of one's race and gender identity is to one's self-concept. Although most of the identity research focuses on separating and teasing apart racial identity and gender identity, Black women often experience these identities simultaneously (Thomas, Hacker, & Hoxha, 2011). In a qualitative study of young adult African American women, gendered racial identity was a more salient identity for the participants compared with the separate constructs of gender or racial identity (Thomas et al., 2011). However, there is a dearth of quantitative research on gendered racial identity centrality because of the lack of measures to assess intersectional aspects of identity. Because of this, we chose to assess gendered racial identity centrality using the MIBI (Sellers et al., 1997), which is a psychometrically sound racial identity scale that we adapted as an intersectional measure of gendered racial identity centrality.

Purpose of the Study

Although there has been an increase in quantitative research on gendered racism using an intersectionality framework, very few studies have used intersectional measures that have been created to assess the intersection of racism and sexism. Thus, we're applying intersectionality to extend Clark et al.'s (1999) biopsychosocial model of perceived racism to gendered racism to illuminate the pathways through which gendered racism may affect mental and physical health. Given that very little research has focused on the influence of gendered racism on health outcomes, we wanted to first explore whether gendered racial microaggressions significantly predicts both physical and mental health outcomes. Then, we wanted to examine our conceptual biopsychosocial model of gendered racism by exploring coping strategies as potential mediators in the relations between gendered racial microaggressions and health outcomes (physical and mental health) among Black women. In addition, we examined gendered racial identity centrality as a potential moderator in the mediational pathway between gendered racial microaggressions, coping strategies, and health outcomes.

On the basis of previous research that has found gendered racism to be significantly associated with psychological distress, our first hypothesis was that gendered racial microaggressions will significantly predict negative self-reported health outcomes (physical and mental health). Previous theoretical (e.g., Clark et al., 1999; Harrell, 2000) and empirical (e.g., Pascoe & Smart Richman, 2009; Thomas et al., 2008) work suggests that disengagement coping strategies mediates the relations between racism and poorer health, and that healthier coping strategies (engagement, spirituality, and social support) mediate the relations between racism and positive health. Thus, our second hypothesis was that coping strategies will significantly mediate the relations between gendered racial microaggressions and self-reported health outcomes. Specifically, a greater frequency of gendered racial microaggressions will be positively related to the use of greater disengagement

coping strategies, which will be related to more negative health outcomes. In addition, a greater frequency of gendered racial microaggressions will be positively related to the use of greater spirituality, interconnectedness/social support, and engagement coping, which will be related to more positive health outcomes. On the basis of Clark et al.'s (1999) biopsychosocial model, our third hypothesis predicted a moderated mediation model, such that the combination of greater gendered racial microaggressions and lower levels of gendered racial identity centrality will be positively related to a greater use of disengagement coping, which in turn, will be negatively related to health outcomes. In addition, the combination of greater gendered racial microaggressions and higher levels of gendered racial identity centrality will be positively related to a greater use of spirituality, interconnectedness/social support, and engagment coping, which in turn, will be positively related to health outcomes.

Method

Participants

The final sample included 231 Black women. The majority of the participants identified as African American or Black (88%); the remaining participants identified as biracial/multiracial (6%); an African ethnic background (4%; e.g., Kenyan, Nigerian); or Caribbean, Jamaican, or Caribbean American (2%). Participants ranged in age from 18 to 78, with a mean age of approximately 37 years (SD = 12.38). The majority of women (87%) identified as heterosexual, and the remainder identified as lesbian, bisexual, queer, asexual, or other. A majority of participants (60%) self-identified as middle class. Participants' education level was assessed across four categories: high school and less (2%), some college/associates' degree (11%), bachelor's degree (25%), and graduate/professional degree (62%). Approximately 92% of participants were born in the United States. In terms of geographic region, a majority of our participants (54%) were from the Southeast, 18% were from the Midwest, 17% were from the Northeast, and 10% were from the West Coast.

Procedure

Prior to data collection, we obtained institutional review board approval. A purposeful sampling method was used to recruit Black women from various geographical locations throughout the United States. Participants were recruited using Facebook posts, Facebook advertisements, listserv e-mails, and flyers. We contacted the e-mail listserv managers and Facebook group administrators of organizations and groups that target African American individuals (e.g., African American student/faculty/staff organizations, African American sororities, and African American professional associations) to request permission to forward our recruitment information to their members for study participation. Participants who were interested in taking part in the study accessed the recruitment information through a URL directing them to the online survey. The survey took approximately 30 min to complete. As an incentive, after participants completed the survey, they could enter their name into a raffle to win one of three $100 gift card awards.

Measures

Gendered racial microaggressions. The 26-item Gendered Racial Microaggressions Scale (GRMS; Lewis & Neville, 2015) was used to assess the frequency of nonverbal, verbal, and behavioral negative racial and gender slights experienced by Black women. Lewis and Neville (2015) demonstrated support for construct validity and found that the GRMS was significantly and positively related to racial and ethnic microaggressions, perceived sexist events, and psychological distress. Participants reported the frequency of gendered racial microaggressions they experienced in their lifetime on a 6-point Likert-type response format ranging from 0 (*never*) to 5 (*once a week or more*). Higher total mean scores indicated a greater frequency of gendered racial microaggressions (Lewis & Neville, 2015). An example item includes, "Someone has made a sexually inappropriate comment about my butt, hips, or thighs." Previous research reported reliability coefficients for the frequency scale of .92 (Lewis & Neville, 2015). In the current sample, the Cronbach's alpha reliability estimate was .92.

