AN EXAMINATION OF THE MODERATING ROLE OF GENDERED RACIAL IDENTITY CENTRALITY IN THE RELATIONSHIP BETWEEN GENDERED RACISM AND DEPRESSION

by

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Abstract

JAIME LEE BEHRENDT-MIHALSKI. An examination of the moderating role of gendered racial identity centrality in the relationship between gendered racism and depression (Under the direction of DRS. ANDREW D. CASE AND RYAN P. KILMER)

Black women experience both racism and sexism, and these experiences have been found to be related to psychological distress and impairment. While research has pointed to the independent negative effects of racism and sexism on mental health, there is a dearth of research exploring the intersecting experience of racism and sexism (i.e., gendered racism) and its mental health consequences for Black women. Intersectionality offers a framework to understand the overlap of identities (e.g., race, gender) and oppressions (e.g., racism, sexism) on individuals' lived experiences. Gendered racism reflects the unique intersection of racism and sexism and, in Black women, the experience of gendered racism has been found to be related to negative mental health outcomes. Further, previous research has found that viewing race as a central aspect of one's self-concept (i.e., strong racial identity centrality) may act as a buffer against stress in the relationship between racism and psychological challenges; however, a review of the literature yielded only one study that examined this relationship in the context of gendered racism in Black women. The goal of this study was to identify psychological and social influences on the relationship between gendered racism and depressive symptoms in Black women.

The present study used a cross-sectional design to examine the relationship between gendered racism and depressive symptoms in Black women and the degree to which gender centrality and gendered racial centrality moderates this relationship.

Findings from this study indicate that frequent experiences of gendered racist events and higher levels of stress appraisal of these events were associated with signficantly higher levels of reported depressive symptoms; however, neither gender centrality nor gendered racial centrality moderated these relationships. The present study helps to elucidate the relationship between Black women's experiences of discrimination and their mental health functioning and highlights the lack of attention that previous research has given to this area of research.

DEDICATION

This thesis is dedicated to my wonderful and loving husband, Alex Behrendt-Mihalski, who has supported me throughout this process and continuously motivated me to be a better person. I would also like to dedicate this thesis to my mother, Jackie Mihalski, who has always pushed me to dream big. Finally, this thesis is dedicated to my amazing grandparents, Pat and Cookie Mihalski; without their unwavering love and support, I would not be the woman I am today.

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Chapter 1: Introduction

Black women[1] in the United States experience stress in the forms of racism and sexism, which scholars have argued places them at an increased risk for negative health outcomes such as depression (Clark, Anderson, Clark, & Williams, 1999; Pascoe & Richman, 2009; Pieterse, Todd, Neville, & Carter, 2011; Williams & Mohammed, 2013). Research on depression in Black women presents a more complex picture when considering the roles of both race and gender. Specifically, Black women report higher rates of depression compared to Black men but similar or lower rates of depression compared to White women (Center for Disease Control and Prevention [CDC], 2012; Kohn & Hudson, 2002; Pratt & Brody, 2014; Rosenfeld, 2012). These findings suggest that Black women, compared to Black men and White women, may experience differential exposure to risk and protective factors associated with depression. Depression can be a source of distress, interfere with an individual's life by preventing them from meeting everyday demands, and act as a risk factor for suicide (American Psychiatric Association [APA], 2015; Wang, et al., 2004). Given the documented associations between perceived discrimination (racism and sexism) and negative mental health outcomes, research is needed to better identify the factors that protect Black women against or elevate their risk for depression. Understanding the correlates and

[1] In this proposal, "Black women" is used instead of "African American women" in order to be inclusive of U.S.-born women of perceived African ancestry as well as women of perceived African ancestry who have migrated to the U.S. from other geographic locations (e.g., Caribbean islands, African countries).

predictors of depression in Black women is of critical importance given the implications of depression for Black women's well-being, livelihood, and families.

Black women differ from Black men and White women in that they experience both racism and sexism. Racism occurs when a society views a group, whose in-group is constructed by observed physical traits and assumed geographic ancestry, as superior to other socially constructed groups (American Association of Physical Anthropologists [AAPA], 1996; Bonilla-Silva, 1997; Jones, 1972; Smedley & Smedley, 2005). A substantial body of research has linked the stress associated with perceived racial discrimination to negative mental health outcomes in Black women, including depression (Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009; Clark et al., 1999; Graham, West, Martinez, & Roemer, 2016; Pascoe & Richman, 2009; Pieterse et al., 2011; Schmitt, Branscombe, Postmes, & Garcia, 2014; Williams & Mohammed, 2013). Sexism is gender-specific discrimination that arises in large part from circumscribed gender roles and results in women having a marginalized status compared to men (Eagly, Eaton, Rose, Riger, & McHugh, 2012; Hurst & Beesley, 2013; Molix, 2014). As with racism, sexism can function as a stressor in the lives of Black women. Some studies have examined the relationship between sexism and psychological well-being and have found that perceived sexism is related to higher levels of psychological distress and higher rates of diagnosed mental illness (e.g., depression; Borrell et al., 2010, 2011; Moradi & Funderburk, 2006; Moradi & Subich, 2004).

1.1. Guiding Theory and Relevant Research

Several constructs, frameworks, and approaches have been posited to describe and facilitate understandings of how identities and oppression overlap and intersect. As one

case in point, intersectionality refers to the overlap of identities (e.g., race, gender) and oppression (e.g., racism, sexism) that individual's experience (Collins, 2015; Hancock, 2007), and intersectionality as a theory asserts that while racism and sexism can independently impact an individual's life, the intersection of race and gender contributes to a unique lived experience among Black women that differs from those of Black men and White women (Borrell et al., 2011; Collins, 2015; Crenshaw, 1991; Harrell, 2000; Klonoff & Landrine, 1995; Schug, Alt, & Klauer, 2015; Sesko & Biernat, 2010; Thomas, Witherspoon, & Speight, 2008). Another construct of relevance, *gendered racism*, refers to the lived experience of the overlap and intersection of racism and sexism that women of color face (Essed, 1991; Lewis & Neville, 2015; Perry, Harp, & Oser, 2013; Thomas et al., 2008; Woods-Giscombé & Lobel, 2008). The Gendered Racism framework was developed to illuminate the experiences of Black women at the intersection of race and gender and provides an opportunity for a more complex and nuanced understanding of their oppression (Essed, 1991; Lewis & Neville, 2015; Perry et al., 2013; Thomas et al., 2008; Woods-Giscombé & Lobel, 2008). In recent years, measures have been developed to assess gendered racism (Szymanksi & Lewis, 2016); however, there is a dearth of empirical literature examining the impact of gendered racism on Black women's mental health (Lewis & Neville, 2015; Szymanski & Lewis, 2016). Thus, the first aim of this study is to examine the relationship between gendered racism and depressive symptoms in a sample of Black women.