Mental and physical health. The 12-item Short Form Health Survey-Version 2 (SF-12v2; Ware, Kosinski, & Keller, 1996) was used to assess self-reported mental and physical health. The measure includes two subscales: Mental Health (six items: e.g., "How much of the time during the last 4 weeks have you felt calm and peaceful?") and physical health (six items, e.g., "During the past 4 weeks, how much did pain interfere with your normal work?" [including both work outside the home and housework]). We chose to calculate a total sum score for each subscale, which has been used in previous research with African American populations (Guyll, Cutrona, Burzette, & Russell, 2010). Items were scored, such that, higher scores on the mental health subscale indicated positive mental health (e.g., little or no psychological distress) and higher scores on the physical health subscale indicated positive physical health (e.g., little or no reported limitations in physical functioning; Maruish, 2012). Previous research with an African American sample has reported reliability coefficients for the mental health subscale and physical health subscale of .76 and .81, respectively (Cernin, Cresci, Jankowski, & Lichtenberg, 2010). Cronbach's alpha coefficients for the current study were: mental health (α = .83) and physical health (α = .73).

Coping strategies. The 28-item Brief Coping with Problems Experienced Inventory (Brief COPE; Carver, 1997) was used as a multidimensional assessment of participants' responses to stress. Participants report their tendency to engage in a particular coping strategy on a 4-point Likert-type scale, ranging from 1 (*I usually do not do this at all*) to 4 (*I usually do this a lot*). Higher scores indicated a respondents' tendency to engage in a particular coping strategy. We modified the instructions and asked women to respond to items based on how they coped with a recent experience of racism and sexism as a Black woman to assess situational coping with a recent gendered racial stressor. The Brief COPE (Carver, 1997) assesses 14 types of coping strategies, which can be grouped into higher order factors for parsimony and ease of interpretability. We chose to utilize Greer's (2007) four higher order factor subscales for our study, which has been shown to have a better model fit for African American populations. The four higher order factors include, *spirituality* (religion, acceptance, and planning), *interconnectedness/social support* (vent emotions, emo-

tional social support, and instrumental social support), *problem-oriented/engagement* coping (active coping, humor, and positive reinterpretation/positive reframing), and *disengagement* coping (behavioral disengagement, substance use, denial, self-blame, and self-distraction). Cronbach's alpha coefficients ranged from .74 (disengagement) to .88 (interconnectedness; Greer, 2007). Cronbach's alpha reliability estimates for the current study included: spirituality ($\alpha = .75$), social support ($\alpha = .88$), engagement ($\alpha = .72$), and disengagement ($\alpha = .71$).

Gendered racial identity centrality. We assessed gendered racial identity centrality using a modified version of the 10-item Multidimensional Inventory of Black Identity Centrality subscale (MIBI-Centrality; Sellers et al., 1997) to measure the intersection of racial and gender identity centrality. We selected the MIBI because it is a multidimensional Black racial identity measure that assesses three aspects of racial identity: centrality, regard, and ideology (Sellers et al., 1997; Sellers, Smith, Shelton, Rowley, & Chavous, 1998). An example item includes, "Being a *Black woman* is important to my self-image." Participants responded based on a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores indicated higher levels of gendered racial identity centrality. Previous studies have reported Cronbach's alpha coefficients ranging from .77 to .84 (Oney, Cole, & Sellers, 2011). In the current study, the Cronbach's alpha coefficient was .80.

Demographic questionnaire. A demographic questionnaire was constructed for the study to obtain information about participants' age, race, ethnicity, gender, sexual orientation, and geographic location.

Data Analytic Plan

Hypothesis 1 was tested using simple linear regression analysis. Hypothesis 2 was tested using mediation Model 4 of the PROCESS macro (Hayes, 2013). Hypothesis 3 was tested using Model 8 of the PROCESS macro, which tests for moderated mediation. For the current study, analyses were conducted using 1,000 bootstrapping resamples to produce 95% bias-corrected confidence intervals for the indirect effect. For all mediation and moderated mediation analyses, we identified significant effects if the 95% confidence intervals of indirect effects did not include zero. On the basis of the recommendation of Hayes (2015), we chose to interpret the significance of the moderated mediation results based on the significance of the index of moderated mediation. If the index of moderated mediation was significant, we then followed recommendations of Preacher et al. (2007) and probed the indirect effect at the levels of the moderator to assess the direction of the moderated mediation.

Results

Preliminary Analyses

Out of the final sample of 231 participants who were included in the analysis, a small amount of missing data remained. Analysis of the patterns of missing data revealed that the missing data for GRMS items ranged from 0% to 9%. All other measures in this study (Brief COPE, SF-12v2, and MIBI-Centrality) had 4% or less missing cases. In addition, Little's (1988) missing completely at random (MCAR) analysis revealed an insignificant chi-square statistic, $\chi^2(1827.51)$, $p = .683$, indicating that the data were missing completely at random. We chose to use the expectation maximization imputation method, which uses a maximum likelihood technique for estimating missing values (Little & Rubin, 2002); this method is appropriate when data are MCAR. Data met guidelines for univariate normality (skewness <3, kurtosis <10; Weston & Gore, 2006). According to sample size recommendations for mediation analysis (Weston & Gore, 2006) and moderated mediation analysis (Aiken & West, 1991), our sample size and estimated parameters had enough power to detect moderate effect sizes.

The Pearson product–moment correlations indicated significant correlations between GRMS, coping subscales, gendered racial identity centrality, mental health, and physical health (see Table 1). GRMS was significantly and positively correlated with all four coping subscales (spirituality, social support, engagement, disengagement). GRMS was negatively correlated with mental health ($r = -.32$, $p < .01$) and physical health ($r = -.18$, $p < .01$). GRMS was positively correlated with gendered racial identity centrality ($r = .19$, $p < .05$).