In light of findings that have linked perceptions of racism and sexism to negative mental health outcomes, researchers have turned their attention to identifying factors that may moderate these relationships. One factor that has been examined is identity, which

refers to characteristics that define an individual, such as traits, relationships with others, group memberships, and one's role within the community (Oyserman, Elmore, & Smith, 2011). One dimension of identity, identity centrality, reflects how important an identity is to one's self-concept (Sellers, Rowley, Chavous, Shelton, & Smith, 1997). Of relevance to the present study, *racial centrality* refers to the importance of race or ethnicity to an individual's self-concept while *gender centrality* is the importance of gender identity to self-concept; the overlap of racial and gender identity centrality is *gendered racial centrality* which reflects the importance of the intersection of racial and gender identities to one's self-concept.

Although these identity constructs would seemingly hold relevance to the relationship between racism and mental health, findings regarding the potential moderating influence of racial identity centrality have been mixed, with some studies indicating that racial identity centrality buffers against negative mental health outcomes (e.g., Seaton, Neblett, Upton, Hammond, & Sellers, 2011; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Sellers & Nicole, 2003). The literature on gender centrality is less developed and even less conclusive. That is, being a woman has been associated with greater psychological distress and higher rates of mental illness, including depression (e.g., CDC, 2012; Kohn & Hudson, 2002; Pratt & Brody, 2014; Rosenfeld, 2012); however, most of these studies assessed gender identity categorically (woman vs. man) instead of dimensionally (i.e., the connection one experiences with, or the degree of importance one places on, gender identity). Few studies have examined gender identity centrality as a buffer against depression, and this review did not identify any studies that have examined this relationship among Black women. The second aim of this study is to

determine whether Black women who have greater gender identity centrality will evidence a stronger relationship between gendered racism and depressive symptoms.

Past research has examined racial and gender identity separately in the context of perceived discrimination and mental health. However, intersectionality theory maintains that identities intersect and overlap (Collins, 2015; Hancock, 2007). Hancock (2007) observes that traditional identity research employs a unitary approach that assumes a primary or master identity (e.g., gender or race). However, a small but growing body of research has shown that Black women often consider their race and gender simultaneously. For example, the Strong Black Woman (SBW) schema described among Black women incorporates both gender and race (Lewis & Neville, 2015; Watson & Hunter, 2015). In combination, these identities have a meaning to Black women that is distinct from the unitary conceptions of their racial and gender identities.

Findings from studies that consider the intersection of racial and gender identity imply that a gendered racial identity may have a different relationship with depression, in the face of gendered racism, than racial or gender identity alone. However, research examining gendered racial identity is lacking and has been largely qualitative. In their review paper, Kohn and Hudson (2002) concluded that, for Black women, being Black may be protective in the relationship between discrimination and depression, but being a woman may elevate that risk. Similarly, Watson and Hunter (2015) in their recent qualitative study found that the Strong Black Women schema creates tensions for Black women that may lead to psychological distress. In the only study identified in this review that examined gendered racial identity as a moderator, Szymanski and Lewis (2016) found that gendered racial identity centrality did not moderate the relationship between

gendered racism and psychological distress, except when African American women reported moderate to high levels of gendered racial identity centrality and detachment coping (e.g., dissociating oneself from a stressor) was used. The authors further pointed out that their study was limited because they did not use a measure of gendered racism or identity centrality that was developed specifically for African American women. Moreover, the present review did not identify any studies that examined the moderating effect of gendered racial identity in the relationship between gendered racism and depression. In light of this gap in the extant literature, the third and final aim of this study is to examine if greater gendered racial centrality in Black women contributes to a stronger relationship between gendered racism and depressive symptoms.

This study intends to fill three important gaps in the intersectionality and gendered racism literature. First, it sought to determine whether there is a relationship between gendered racism and depressive symptoms. Second, it examined whether gender identity centrality is a risk or protective factor in the relationship between gendered racism and depressive symptoms. Third, it examined whether gendered racial identity centrality is a risk or protective factor in the relationship between gendered racism and depressive symptoms.

A brief overview of the current state of the racism and health and sexism and health literatures provides a framework for this study. This is followed by an introduction to the intersectionality and gendered racism framework and review of the corresponding literature. Next, identity centrality as a moderator in the relationship between gendered racism and depression will be discussed. This is followed by a review of the current study with its research questions and hypotheses. The methods section

provides an overview of the study's sample, procedures, and analysis plan. Next, the results are presented and discussion of their implications follows. Finally, the conclusion summarizes main points and findings from this study.

1.2. Overview of Key Terms

Although the central constructs examined in this study have been defined in the preceding section, this section provides a brief overview of these terms and their definitions.

1.2.1. Gendered racism.

Gendered racism may be viewed as either a framework or a phenomenon. As a framework, gendered racism captures the experience of the intersection of racism and sexism and includes a range of domains, including assumptions regarding sexuality and beauty, experiences of silencing and marginalization, and stereotypes of the strong Black woman and angry Black woman (Lewis & Neville, 2015). As a phenomenon, it refers to the lived experience of the intersection of racism and sexism. In this study, gendered racism refers specifically to the intersectional oppression experienced by Black women.

1.2.2. Identity centrality.

Identity centrality refers to the importance of an identity to an individual's self-concept (Sellers et al., 1997).

1.2.3. Gender centrality.

Gender centrality is the importance of gender identity to an individual's self-concept. In this study, gender centrality refers to the importance of being a woman to one's self-concept.

1.2.4. Gendered racial centrality.

Gendered racial centrality is the importance of the intersection of race and gender identity to one's self-concept. In this study, gendered

racial centrality refers to the importance of the Black woman identity to an individual's self-concept.

Chapter 2. Literature Review

2.1. Racism

In the United States, racism can have significant negative consequences for the life experiences and health of Black women (Bonilla-Silva, 1997; Clark et al., 1999; Harrell, 2000; Sue et al., 2007). Race is a social construct by which individuals are categorized into distinct groups based on observable physical characteristics and assumed geographic ancestry (AAPA, 1996; Smedley & Smedley, 2005). Racism is a system of beliefs, cognitions, attitudes, behaviors, and practices based on the ideology that some races are inherently and immutably superior. This system results in the differential treatment of individuals based on their racial classification (AAPA, 1996; Bonilla-Silva, 1997; Jones, 1972). In effect, racism functions as a social hierarchy that stratifies racial groups in regard to their access to opportunities, resources, and power (Bonilla-Silva, 1997; Jones, 1972; Massey, 2007).

Racism exists and impacts the lives and health of Black women at three societal levels: individual, institutional, and cultural (Jones, 1972; Williams & Mohammed, 2013). At the individual level, racism exists as a belief in the inferiority of Blacks and the superiority of Whites and is accompanied by prejudice, stereotypes, and overt and covert discriminatory behaviors targeting Blacks. At an institutional level, racism manifests as policies, practices, and laws that have a disproportionately adverse effect on Blacks (Jones, 1972). Examples of contemporary institutional racism include lower employer response rates for similarly-qualified Black versus White job applicants; the

increased likelihood of Blacks versus Whites being stopped and searched by the police; and Blacks being told about and shown fewer housing properties than their White counterparts (American Civil Liberties Union [ACLU], 2014; Massey, 2007; Pager, Western, & Bonikowski, 2009; The Sentencing Project, 2005). Finally, at the cultural level, racism is manifested through the maintenance of the values, ideals, and preferences of Whites. For example, the relative over-representation of European history, music, and literature versus African forms in school curricula is a form of cultural racism (Jones, 1972).

Though distinct, the three levels of racism overlap and are manifested within specific contexts in the lives of Black women (Harrell, 2000). According to Harrell (2000), racism can be experienced in interpersonal, collective, cultural-symbolic, and sociopolitical contexts and, to that end, she offers examples of how racism is manifested across contexts. For instance, within the interpersonal context, Black women experience racism through prejudice and discrimination directly and vicariously (i.e., observing it happen to others). In the collective context, racism is manifested through the status of Blacks versus Whites in areas such as educational achievement, incidence and prevalence of disease, and treatment within the criminal justice system. Racism in the cultural-symbolic context is perceived in the portrayal and absence of Blacks in art and sciences. Within the sociopolitical context, racism manifests through debate and public discussion on race and institutional practices and policies that impact Blacks. In sum, the lived experience of racism for Black women involves the intertwining of racist ideology, behaviors, institutional practices, and cultural narratives played out in multiple life arenas (Harrell, 2000).

2.2. Racism as a Stressor and Determinant of Health

Findings from a significant body of research suggest that the ubiquity of racism in the lives of Black women can have deleterious health consequences (e.g., Almquist, 1975; Lewis, Mendenhall, Harwood, & Huntt, 2013; Szymanski & Lewis, 2016; Thomas, Hacker, & Hoxha, 2011; Thomas et al., 2008). Several models have delineated the relationship between racism and health, proposing that perceptions of racism can result in stress (Clark et al., 1999; Harrell, 2000), which has been referred to as "racism-related stress" or "race-related stress" (Harrell, 2000). Racism-related stress has been linked to negative psychological and physiological sequelae, including increased levels of depression, lowered self-esteem, frustration, fear, and deteriorated functioning of the immune, endocrine, and cardiovascular systems (Clark et al., 1999; Williams & Mohammed, 2013).

Racism-related stress is theorized to impact negatively the health of Black women through at least two pathways (Clark et al., 1999; Pascoe & Richman, 2009). First, racism-related stress can stimulate a marked physiological and emotional response that places the individual at risk for disease and psychological impairment. Second, racism-related stress can lead to maladaptive coping behaviors such as overeating, smoking, and using substances (Clark et al., 1999). Several studies lend support to the assertion that racial discrimination has health consequences for Black women (Brondolo et al., 2009; Clark et al., 1999; Graham et al., 2016; Pascoe & Richman, 2009; Pieterse et al., 2011; Schmitt et al., 2014; Williams & Mohammed, 2013). For example, in a meta-analysis exploring the relationship between perceived discrimination and psychological well-being (e.g., depression, anxiety) among racial minority groups, correlational analyses

showed that experiences of perceived racial discrimination were negatively related to psychological well-being, and this relationship was exacerbated for marginalized groups (Schmitt et al., 2014). In their meta-analysis of experimental studies, Schmitt and colleagues (2014) found that exposure to more pervasive forms of discrimination was negatively related to psychological well-being. Other studies have found perceived racial discrimination to be associated with higher levels of depression, anxiety, and psychological distress, and lower levels of life satisfaction and perceived quality of life (see Pascoe & Richman, 2009 for a review). In their meta-analysis focusing exclusively on Black Americans, Pieterse and colleagues (2011) found perceived racism to be positively related to psychological distress, with a particularly robust finding linking perceived racism with depression and anxiety. Taken together, these findings highlight the high psychological toll of racism in the lives of Black persons.

Although this body of literature sheds light on the potential multi-faceted consequences of racism, these studies are limited by their reliance on the victim's perception in assessing racism as opposed to so-called "objective" or nonconscious indicators of racism. There are two main reasons that studies have focused on perception. First, psychology's historical focus has been on individual-level phenomena as measured through self-report. Unfortunately, this approach does not lend itself well to understanding the impact of structural dimensions of racism such as segregation and poverty and their association with health. Second, the primary theoretical framework by which psychologists have examined the relationship between racism and health is Lazarus and Folkman's (1987) Transactional Stress Model, which emphasizes the central role of *perception* in the psychosocial pathway by which racism influences health.

Despite this limitation, the findings strongly suggest that the perception of racial discrimination can have pernicious consequences for the psychological well-being of Black women.

2.3. Sexism

Black women's health may also be negatively affected by sexism. Sexism has been conceptualized as a complex form of discrimination based on gender that occurs across multiple domains in a person's life. Some scholars maintain that, in the United States, the effects of sexism are specific to women because of their marginalized status, which results in women having less access to status and resources compared to men (Allport, 1954; Eagly et al., 2012; Hurst & Beesley, 2013); however, other scholars assert that both men and women can experience sexism (Molix, 2014). Sexism is considered a gender-specific stressor and has generally been argued to have similar effects on health as generic life stressors (Hurst & Beesley, 2013). However, because sexist experiences are theorized to be pervasive in women's lives and are of an extremely personal nature, some have argued that they produce an exacerbated stress response (Kanner, Coyne, Schefer, & Lazarus, 1981; Klonoff & Ladrine, 1995; Molix, 2014).

Sexism can be thought of as discrimination based on gender and supported by traditional gender roles. Smith, Johnston-Robledo, McHugh, and Chisler (2010) define sex as the biological, dichotomous categorization of male and female that is primarily used to describe non-human animals. In contrast, Smith and colleagues (2010) define gender as a cultural construction used to describe boys and men, and girls and women that is revealed through gender roles. Gender roles refer to the attitudes, behaviors, and characteristics that are commonly associated with being a man or woman and these roles

are often tied to perceptions of masculinity and femininity (Smith et al., 2010). Traditional gender roles for boys and men are characterized as "masculine" and include suppressing emotion, providing for one's family, placing work before other demands, and not engaging in feminine behavior. For girls and women, traditional gender roles are feminine and involve expressing emotions freely but suppressing anger, placing one's partner and children before other demands, passiveness, and submissiveness (Smith et al., 2010).

Research has revealed that gender roles are largely endorsed by the U.S. public. In a study of college students (Smith et al., 2010), femininity was viewed to be associated with subordination, a soft demeanor, and an emphasis on fashion, grooming, and physical beauty. Masculinity was not considered to be contradictory to femininity but, instead, it was associated with strength, independence, and particular preferences and activities (e.g., beer, football). Scholars maintain that the gender roles of masculinity and femininity are problematic because they confine individuals to specific attitudes and behaviors which can contribute to sexism (Smith et al., 2010). Traditional gender role conceptualizations are social constructions that are limited; this notion holds for those who identify as the gender that aligns with their sex at birth and is illustrated further when considering individuals who identify as trans*gender and do not subscribe to the traditional binary gender roles ascribed to those who are born as male or female. Trans*gender individuals have fluidity in their gender roles and may identify as a woman, man, both, or neither (Nagoshi, Brzuzy, & Terrell, 2012). The fluidity of gender roles, even within the context of a given society, and their classification as behaviors that fit social constructs, support the notion that gender roles and identity are more accurately

framed on a broader spectrum or dimension, rather than as a dichotomy (i.e., male, female).