Regression Analyses

Simple linear regression analysis was used to test if GRMS significantly predicted mental and physical health (see Table 2). GRMS significantly predicted mental health scores ($\beta = -.32$), $t(228) = -5.18$, $p < .001$, and also explained a significant proportion of the variance in mental health scores ($R^2 = .11$), $F(1,$

Table 1
Intercorrelations, Means, and Standard Deviations for all Study Variables

Variable	*M*	*SD*	α	1	2	3	4	5	6	7	8
1. GRMS	1.99	.90	.92	—	.20	.28**	.30**	.41**	.19*	−.32**	−.18**
2. Spirituality	2.82	.70	.75		—	.49**	.57**	.22**	.13*	−.06	−.13*
3. Social support	2.48	.81	.88			—	.46**	.26**	.38**	−.18**	−.08
4. Engagement	2.32	.61	.72				—	.37**	.08	−.14*	−.06
5. Disengagement	1.75	.53	.71					—	.05	−.54**	−.28**
6. GRI centrality	5.71	1.03	.81						—	−.10	.14*
7. Mental health	21.37	3.83	.81							—	.47**
8. Physical health	21.07	4.66	.74								—

Note. GRMS = gendered racial microaggressions; GRI centrality = gendered racial identity centrality.
* $p < .05$. ** $p < .01$.

Table 2
Linear Regression Analyses Examining GRMS as a Predictor of Mental and Physical Health

Predictor variable	Outcome variable	*B*	β	*t*	R^2	*F*	*df*
GRMS							
	Mental health	−1.68	−.32	−5.18	.11	26.79***	(1, 228)
	Physical health	−.79	−.18	−2.83	.03	8.02**	(1, 229)

Note. *B* and *t* values reflect values from the final regression equation. GRMS = gendered racial microaggressions.
** $p < .01$. *** $p < .001$.

228) = 26.79, $p < .001$. In addition, GRMS significantly predicted physical health (β = −.18), $t(228) = -2.83$, $p < .01$, and explained a significant proportion of the variance in physical health scores ($R^2 = .03$), $F(1, 229) = 8.02$, $p < .01$.

Mediation Analyses

We ran a series of four mediation analyses using Model 4 of the PROCESS macro (Hayes, 2013) to test coping strategies (spirituality, social support, engagement, and disengagement) as a mediator of the relation between GRMS and mental health and physical health (see Figure 1). GRMS indirectly influenced mental health ($B = -1.05$; $SE = .20$, 95% CI [−1.476, −.688]) and physical health ($B = -.42$; $SE = .15$, 95% CI [−.768, −.157]) through disengagement coping (see Table 3 for bootstrapping results). The direction of the paths from GRMS to the disengagement mediator (path a) and from the disengagement mediator to mental and physical health (path b) indicate that experiencing a greater frequency of GRMS is associated with increased disengagement coping strategies, which in turn, is associated with greater negative mental and physical health outcomes (path c'). There was no evidence that GRMS indirectly influenced mental or physical health through spirituality, social support, or engagement coping.

Moderated Mediation Analysis

Given that spirituality, social support, and engagement coping did not significantly mediate the GRMS-health link, we chose to focus on disengagement coping in the moderated mediation model. Thus, we ran a moderated mediation analysis using Model 8 of the PROCESS macro (Hayes, 2013) to test the ability of disengagement coping to mediate the relation between GRMS and health outcomes with gendered racial identity centrality as the moderator (see Figure 2). As shown in Table 4, GRMS was significantly related to disengagement coping, which in turn, predicted mental health (overall model: $R^2 = .31$), $F(4, 225) = 25.21$, $p < .001$, and physical health ($R^2 = .16$), $F(4, 226) = 12.56$, $p < .001$. Gendered racial identity centrality significantly moderated the link between GRMS and both mental and physical health. The indexes of moderated mediation were statistically different from zero for

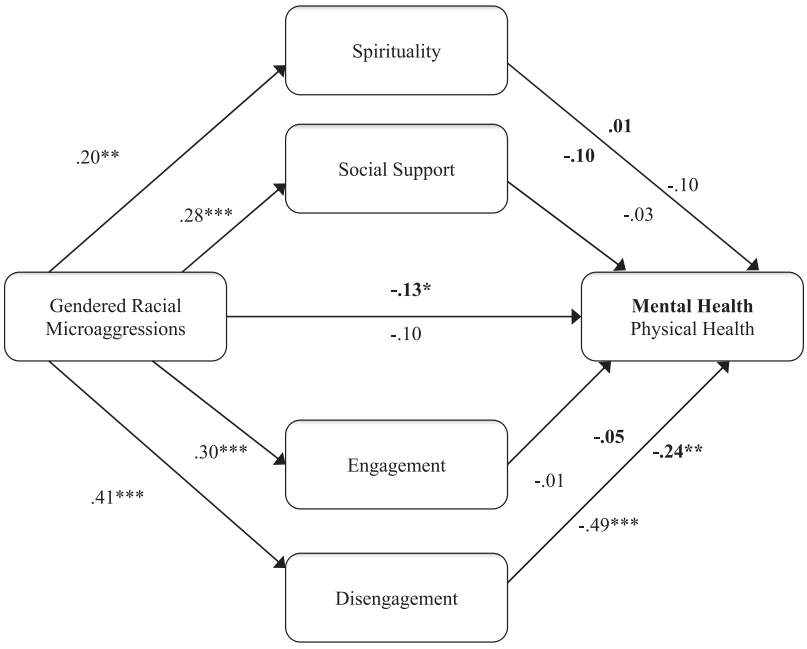

Figure 1. Path model of coping as the mediator of the relation between gendered racial microaggressions and health outcomes. *Note*. Values in bold represent mental health. All values reflect standardized coefficients. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3
Direct and Indirect Effects of GRMS on Mental and Physical Health Through Coping Strategies

Variable	Coefficient		95% CI		ΔR^2
	B	*SE*	Lower	Upper	
Mental health					.32***
GRMS	−.68	.32	−1.31	−.04	
Spirituality	.01	.07	−.13	.17	
Social Support	−.14	.11	−.42	.03	
Engagement	−.07	.11	−.32	.11	
Disengagement	−1.05	.20	−1.48	−.69***	
Physical health					.10***
GRMS	−.41	.30	−1.01	.19	
Spirituality	−.08	.06	−.23	.00	
Social Support	−.03	.08	−.22	.13	
Engagement	−.01	.09	−.19	.16	
Disengagement	−.42	.15	−.77	−.16***	