Studies suggest that women experience two types of sexism, which are perpetrated by both men and women: benevolent and hostile (Glick & Fiske, 1997; Glick et al., 2004; Molix, 2014; Sibley et al., 2009). Benevolent sexism is a paternalistic form of sexism that is shrouded in the misrepresentation of biased behavior as protective of women (Glick et al., 2004). For instance, it is evident in the notions that women are less able to complete physically taxing activities or women are more nurturing and emotional. Hostile sexism refers to antagonistic behaviors towards women who challenge male superiority or power through the embrace of feminist ideology or perceived trickery (Glick et al., 2004). Examples include beliefs that women belong in the kitchen instead of competing for employment with men or the denial of the existence of marital rape.

Sexism also occurs at the cultural level, as evidenced by typical portrayals of women, such as stereotypes and the objectification of women (Brabeck & Ting, 2000; Swim, Hyers, Cohen, & Ferguson, 2001). Evidence suggests that women are cast into different stereotypical roles (e.g., good wife, Madonna, whore) based on men's perception(s) and as justification for women's subordinate position. Based on cultural stereotypes and women's lower social status, they are also subject to sexual objectification and denigrating comments at a significantly higher rate than men (Swim et al., 2001).

Negative stereotypes of women are particularly harmful because they do not and cannot adequately capture the complexity of womanhood and they serve to uphold a social hierarchy in which men are dominant (Brabeck & Ting, 2000; Glick et al., 1997;

Sibley et al., 2009). Because women in the United States reside in a culture that holds negative views about them, these views can be internalized and contribute to women using different strategies, such as self-silencing, to live up to cultural norms and connect with others (Hurst & Beesley, 2013; Jack, 1999; Sibley et al., 2009). Self-silencing refers to the strategy of withholding parts of oneself (e.g., identities, attitudes, beliefs) in order to maintain relationships and a positive appearance; however, this strategy leads to isolation and is related to psychological distress (Hurst & Beesley, 2013). Through the pervasive negative stereotyping of women and their experiences of sexism, women experience stress, which negatively impacts health and puts them at an increased risk for impaired psychological well-being, including depression (Borrell et al., 2010, 2011; Moradi & Funderburk, 2006; Moradi & Subich, 2004).

2.4. Sexism as a Stressor and Health Determinant

Consistent with the broader literature regarding discrimination, sexism can be conceptualized as a set of stressors that negatively impacts health (Allport, 1954; Clark et al., 1999; Feagin & Beenefield, 2014; Graham et al., 2016; Gee et al., 2012; Harrell, 2000; Pascoe & Richman, 2009; Pieterse et al., 2011; Williams & Mohammed, 2013), across cultural, institutional, and interpersonal levels (Borrell et al., 2010, 2011; Hurst & Beesley, 2013; Klonoff et al., 2000; Molix, 2014; Moradi & Subich, 2004; Moradi & Funderburk, 2006). Researchers have documented a link between perceived sexism and higher levels of psychological distress and rates of diagnosed mental illness (e.g., anxiety, depression), as well as lower self-rated mental health (Borrell et al., 2010, 2011; Moradi & Funderburk, 2006; Moradi & Subich, 2004). Further, the sexism that women face has been conceptualized as “stressful life events” and “daily hassle” stressors, which have

been found to be associated with negative health outcomes (Borrell et al., 2010, 2011; Molix, 2014; Moradi & Funderburk, 2006; Moradi & Subich, 2004). Because of the pervasiveness of sexism and its observed effects on mental health, it is important to consider the relationship between sexism and depressive symptoms in Black women who may face a number of social stressors, including poverty and discrimination (APA, 2013; CDC, 2012; Pratt & Brody, 2014; Rosenfield, 2012; Wang et al., 2004; Ward & Heidrich, 2009).

2.5. Conceptualizing Racism *and* Sexism: Intersectionality and Gendered Racism

Scholars have increasingly underscored the need to examine discrimination across multiple marginalized identities (Borrell et al., 2011; Collins, 2015; Crenshaw, 1991; Harrell, 2000; Klonoff & Landrine, 1995). Intersectionality theory maintains that, because Black women have marginalized racial and gender identities and are victims of racism and sexism, it is important to understand the intersection of their race and gender, and how this intersection influences their experiences of oppression (Allport, 1954; Clark et al., 1999; Harrell, 2000; Pascoe & Richman, 2009; Pieterse et al., 2011; Williams & Mohammed, 2013).

Intersectionality is an approach to research and analysis that assumes social identities (e.g., gender, race/ethnicity, class, sexuality) and social inequalities overlap and operate in a reciprocal manner, such that each has an influence on the other and creates a unique lived experience (Collins, 2015; Hancock, 2007). The intersectional approach is increasingly used in several disciplines to examine discrimination, mental health, physical health, coping behaviors and substance use, education, the labor market, sexual

violence, and numerous other topics within diverse populations (e.g., Bowleg, 2008; Browne & Misra, 2003; Collins, 2015; Hancock, 2007; Hankivsky, 2012).

The assumption undergirding the intersectionality approach is that the complexity of overlapping identities requires that researchers: (a) recognize multiple categories of identity as equally important at the level of individual integration (Hancock, 2007); (b) understand the complex power dynamics, roles, and relationships that exist within each societal problem (Collins, 2015); (c) ask precise questions that assume identities are overlapping and inseparable rather than unitary constructs (Bowleg, 2008); and do not attempt to take all identities into account but, rather, have an understanding of which identities are especially salient in a given relationship and what the analysis omits by not including other identities (Hankivsky, 2012). For Black women, the extant literature suggests that their racial and gender identities as well as their experiences of racism and sexism are particularly salient (Almquist, 1975; Collins, 2015; Crenshaw, 1991; Sesko & Biernat, 2010). Intersectionality offers a lens to examine the oppression experienced by Black women (Almquist, 1975; Collins, 2015; Crenshaw, 1991; Sesko & Biernat, 2010).

Over the history of social science, scholars have introduced several approaches to conceptualizing identity. One approach assumes individuals have a master status or identity (e.g., racial identity) that primarily shapes their life experiences (Hughes, 1945). Another approach maintains that individuals are the sum of their multiple identities (Hancock, 2007). Intersectionality seeks to move beyond identity conceptualization as either a single overarching marginalized identity or multiple additive marginalized identities to an understanding of identity as the *integration* of equally important identities held by individuals (Hancock, 2007). This approach is particularly important for

understanding the experience of oppression and its effects on psychological health. That is, groups like Black women who hold more than one marginalized identity may encounter multiple forms of discrimination and these experiences can have distinct implications for mental health (Almquist, 1975; Romero, Edwards, Fryberg, & Orduna, 2014; Sevelius, 2012).

The oppression of Black women has traditionally been conceptualized in three ways: (a) "double jeopardy", (b) interactional and (c) intersectional (see Thomas et al., 2008). Double jeopardy focuses on the cumulative distress Black women experience from separate, unitary experiences of racism and sexism. For example, Klonoff, Landrine, and Ullman (1999) found that the combination of being Black, being a woman, and experiencing greater stress and discrimination was related to higher levels of psychiatric symptoms. The limitation of this approach is that it assumes that all social inequalities are equal and that they can be meaningfully understood as separate and distinct experiences (Thomas et al., 2008).

The interactional approach is more complex than the double jeopardy approach; it attempts to capture the effect of the interaction of racism and sexism on Black women's experiences. In other words, a statistical interaction of racism and sexism is analyzed with the main effect variables of sexism and racism to better understand the additive and multiplicative effects of both types of discrimination on Black women. Moradi and Subich (2003), for example, examined the relationship between racism, sexism, and psychological distress in a sample of 137 Black women with an interactional approach. A path analysis was run using racism, sexism, age, and an interaction term of racism X sexism to predict psychological distress. Racism and sexism were strongly correlated

with one another but only sexism had a distinct effect on psychological distress and the interaction term of racism X sexism did not predict psychological distress. Though the interactional approach offers a more complex analysis of multiple identities than the double jeopardy conceptualization, this strategy is also limited because it assumes racism and sexism should be measured separately and combined rather than measuring the overlapping experience of racism and sexism. In order words, an interactional approach measures the experience of racism and sexism separately and then attempts to overlap them statistically (Thomas et al., 2008), rather than attempting to assess the distinct experience of the intersection of racism and sexism.

The final approach to understanding the oppression and marginalization of Black women is the intersectional approach of gendered racism, which offers the most conceptual complexity—and, ideally, the greatest alignment with individuals' actual experiences—of the three approaches. Specifically, gendered racism aims to understand the blended phenomenon of racism and sexism as it is experienced by Black women (Thomas et al., 2008). Based on the assumption that an intersectional gendered racial identity is more salient than the separate racial and gender identities, gendered racism provides a framework to understand how sexism and racism work together to create a unique lived experience (Essed, 1991; Thomas et al., 2011). The implication of this assumption for Black women is that they experience a form of oppression at the intersection of race and gender that differs from the oppression faced by Black men and White women. Because of this intersection, it is necessary that measures capture the blending of racism and sexism in the lives of Black women (Schug, Alt, & Klauer, 2015; Sesko & Biernat, 2010; Thomas et al., 2008).

It is important to note the three varying approaches to framing the oppression of Black women because these conceptualizations were created to better explain the relationships among oppression, psychological well-being and impairment, and the factors that affect this relationship (e.g., identity centrality, coping style). However, consensus has not been achieved regarding the best approach, and scholars continue to utilize each of the three approaches to understand how oppression functions in the lives of Black women (Thomas et al., 2008). While an increasing number of scholars have argued for the need to utilize an intersectional approach (Almquist, 1975; Bowleg, 2008; Collins, 2015; Crenshaw, 1991; Hancock, 2007; Kohn & Hudson, 2002; Lewis & Neville, 2015; Rosenfield, 2012; Schug et al., 2015; Sesko & Biernat, 2010; Thomas et al., 2008), there is a dearth of research that examines the intersectional effects of racism and sexism on psychological well-being and impairment as well as the other factors that may influence this relationship.

2.5.1. Gendered racism. The framework of gendered racism contends that racial stereotypes are gendered and reflect a representation of the masculine or feminine, with the Black identity being implicitly associated with the masculine (Schug et al., 2015; Sesko & Biernat, 2010). The association of Black with male and White with female is argued to be a historical conflation designed to erase the womanhood of Black women (Goff, Thomas, & Jackson, 2008; Schug et al., 2015). While this notion has been challenged since Sojourner Truth questioned "ain't I a woman?," it persists. For instance, in a sample of mostly White undergraduates categorizing photos of Black and White men and women, Black women were assumed to be men more often and were rated as less

attractive because of their perceived masculinity compared to White women (Goff et al., 2008).

The implicit association of Blackness with masculinity puts Black men in the position of prototypicality and Black women in the position of non-prototypicality (Goff et al., 2008; Purdie-Vaughns & Eibach, 2008; Sesko & Biernat, 2010). A prototypical identity refers to the automatic associations, based on norms and values of the dominant culture, that individuals make when considering an identity group. Because Blackness is not automatically associated with womanhood, Black women are placed within a non-prototypical position of identity in which they can experience intersectional invisibility (Purdie-Vaughns & Eibach, 2008; Schug et al., 2015). Intersectional invisibility refers to the inability to be totally recognized within all of one's identities. This phenomenon can be explained via the librarian's dilemma: when a library receives a copy of a history book about Black women, is it cataloged within Black history or women's history? Within this context, regardless of where the librarian catalogs the book, one identity is favored while another is neglected and, therefore, individuals with overlapping identities may be invisible and not fully recognized in all of their identities (Purdie-Vaughns & Eibach, 2008; Sesko & Biernat, 2010).

According to Purdie-Vaughns and Eibach (2008), individuals with one marginalized identity (e.g., White women) are more likely to experience overt discrimination and oppression compared to individuals with multiple marginalized identities. Those with multiple marginalized identities (e.g., Black women) are less likely to experience overt discrimination but are marginalized by their invisibility in history, culture, and policy. Another consequence of intersectional invisibility and non-

prototypicality was illustrated by an experiment by Sesko and Biernat (2010) in which participants were significantly less likely to give credit to Black women for their contributions to a conversation compared to Black men, White men, and White women. Thus, individuals who experience intersectional invisibility may not be recognized as full members of their identity group and may not be given proper recognition for their contributions (Purdie-Vaughns & Eibach, 2008; Sesko & Biernat, 2010).

Black women experience both racism and sexism; however, they also experience the blending of racism and sexism through gendered racism (Essed, 1991; Lewis & Neville, 2015; Perry et al., 2013; Thomas et al., 2008; Woods-Giscombé & Lobel, 2008). Gendered racism refers to the cumulative effect of living with marginalized gender and racial identities. Gendered racism captures Black women's unique lived experiences in domains such as assumptions regarding sexuality and beauty, experiences of silencing and marginalization, and the stereotypes of the strong Black woman and angry Black woman (Lewis & Neville, 2015). Gendered racism extends beyond the traditional unitary conceptualizations of racism and sexism and aims to capture the distinctive experience of oppression in the overlap of marginalized racial and gender identities. Thus, utilization of the gendered racism framework allows for a more complete understanding of how the stressors of racism and sexism intersect and influence psychological well-being.