Note. GRMS = gendered racial microaggressions.
*** $p < .001$.

mental health (index = .34, *SE* = .17, 95% CI [.01, .72]) and physical health (index = .11, *SE* = .07, 95% CI [.01, .29]). The 95% confidence intervals indicate that the indirect effect was significant at each level of gendered racial identity centrality for mental and physical health (see Table 4). For mental health, the 95% confidence intervals were significant when gendered racial identity centrality was low (*SD* −1; *B* = −1.40, *SE* = .30, 95% CI [−2.04, −.87]); at the mean (*B* = −1.06, *SE* = .20, 95% CI [−1.49, −.68]); and high (*SD* +1; *B* = −.71, *SE* = .23, 95% CI [−1.26, −.30]). For physical health, the 95% confidence intervals were significant when gendered racial identity centrality was low (*SD* −1; *B* = −.47, *SE* = .19, 95% CI [−.92, −.15]); at the mean (*B* = −.36, *SE* = .14, 95% CI [−.68, −.11]); and high (*SD* +1; *B* = −.24, *SE* = .11, 95% CI [−.51, −.06]). The conditional indirect effects at different levels of the moderator indicate that there was a stronger effect on mental and physical health at lower levels of gendered racial identity centrality. Figure 3 illustrates the moderating effect, such that, the combination of higher GRMS, greater use of disengagement coping, and lower levels of gendered racial identity centrality was associated with negative mental and physical health outcomes.

Discussion

The purpose of our study was to apply intersectionality theory to Clark et al.'s (1999) biopsychosocial model of racism by exploring the influence of gendered racial microaggressions on the mental and physical health of Black women. In addition, we explored coping strategies as potential mediators in the relations between gendered racial microaggressions and health outcomes and gendered racial identity centrality as a potential moderator in the mediational pathway between gendered racial microaggressions, coping strategies, and health outcomes. Our findings highlight the unique intersectional experiences of subtle forms of racism and sexism for a diverse, yet predominantly middle class sample of Black women with postsecondary and advanced education. Thus, our sample may not be representative of the experiences of all Black women but may represent the unique experiences of Black middle class women.

On the basis of our research findings, our first research hypothesis was supported. Gendered racial microaggressions significantly predicted health outcomes. Specifically, experiencing a greater frequency of gendered racial microaggressions was significantly related to more negative mental health. These findings support previous studies (Pascoe & Smart Richman, 2009; Pieterse et al., 2012) that found a significant link between perceived discrimination and mental health. Our findings also support research (Lewis & Neville, 2015; Thomas et al., 2008) that has found a greater frequency of gendered racism to be significantly and positively related to psychological distress for Black women. In addition, we also found that a greater frequency of gendered racial microaggressions significantly predicted negative physical health. These findings support previous meta-analysis studies that have found a link between perceived discrimination and poorer physical health (Pascoe & Smart Richman, 2009). However, our findings extend the literature by being one of the first studies to specifically explore the association between gendered racism and self-reported physical health.

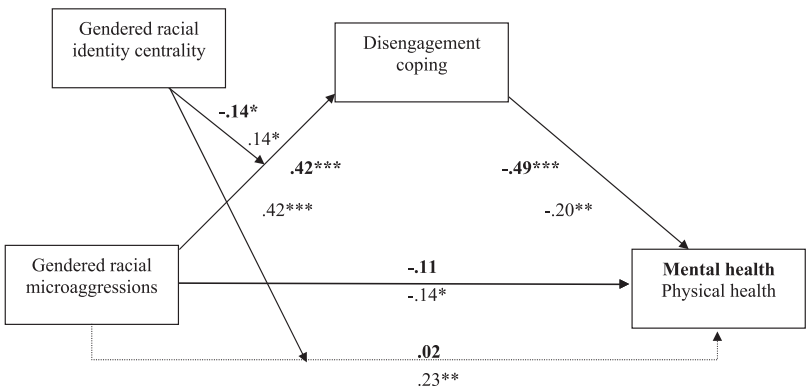

Figure 2. Moderated mediation model depicting disengagement coping mediating the relation between gendered racial microaggressions and health outcomes with gendered racial identity centrality as the moderator. *Note*. Dashed line indicates conditional indirect effect. Values in bold represent mental health. All values reflect standardized coefficients. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4
Moderated Mediation Analysis for GRMS, Gendered Racial Identity Centrality, Coping, and Mental and Physical Health

Variable	*B*	*SE* B	*t*
Mental health			
Mediator – Disengagement coping			
Predictor: GRMS	.24	.04	6.79***
Moderator: Gendered racial identity centrality	−.02	.03	−.76
Interaction: GRMS × Gendered racial identity centrality	−.08	.04	−2.18*
Outcome – Mental health			
Mediator: Disengagement coping	−4.32	.54	−7.98***
Predictor: GRMS	−.58	.32	−1.81
	Boot indirect effect/index	Boot *SE*	95% CI
−1 *SD*	−1.40	.30	−2.04, −.87
Mean	−1.06	.20	−1.49, −.68
+1 *SD*	−.71	.23	−1.26, −.30
Index of moderated mediation	.34	.17	.01, .72
Variable	*B*	*SE* B	*t*
Physical health			
Mediator – Disengagement coping			
Predictor: GRMS	.25	.04	6.81***
Moderator: Gendered racial identity centrality	−.02	.03	−.78
Interaction: GRMS × Gendered racial identity centrality	−.08	.04	−2.19*
Outcome – Physical health			
Mediator: Disengagement coping	−1.45	.50	−2.96**
Predictor: GRMS	−.58	.29	−2.00*
	Boot indirect effect/index	Boot *SE*	95% CI
−1 *SD*	−.47	.19	−.92, −.15
Mean	−.36	.14	−.68, −.11
+1 *SD*	−.24	.11	−.51, −.06
Index of moderated mediation	.11	.07	.01, .29