2.6. Gendered Racism as a Stressor and Health Determinant

It is important to consider the role gendered racism plays in the stress process of Black women because it can have significant implications for their psychological well-being (Lewis & Neville, 2015; Perry et al., 2013; Woods-Giscombé & Lobel, 2008). Given the literature on racism and sexism as stressors for marginalized groups (e.g.,

Borrell et al., 2010, 2011; Clark et al., 1999; Harrell, 2000; Hurst & Beesley, 2013; Pascoe & Richman, 2009; Pieterse et al., 2011; Williams & Mohammed, 2013) and the intersection of racism and sexism for Black women (Almquist, 1975; Collins, 2015; Crenshaw, 1991; Sesko & Biernat, 2010), it is not surprising that gendered racism has been demonstrated to be a stressor (Lewis & Neville, 2015; Woods-Giscombé & Lobel, 2008). In a study assessing gendered racial microaggressions, 90% or more of the sample of Black women reported experiencing microaggressions in the form of sexual objectification, being silenced and marginalized in academic and professional settings, and having the stereotypes of the "Angry Black woman" and the "Strong Black woman" projected upon them. Each of these experiences was rated in terms of stress appraisal with sexual objectification rated as stressful, experiences of being silenced and marginalized rated as moderately stressful, being stereotyped as an "angry Black women" rated as slightly to moderately stressful, and the stereotype of "strong Black woman" rated as the least stressful of the four factors (Lewis & Neville, 2015).

Gendered racism combines sexism and racism and may be a mechanism that contributes to social inequality (Essed, 1991; Lewis & Neville, 2015; Perry et al., 2013; Thomas et al., 2008; Woods-Giscombé & Lobel, 2008). Moreover, the stress experienced through gendered racism may contribute to poor mental health outcomes (Geronimus, Hicken, Kenne & Bound, 2006; Perry et al., 2013). Notwithstanding the potential influence and impact of gendered racism, minimal empirical research has examined the role of gendered racism in Black women's health (Lewis & Neville, 2015). Prior studies focusing on the interactional effect of sexism and racism have consistently found that sexism and racism are strongly correlated and related to health outcomes (e.g.,

psychological distress); however, the interaction between sexism and racism was not significant in these works (Moradi & Subich, 2003; Stevens-Watkins, Perry, Pullen, Jewel, & Oser, 2014). While studies examined the interactional relationship between racism and sexism, few have tested the intersectional relationship between racism and sexism, and none have tested the effect of this relationship on depression. An intersectional analysis of racism and sexism is necessary in order to better understand the effects of gendered racism on health (Lewis & Neville, 2015).

2.7. Identity Centrality as a Modifying Factor in the Relationship between Gendered Racism and Psychological Well-Being

Past research has shown that racism and sexism are independently and negatively associated with psychological well-being in Black women (e.g., Borrell et al., 2010, 2011; Lewis et al., 2013; Molix, 2014; Szymanski & Lewis, 2016; Thomas et al., 2011; Thomas et al., 2008). Thus, there is reason to suspect that gendered racism is associated with psychological well-being. However, it is likely that this relationship is not a straightforward one and is subject to a number of potential modifying factors. Theories of racism-related stress, based on Lazarus and Folkman's (1987) Transactional Model of Stress, maintain that not all racist events produce racism-related stress and that personal and social resources may lessen the health impact of racism-related stress (e.g., Clark et al., 1999; Harrell, 2000). In other words, racism-related stress occurs only if a racist stimulus is beyond the individual's capacity to cope with it. Indeed, research has demonstrated that coping mechanisms such as social support, spirituality, and racial identity may circumvent the stress response or lessen its impact on biological and psychological systems (Brondolo et al., 2009; Lewis et al., 2013; Thomas et al., 2008).

Because racial identity may serve as a protective factor against stress (Caldwell et al., 2004; Schmitt et al., 2014), it is important to examine how racial and other identities intersect to function as protective and risk factors.

Individuals hold many social identities, including ones reflecting their race and gender, that provide guidance related to understanding and interacting in society based on socially constructed expectations for various identities (e.g., men hold open doors for women). Identifying with a group and holding that identity as a core part of one's self-concept is referred as identity centrality (Sellers et al., 1997). Identity centrality can provide social validation and may serve a positive function; however, identity centrality can adversely affect an individual's stress levels and health when a negative or traumatic experience is attributed to that identity (Halim & Ruble, 2010). For example, if a Black woman attributed an experience of sexual harassment to her identity as a woman, her gender identity may elicit stress and negative attitudes. Thus, identity centrality may act as a protective or risk factor for psychological well-being or impairment in the face of perceived discrimination.

There is debate within the literature about whether race and gender identities in Black women function as protective or risk factors for negative mental health outcomes, such as depression and psychological distress (Kohn & Hudson, 2002; Moradi & Subich, 2003; Sesko & Biernat, 2010; Thomas et al., 2008; Thomas et al., 2011; Watson & Hunter, 2015). Research findings have been mixed regarding how identity centrality affects the relationship between perceived racial discrimination and health (Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous, & Zimmerman, 2004; Pascoe & Richman, 2009). In addition, very few studies have considered racial centrality or gendered racial

centrality as a potential moderator in the relationship between gendered racism and psychological well-being and impairment. However, in a review, Kohn and Hudson (2002) state that, for Black women, their racial identity appears to serve as a protective factor for depression while gender identity seems to function as a risk factor.

In another study, Szymanski and Lewis (2016) assessed how coping mechanisms influence the relationship between gendered racism and psychological distress and the effect of gendered racial identity centrality on these relationships. Findings from this study suggested that when Black women reported moderate to high levels of gendered racial identity centrality, it acted as a risk factor and influenced the indirect effect of gendered racism on psychological distress through the use of detachment coping (Szymanski & Lewis, 2016). Put another way, Black women who viewed their gendered racial identity as central to their identity were more likely to use detachment coping, or disengage from a stressor, which contributed to a stronger, positive link between experiences of gendered racism and psychological distress. These findings are notable when considered within the context of the documented high depression rates among Black women (CDC, 2012; Kohn & Hudson, 2002; Pratt & Brody, 2014). For this reason, it is important to explore gender centrality and gendered racial centrality and their potential moderating roles in the relationship between gendered racism and depression.

Prior research on identity centrality has been limited because it typically has been used to focus on one identity, primarily race, rather than the intersection of multiple identities (Sellers et al., 1997). For instance, studies assessing racial centrality have found that a strong racial identity is positively linked to psychological well-being (e.g., Seaton et al., 2011; Sellers et al., 2003; Sellers & Nicole, 2003). Settles (2004) examined

gender centrality to understand identity conflict in women who are scientists, a traditionally male role. However, the present review did not identify any other study that has assessed gender centrality. Thus, while it is generally considered a limitation to use a unitary approach to identity rather than an intersectional approach, research has not fully explored the importance of gender centrality in the relationship between gendered racism and depression. This study will build on the existing literature by assessing the role of both gender centrality and gendered racial centrality for Black women in the relationship between gendered racism and depressive symptoms.

2.8. The Present Study

There is a dearth of empirical research examining the potential influence of gendered racism on Black women's health. In order to understand the unique effects of gendered racism on Black women's health, intersectional analysis is necessary (Lewis & Neville, 2015). Furthermore, few studies have examined how Black women's identity centrality affects the relationship between discrimination and psychological well-being and impairment. This study helps address gaps in the literature by examining the relationship between gendered racism and depressive symptoms and the moderating effects of gender centrality and gendered racial centrality at the level of individual perception (see Appendix A). This study aims to test:

1. What is the relationship between gendered racism and psychological well-being, as operationalized by depressive symptoms?

    H_1: There will be a positive correlation between gendered racism and depressive symptoms.

2. How does the perceived centrality of gender identity affect the relationship between gendered racism and psychological well-being, as operationalized by depressive symptoms?

H_2: Gender centrality will moderate the relationship between gendered racism and depression such that greater gender centrality will be associated with higher levels of depressive symptoms.

3. How does the intersection of racial and gender identity centrality affect the relationship between gendered racism and psychological well-being, as operationalized by depressive symptoms?

H_3: Gendered racial centrality will moderate the relationship between gendered racism and depression such that higher levels of gendered racial centrality will be associated with higher levels of depressive symptoms.

Chapter 3. Method

3.1. Participant Recruitment and Selection

The current study collected data from adult women who self-identified as Black or African American. To determine the sample size needed to address the study's aims, I conducted a power analysis using G*Power 3.1.9.2. Results indicated that with two predictors in a fixed model linear multiple regression, examining the deviation from zero in R^2 and using a medium effect size of .15 (see Erdfelder, Faul, & Buchner, 1996), 107 participants were needed to obtain adequate power. Using a large effect size (.35), 48 participants were needed to obtain adequate power.

Multiple strategies were used to recruit participants. The study was posted on a subject pool system (i.e., Sona) for a department of psychology at a large, urban, predominantly White Southeastern university. Snowball sampling occurred by sending emails to networks of researchers at other academic institutions, with a focus on Historically Black Colleges and Universities, with information about and the link to complete the study. Black women who participated in a study about cardiovascular health in African American students were given information about the current study, and all individuals who participated in the cardiovascular health study were asked to provide names and email addresses for potentially interested individuals. After completing the present study online, participants were asked to forward the study link to Black women who they thought might be interested in participating. Participants also had the opportunity to provide names and email addresses of individuals who they believed might

be interested in completing the study directly to me, and I sent an email with information about the study and the link to those individuals. Finally, flyers advertising the study were posted on the university campus and in other locations around the community (e.g., apartment complex mail areas). In light of these methods, it is not possible to ascertain how many potential participants received information about the study nor the proportion of those who followed up with the project team.

A total of 156 participants completed measures, and data from 21 participants were excluded, resulting in a sample of $n = 135$. Of the 21 participants with excluded data, five participants spent less than ten minutes completing the battery of measures and their data were excluded from analyses to ensure data were valid and reliable. Two participants were under the age of 18 and their data were deleted from the database to comply with the UNC Charlotte Institutional Review Board Approval. Participants ($n = 14$) who completed less than 70% of the measures were also excluded.

3.2. Participants

Of the 135 participants, 130 (96.29%) identified as a Black or African American women, four (2.96%) identified as women who are Black or African American and Hispanic or Latino, and one (.74%) identified as Black or African American genderqueer/gender non-conforming individual. The mean age of participants was 21.35 years ($SD = 5.34$). In this sample, 119 (86.90%) participants were born in the United States. Most participants (95.60%) were enrolled in school, and over half reported an annual family income at or above $50,000 (see Table 1).

Of the 135 participants who were included in this study, 95 were recruited via Sona and 40 were recruited online and on campus. In the non-Sona sample, 36

participants were undergraduate or graduate students. Participants from the non-Sona and Sona samples were compared on demographics (i.e., age, marital status, income) and key variables (i.e., gendered racism, gender centrality, gendered racial centrality, and depressive symptoms) with Chi-square analysis. In terms of demographic characteristics, participants in the Sona and non-Sona samples did not significantly differ` (p's > .05); however, age trended toward significance (p = .05). Further, participants who were recruited via Sona had significantly lower scores on the gender centrality measure (M = 43.0, SD = 7.46) compared to non-Sona (M = 46.6, SD = 7.23) participants (p = .03); however, the samples did not differ on other key variables (p's > .05).

Participants with more than 70% of complete data were retained in the final sample for analysis and, thus, differing levels of missing data across measures contributed to the sample size varying by analysis. A total of n = 79 participants completed the battery of measures in their entirety. This sample was compared to participants who did not complete 100% of the measure on demographic characteristics (i.e., age, marital status, income) and key variables (i.e., gendered racism, gender centrality, gendered racial centrality, and depressive symptoms) using a Chi-square analysis. Differences did not exist between the samples in terms of demographics; however, participants who completed the battery of measures in their entirety reported significantly lower levels of depressive symptoms (M = 11.63, SD= 4.72) compared to those who did not fully complete the measures (M = 14.00, SD = 5.00) but completed more than 70% (p = .04) . The samples did not differ on the other key study variables.

3.3. Procedure

Study procedures were approved by the UNC Charlotte Institutional Review Board. Participants received access to the online study via a link (available from Sona, study informational flyers, or emails), and consented to and completed the study online through Qualtrics, an online survey platform. As an incentive, student participants received research credit for a university psychology course in which they were enrolled. Non-sona participants had the option to provide their email address for a gift card lottery. At the conclusion of data collection for the larger study out of which this effort grows, 10 participants will be randomly chosen to receive a $25 gift card.

3.4. Measures

3.4.1. Demographics.

Basic demographic data (Table 1) were collected, including: race and ethnicity, gender, age, marital status, and socioeconomic status (e.g., education, parent's education, zip code).

3.4.2. Gendered racism.

I used the Gendered Racial Microaggressions Scale (GRMS; Lewis & Neville, 2015) to assess gendered racism (Appendix C). The GRMS' approach aligns with conceptualizations of intersectionality because it was developed to assess the diverse experiences of the intersection of racism and sexism (i.e., enacted verbally, behaviorally, and environmentally) faced by Black women (Lewis & Neville, 2015).

The GRMS assesses the perceived frequency of gendered racist events and the respondent's stress appraisal of these events. Both frequency and stress appraisal are assessed in response to 26 items, using a six-point scale for each (0 = never, 5 = once a week or more; 0 = not at all stressful, 5 = extremely stressful; Lewis & Neville, 2015).

The GRMS is comprised of four factors that have been shown to have acceptable internal validity: (a) assumptions of beauty and sexual objectification (α = .87); (b) silenced and marginalized (α = .88); (c) strong Black woman stereotype (α = .74); and (d) angry Black woman stereotype (α = .75; Lewis & Neville, 2015). This study employed the total scores (i.e., sum of item scores from all subscales) for frequency and stress appraisal. In this sample, the GRMS total frequency measure (α = .93) and GRMS stress appraisal measure (α = .94) demonstrated excellent internal consistency.

3.4.3. Gender centrality. The Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1997) is a 51-item scale measuring three dimensions of Black racial identity across six subscales, and this study used an adapted version of the scale's Centrality dimension to measure gender centrality (MIBI-G; see Appendix D). The Centrality dimension of the MIBI assesses the importance of racial identity to an individual's self-concept and has been found to demonstrate construct validity and reliability (α = .75-.78). Eight items comprise the Centrality dimension (e.g., my destiny is tied to the destiny of other Black people) with three items being reversed scored (e.g., being Black is unimportant to my sense of what kind of person I am).