Note. GRMS = gendered racial microaggressions.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Our second research hypothesis exploring the role of coping strategies in mediating the relations between gendered racial microaggressions and health outcomes was partially supported. We found partial support for the role of coping strategies in mediating the gendered racial microaggressions-health link. Specifically, disengagement coping mediated the relations between gendered racial microaggressions and both mental and physical health, such that a greater frequency of gendered racial microaggressions was positively related to the use of greater disengagement coping strategies, which in turn, was related to more negative mental and physical health. Our findings complement previous research that has found that the use of greater avoidant coping strategies significantly mediated the racism-distress link for African American individuals, in general, (Seaton, Neblett, Upton, Powell Hammond, & Sellers, 2011; Szymanski & Obiri, 2011; Utsey et al., 2000) and the gendered racism-distress link for Black women, in particular (Thomas et al., 2008; Szymanski & Lewis, 2016). Thus, when experiencing greater gendered racism, the use of greater disengagement coping strategies negatively influences the mental and physical health of Black women. Contrary to our hypothesis, we found no support for the mediating role of spirituality, social support, or engagement coping in the link between gendered racial microaggressions and mental and physical health. However, these findings are consistent with previous studies that have also failed to find a significant mediating role of positive coping in the racism-health link (Seaton et al., 2011; Szymanski & Obiri, 2011; Utsey et al., 2000). It is possible that positive or engagement coping strategies could be helpful in the face of gendered racism, but this was not supported in our specific study with Black women. It is possible that there are additional factors, such as culturally specific coping strategies, that are important to consider when exploring the mediating role of engagement coping strategies in the discrimination-health link.

Our third research hypothesis, which explored the ability of gendered racial identity centrality to moderate the indirect relations between gendered racial microaggressions and health outcomes through the mediating role of coping strategies was partially supported. Specifically, the conditional indirect effect of gendered racial identity centrality indicates there is a stronger effect of the link between gendered racial microaggressions and mental and physical health through disengagement coping at lower levels of gendered racial identity centrality, such that, the combination of higher gendered racial microaggressions and lower gendered racial identity centrality levels was associated with more negative health outcomes. These findings complement previous research that has found certain dimensions of ethnic identity to serve as a buffer against the negative effects of perceived racism and microaggressions (Fischer & Shaw, 1999;

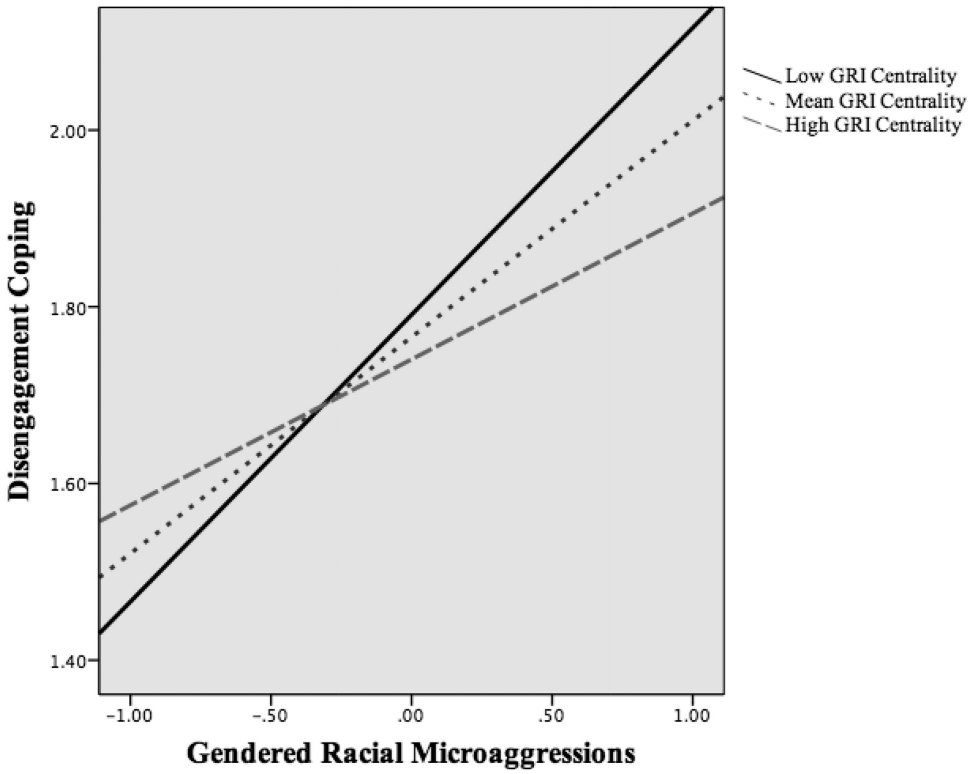

Figure 3. Interaction of gendered racial microaggressions and gendered racial identity centrality on disengagement coping. *Note.* GRI Centrality = gendered racial identity centrality.

Torres & Taknint, 2015). Our findings provide additional support for the importance of exploring the intersectional nature of both gendered racism experiences and gendered racial identity centrality to better understand the ways that the centrality of one's intersectional identity may be protective.

The current study suggests that higher levels of gendered racial identity centrality can serve to buffer Black women against the negative mental and physical health consequences of gendered racial microaggressions. Previous studies have found that individuals who experience greater perceived discrimination and who have a lower level of racial identity centrality engage in more avoidant coping strategies because these experiences seem out of their control (Seaton, Upton, Gilbert, & Volpe, 2014). Another way to interpret these findings is that a Black woman's decision to choose disengagement/avoidant coping strategies may be a self-protective way to take control of a situation that seems to be outside one's control. For example, Lewis, Mendenhall, Harwood, and Browne Huntt (2013) argue that inactive coping could serve a self-protective function for Black women if they experience microaggressions in situations where they have less power to actively confront the perpetrator (e.g., when a supervisor or teacher says something racist and sexist). This highlights the contextual factors and power dynamics that may influence Black women's strategic coping strategies. It is also possible that Black women with lower levels of gendered racial identity centrality have not developed adequate coping strategies for gendered racism given that aspects of their identity attached to these discriminatory experiences are not salient to them. Contrary to expectation, we did not find support for the moderating role of gendered racial identity centrality in the mediational pathway between gendered racial microaggressions, spirituality, social support, or engagement coping and health outcomes. However, these findings are consistent with recent studies that have also not found significant meditational pathways for engagement forms of coping in the racism-distress link (Seaton et al., 2014; Szymanski & Lewis, 2016). Given that identity processes may be particularly important in promoting a positive sense of self-esteem (Tajfel & Turner, 1979), it is possible that in order to better assess the role of gendered racial identity centrality in the meditational pathway between gendered racism and positive/engagement coping, that researchers should consider measuring positive health outcomes, such as psychological well-being, self-esteem, or life satisfaction.

Limitations and Directions for Future Research

Although this study makes several important contributions to intersectionality research on gendered racism, some limitations should be considered. The first limitation is related to measurement. Although this study sought to explore gendered racial microaggressions, gendered racial identity centrality, and coping strategies through an intersectional lens, some of the measures were not theoretically designed to measure intersectional constructs. For example, despite the Brief COPE (Carver, 1997) yielding significant findings in the current study, it was not constructed to capture the range of coping strategies Black women utilize to cope with gendered racism. It is possible that limitations in the types of coping strategies measured limited some of our findings. Future research could explore the factor structure of the

adapted version of the Brief COPE (Carver, 1997) for use with Black women. In addition, future research should include the development of new intersectional measures that are explicitly designed to assess the experience of multiply marginalized groups (Else-Quest & Hyde, 2016). Another measurement limitation is the self-report nature of the health outcome measure we used. Social desirability could have impacted the participants' self-reports of their health status. Given the role of the physiological stress response in the stress and coping process, it would be important for future research to assess health using more objective measures, such as salivary cortisol, heart rate variability, or blood pressure to further investigate the biopsychosocial impact of gendered racism on the health of Black women.

The second limitation in this study is the limited within group diversity of our sample of Black women. Middle class Black women with higher levels of education were overrepresented in our sample, which could be due in part to the data collection method used. Specifically, collecting data using online surveys limits the social class diversity of the sample because social class disparities exist in Internet access. In addition, our purposeful sampling method also relied on sending recruitment information to university and professional e-mail listserves and Facebook groups, which could have led to a higher socioeconomic status sample. Future studies should make an intentional effort to recruit a more diverse community-based sample by using paper-and-pencil surveys. Future studies should also increase recruitment efforts to target Black sexual minority women, who are often overlooked in the extant literature (DeBlaere & Bertsch, 2013). Likewise, immigration status among some participants in the current study could impact their gendered racial identity development (Case & Hunter, 2014). Perhaps Black immigrant women included in the current study who identified as Black, but not African American or U.S.-born, could have more culturally nuanced ways of coping with gendered racism. Future studies should explore the within-group differences among Black women's gendered racial experiences.

A final important limitation is our focus on individual-level variables. As psychologists, we tend to focus on the influence of individual-level discrimination on health outcomes. Although it is important to explore the impact of discrimination on health as a way to explore health disparities, it is also important to expand our focus beyond individual and interpersonal levels of oppression. Future research could collect data on systemic variables, such as environmental racism and segregation, by compiling neighborhood level data, to assess the impact of multiple and interlocking forms of oppression at the individual, interpersonal, institutional, and cultural levels. For example, researchers could use multilevel modeling to explore the ways these levels of discrimination are nested and influence important outcomes for individuals and communities (Else-Quest & Hyde, 2016). In addition, the inclusion of policy level variables could more directly illuminate the impact of structural inequality on Black women's experiences of gendered racism (Bowleg & Bauer, 2016).

Implications

The current study has important implications for counseling psychologists and mental health professionals. Clinicians need to develop a greater awareness of subtle forms of gendered racism that impact Black women and be more informed, empathic, and supportive in helping clients combat gendered racism. Our findings indicated that gendered racial identity centrality was found to buffer Black women against the negative effects of gendered racism. Psychologists should seek to develop specific treatment interventions to assist their Black women clients in developing higher gendered racial identity centrality. In addition, it is important for practitioners to find ways to assess their client's level of gendered racial identity and explore how central the intersection of their race and gender is to their self-concept.

Although not a specific focus of the current study, group-level interventions, such as social support, empowerment, and consciousness-raising groups could be helpful in providing Black women clients with opportunities to receive support and validation about their gendered racism experiences. For example, Black women who feel isolated at predominantly White institutions could benefit from Black women social organizations to connect with other Black women and develop a sense of community. Although not a focus of this study, future work should also seek to develop systemic interventions that could foster positive gendered racial identity for Black women and promote positive social change. For example, one collective coping strategy and form of resistance for Black women has come from social media campaigns that support and empower Black women, such as the Twitter hashtag "#BlackGirlMagic" or the "Black Girls Rock!" nonprofit empowerment program, which seeks to celebrate the beauty, resilience, and positive accomplishments of Black women and empower them within a larger societal context that devalues them (Wilson, 2016). It is important for these positive group-level interventions that have been created by Black women to be coupled with a push for institutional-level change.

Given the prevalence of racism in the contemporary sociopolitical moment, it is important for psychologists to consider the ways that racism operates at both micro and macro levels in society and consider implications for our work at individual, institutional, and cultural levels. It is imperative that researchers and practitioners develop a more nuanced intersectional lens to explore the gendered racism that Black women and girls experience in various aspects of their lives, from individual contexts to institutions, such as education and health care settings (Crenshaw, Ocen, & Nanda, 2015). Although this study is focused on how gendered racism influences individual-level variables, it is important for intersectional researchers in counseling psychology to continue to push the boundaries of our discipline and consider how Black women are embedded in social-structural contexts that may serve to buffer or exacerbate the impact of gendered racism in their everyday lives.

References

Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park, CA: SAGE.

Beal, F. (1970). Double jeopardy: To be Black and female. In T. Cade (Ed.), *The Black woman: An anthology* (pp. 90–100). New York, NY: Signet.

Bowleg, L. (2008). When Black + Lesbian + Woman ≠ Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles, 59*(5–6), 312–325. http://dx.doi.org/10.1007/s11199-008-9400-z

Bowleg, L., & Bauer, G. (2016). Invited reflection: Quantifying intersectionality. *Psychology of Women Quarterly, 40,* 337–341. http://dx.doi.org/10.1177/0361684316654282

Brondolo, E., Gallo, L. C., & Myers, H. F. (2009). Race, racism and health: Disparities, mechanisms, and interventions. *Journal of Behavioral Medicine, 32,* 1–8. http://dx.doi.org/10.1007/s10865-008-9190-3

Brondolo, E., ver Halen, N. B., Pencille, M., Beatty, D., & Contrada, R. J. (2009). Coping with racism: A selective review of the literature and a theoretical and methodological critique. *Journal of Behavioral Medicine, 32,* 64–88. http://dx.doi.org/10.1007/s10865-008-9193-0

Burrow, A. L., & Ong, A. D. (2010). Racial identity as a moderator of daily exposure and reactivity to racial discrimination. *Self and Identity, 9,* 383–402. http://dx.doi.org/10.1080/15298860903192496

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the brief COPE. *International Journal of Behavioral Medicine, 4,* 92–100. http://dx.doi.org/10.1207/s15327558ijbm0401_6

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56,* 267–283. http://dx.doi.org/10.1037/0022-3514.56.2.267

Case, A. D., & Hunter, C. D. (2014). Cultural racism-related stress in Black Caribbean immigrants: Examining the predictive roles of length of residence and racial identity. *The Journal of Black Psychology, 40,* 410–423. http://dx.doi.org/10.1177/0095798413493926

Cernin, P. A., Cresci, K., Jankowski, T. B., & Lichtenberg, P. A. (2010). Reliability and validity testing of the short-form health survey in a sample of community-dwelling African American older adults. *Journal of Nursing Measurement, 18,* 49–59. http://dx.doi.org/10.1891/1061-3749.18.1.49

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans. A biopsychosocial model. *American Psychologist, 54,* 805–816. http://dx.doi.org/10.1037/0003-066X.54.10.805

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist, 64,* 170–180. http://dx.doi.org/10.1037/a0014564

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York, NY: Routledge.

Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1,* 139–167. Retrieved from http://chicagounbound.uchicago.edu/uclf/

Crenshaw, K. W., Ocen, P., & Nanda, J. (2015). *Black girls matter: Pushed out, overpoliced, and underprotected. African American Policy Forum*. Retrieved from http://www.aapf.org/publications/

DeBlaere, C., & Bertsch, K. N. (2013). Perceived sexist events and psychological distress of sexual minority women of color: The moderating role of womanism. *Psychology of Women Quarterly, 37,* 167–178. http://dx.doi.org/10.1177/0361684312470436

Else-Quest, N. M., & Hyde, J. S. (2016). Intersectionality in quantitative psychological research: I. Theoretical and epistemological issues. *Psychology of Women Quarterly, 40,* 155–170. http://dx.doi.org/10.1177/0361684316629797

Essed, P. (1991). *Understanding everyday racism: An interdisciplinary theory*. Thousand Oaks, CA: SAGE.

Everett, J. E., Hall, J. C., & Hamilton-Mason, J. (2010). Everyday conflict and daily stressors: Coping responses of Black women. *Affilia, 25,* 30–42. http://dx.doi.org/10.1177/0886109909354983

Fischer, A. R., & Shaw, C. M. (1999). African Americans' mental health and perceptions of racist discrimination: The moderating effects of racial socialization experiences and self-esteem. *Journal of Counseling Psychology, 46,* 395–407. http://dx.doi.org/10.1037/0022-0167.46.3.395

Greer, T. M. (2007). Measuring coping strategies among African Americans: An exploration of the latent structure of the COPE Inventory. *The Journal of Black Psychology, 33,* 260–277. http://dx.doi.org/10.1177/0095798407302539

Guyll, M., Cutrona, C., Burzette, R., & Russell, D. (2010). Hostility, relationship quality, and health among African American couples. *Journal of Consulting and Clinical Psychology, 78,* 646–654. http://dx.doi.org/10.1037/a0020436

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70,* 42–57. http://dx.doi.org/10.1037/h0087722

Hayes, A. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (1st ed.). New York, NY: Guilford Press.

Hayes, A. F. (2015). An index and test of linear moderated mediation. *Multivariate Behavioral Research, 50,* 1–22. http://dx.doi.org/10.1080/00273171.2014.962683

Klonoff, E. A., & Landrine, H. (1995). The schedule of sexist events: A measure of lifetime and recent sexist discrimination in women's lives. *Psychology of Women Quarterly, 19,* 439–472. http://dx.doi.org/10.1111/j.1471-6402.1995.tb00086.x

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Lewis, J. A., & Grzanka, P. R. (2016). Applying intersectionality theory to research on perceived racism. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/14852-003

Lewis, J. A., Mendenhall, R., Harwood, S. A., & Browne Huntt, M. (2013). Coping with gendered racial microaggressions among Black women college students. *Journal of African American Studies, 17,* 51–73. http://dx.doi.org/10.1007/s12111-012-9219-0

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the Gendered Racial Microaggressions Scale for Black women. *Journal of Counseling Psychology, 62,* 289–302. http://dx.doi.org/10.1037/cou0000062

Little, R. J. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American Statistical Association, 83,* 1198–1202. http://dx.doi.org/10.1080/01621459.1988.10478722

Little, R. J. A., & Rubin, D. B. (2002). *Statistical analysis with missing data* (2nd ed.). New York, NY: Wiley & Sons. http://dx.doi.org/10.1002/9781119013563

Maruish, M. E. (Ed.), (2012). *User's manual for the SF-12v2 Health Survey* (3rd ed.). Lincoln, RI: Quality Metric Incorporated.

Oney, C. N., Cole, E. R., & Sellers, R. M. (2011). Racial identity and gender as moderators of the relationship between body image and self-esteem for African Americans. *Sex Roles, 65*(7–8), 619–631. http://dx.doi.org/10.1007/s11199-011-9962-z

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35,* 888–901. http://dx.doi.org/10.1093/ije/dyl056

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135,* 531–554. http://dx.doi.org/10.1037/a0016059

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59,* 1–9. http://dx.doi.org/10.1037/a0026208

Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research, 42,* 185–227. http://dx.doi.org/10.1080/00273170701341316

Seaton, E. K. (2009). Perceived racial discrimination and racial identity profiles among African American adolescents. *Cultural Diversity & Ethnic Minority Psychology, 15,* 137–144. http://dx.doi.org/10.1037/a0015506

Seaton, E. K., Neblett, E. W., Upton, R. D., Hammond, W. P., & Sellers, R. M. (2011). The moderating capacity of racial identity between per-

ceived discrimination and psychological well-being over time among African American youth. *Child Development, 82,* 1850–1867. http://dx.doi.org/10.1111/j.1467-8624.2011.01651.x

Seaton, E. K., Upton, R., Gilbert, A., & Volpe, V. (2014). A moderated mediation model: Racial discrimination, coping strategies, and racial identity among Black adolescents. *Child Development, 85,* 882–890. http://dx.doi.org/10.1111/cdev.12122

Sellers, R. M., Caldwell, C. H., Schmeelk-Cone, K. H., & Zimmerman, M. A. (2003). Racial identity, racial discrimination, perceived stress, and psychological distress among African American young adults. *Journal of Health and Social Behavior, 44,* 302–317. http://dx.doi.org/10.2307/1519781

Sellers, R. M., Rowley, S. A. J., Chavous, T. M., Shelton, J. N., & Smith, M. A. (1997). Multidimensional inventory of black identity: A preliminary investigation of reliability and construct validity. *Journal of Personality and Social Psychology, 73,* 805–815. http://dx.doi.org/10.1037/0022-3514.73.4.805

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84,* 1079–1092. http://dx.doi.org/10.1037/0022-3514.84.5.1079

Sellers, R. M., Smith, M. A., Shelton, J. N., Rowley, S. A. J., & Chavous, T. M. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review, 2,* 18–39. http://dx.doi.org/10.1207/s15327957pspr0201_2

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*(5–6), 301–311. http://dx.doi.org/10.1007/s11199-008-9501-8

Shorter-Gooden, K. (2004). Multiple resistance strategies: How African American women cope with racism and sexism. *The Journal of Black Psychology, 30,* 406–425. http://dx.doi.org/10.1177/0095798404266050

Szymanski, D. M., & Lewis, J. A. (2016). Gendered racism, coping, identity centrality, and African American college women's psychological distress. *Psychology of Women Quarterly, 40,* 229–243. http://dx.doi.org/10.1177/0361684315616113

Szymanski, D. M., & Obiri, O. (2011). Do religious coping styles moderate or mediate the external and internalized racism-distress links? *The Counseling Psychologist, 39,* 438–462. http://dx.doi.org/10.1177/0011000010378895

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Monterey, CA: Brooks/Cole.

Thomas, A. J., Hacker, J. D., & Hoxha, D. (2011). Gendered racial identity of Black young women. *Sex Roles, 64,* 530–542. http://dx.doi.org/10.1007/s11199-011-9939-y

Thomas, A. J., Witherspoon, K. M., & Speight, S. L. (2008). Gendered racism, psychological distress, and coping styles of African American women. *Cultural Diversity & Ethnic Minority Psychology, 14,* 307–314. http://dx.doi.org/10.1037/1099-9809.14.4.307

Torres, L., & Taknint, J. T. (2015). Ethnic microaggressions, traumatic stress symptoms, and Latino depression: A moderated mediational model. *Journal of Counseling Psychology, 62,* 393–401. http://dx.doi.org/10.1037/cou0000077

Utsey, S. O., Adams, E. P., & Bolden, M. (2000). Development and validation of the Africultural Coping Systems Inventory. *The Journal of Black Psychology, 26,* 194–215. http://dx.doi.org/10.1177/0095798400026002005

Ware, J., Jr., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care, 34,* 220–233. http://journals.lww.com/lww-medicalcare/pages/default.aspx http://dx.doi.org/10.1097/00005650-199603000-00003

Weston, R., & Gore, P. A., Jr. (2006). A brief guide to structural equation modeling. *The Counseling Psychologist, 34,* 719–751. http://dx.doi.org/10.1177/0011000006286345

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93,* 200–208. http://dx.doi.org/10.2105/AJPH.93.2.200

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health, 5*(3–4), 243–268. http://dx.doi.org/10.1080/713667453

Wilson, J. (2016, January 12). The meaning of #BlackGirlMagic, and how you can get same of it. *Huffpost*. Retrieved from http://www.huffingtonpost.com/entry/what-is-black-girl-magic-video_us_5694dad4e4b086bc1cd517f4

Woods, K. C., Buchanan, N. T., & Settles, I. H. (2009). Sexual harassment across the color line: Experiences and outcomes of cross- versus intraracial sexual harassment among Black women. *Cultural Diversity & Ethnic Minority Psychology, 15,* 67–76. http://dx.doi.org/10.1037/a0013541

Received September 13, 2016
Revision received May 1, 2017
Accepted May 2, 2017 ■