The MIBI uses a 7-point Likert-type response metric, ranging from strongly disagree (1) to strongly agree (7), and is scored by averaging subscale responses. Using Settles (2004) as a model, the MIBI was adapted to focus on gender rather than racial centrality (α = .79). For example, instead of asking if being Black is an important part of an individual's self-image, the adapted MIBI items focus on one's gender. The adapted MIBI includes the same eight items as the original and uses the same scale and scoring

method. In this sample, the adapted Gender Centrality MIBI demonstrated good internal consistency (α = .88).

3.4.4. Gendered Racial Centrality. The Centrality dimension of the MIBI was modified to assess gendered racial centrality in the current sample. A psychometrically sound measure of gendered racial centrality was not identified via the review for this study. However, because (a) the original validation of the MIBI by Sellers and colleagues (1997) involved a sample that included a large proportion (68%) of Black women, and (b) the measure's items were modified successfully by Settles (2004) to assess gender centrality in women scientists, it was deemed appropriate to adapt the MIBI items for the purpose of measuring gendered racial centrality in Black women. In turn, all eight items of the original Centrality dimension were modified to reflect the experience of being a Black women, (MIBI-GR; see Appendix E). Thus, participants rated their agreement with statements such as, "in general, being a Black women is an important part of my self-image." The same scoring method was utilized (see Gender Centrality, 2.4.3 above) and, in this sample, the adapted Gendered Racial Centrality MIBI demonstrated good internal consistency (α = .83).

3.4.5. Depressive Symptoms. The depression subscale of the Depression Anxiety Stress Scales (DASS-21) was used to measure depressive symptoms in this study (see Appendix F; Lovibond & Lovibond, 1995a). The DASS-21 is a 21-item measure assessing self-reported psychological states of depression, anxiety, and stress, using a four-point metric (0 = didn't apply to me at all; 1 = applied to me to some degree, or some of the time; 2 = applied to me a considerable degree, or a good part of the time; 3 =

applied to me very much, or most of the time) and scored by summing each subscale and multiplying each summed score by two.

The depression subscale of the DASS-21 includes 7 items (e.g., I couldn't seem to experience any positive feeling at all; I found it difficult to work up the initiative to do things). A study comparing the original DASS to the Beck Depression Inventory and Beck Anxiety Inventory found high correlations between the measures (.74, .81; Lovibond & Lovibond, 1995b) The depression subscale of the DASS-21 also has high internal consistency (α = .83; Norton, 2007). The DASS-21 is based on the assumption that differences in depression, anxiety, and stress between clinical and non-clinical populations are based on the degree to which each psychological state is experienced and reported. Therefore, this assumption does not allow for direct comparison to diagnostic categories used in systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (Lovibond & Lovibond, 1995a). In this sample, the depression subscale of the DASS-21 demonstrated good internal consistency (α = .89).

Chapter 4. Analytic Approach

After running descriptive analyses on all study variables, I examined the skewness and kurtosis of the dependent variable to ensure that they did not violate the assumptions of normality associated with linear models. The skewness for depressive symptoms, 1.03 (*SE* = 0.21) exceeded the parameters for normality (Hayes, 2013). Individuals who reported higher scores on the measure of depressive symptoms (>19) were identified as outliers that skewed the normal distribution; thus, the depressive symptoms measure was transformed into a logarithmic variable (i.e., data were converted to allow for a comparison of the geometric mean as opposed to the arithmetic mean) in order to reduce skew in the distribution and meet assumptions for normality (Hayes, 2013). Next, predictor and moderator variables (i.e., gendered racism frequency, gendered racism stress appraisal, gender centrality, gendered racial centrality) were centered to the mean in order to reduce the likelihood of multicollinearity and standardize coefficients to facilitate interpretation (Frazier, Tix, & Barron, 2004). Interaction terms between the predictors and moderators were then created (i.e., gendered racism frequency X gender centrality, gendered racism frequency X gendered racial centrality, gendered racism stress appraisal X gender centrality, gendered racism stress appraisal X gendered racial centrality; Baron & Kenny, 1987; Frazier et al., 2004). As a final preliminary step, zero-order correlations testing the relationships among demographic variables gendered racism, gender centrality, gendered racial centrality, and depressive symptoms were computed.

To test hypothesis one, which examined the relationship between gendered racism and depressive symptoms, I conducted two simple linear regressions. While the correlation and regression results yield the same information about the magnitude of the relationship between two variables, the linear regression approach was used here to standardize results reporting across the study's hypotheses. In the first regression, I entered gendered racism frequency as the predictor and depressive symptoms as the criterion. In the second simple linear regression, I entered gendered racism stress appraisal as the predictor and depressive symptoms as the criterion.

To test my second hypothesis, I conducted two two-step hierarchical multiple regressions to understand the relationship between gendered racism and depressive symptoms with gender centrality as a moderator (Baron & Kenny, 1987; Frazier et al., 2004). In Step 1 of the first regression, I entered gendered racism frequency and gender centrality as the predictor of the criterion depressive symptoms. In Step 2, the interaction term gendered racism frequency X gender centrality was included as a predictor of the criterion depressive symptoms. The second analysis followed a similar structure but examined gendered racism stress appraisal (instead of frequency).

To test my third hypothesis and the relationship between gendered racism and depressive symptoms with gendered racial centrality as a moderator, I conducted two two-step hierarchical multiple regressions (Baron & Kenny, 1986; Frazier et al., 2004). In Step 1 of the first analysis, I entered gendered racism frequency and gendered racial centrality as the predictors of the criterion of depressive symptoms. In Step 2, the interaction term of gendered racism frequency X gendered racial centrality was included as a predictor of the criterion depressive symptoms. The second hierarchical multiple

regression employed a structurally similar analysis to examine gendered racism stress appraisal.

Chapter 5. Results

5.1. Descriptive Statistics

Descriptive statistics for the sample's demographic characteristics are presented in Table 1. In this sample, most participants were single or never married, and over half of the sample had incomes at or above $50,000, with one out in five participants reporting an annual household income at or above $100,000. Descriptive statistics for the study's key variables of interest and zero-order correlations among those variables are presented in Table 2. On average, participants reported experiencing gendered racist events almost once a month but reported that these events were typically not stressful. Participants reported that their gender identity (i.e., woman) was somewhat important to their self-concept and that their gendered racial identity (i.e., Black woman) was slightly less important. Low levels of depressive symptoms were reported by participants, with most indicating that statements exemplifying depressive symptoms did not apply to them at all or applied to some degree or some of the time.

Correlations revealed positive significant relationships between gendered racism frequency and gendered racism stress appraisal (r (91) = .81, p = .00) and gendered racial centrality (r (109) = .34, p = .00). Correlational analyses also revealed positive significant associations between gendered racism stress appraisal and gendered racial centrality (r (91) = .32, p = .00). Thus, women who reported higher gendered racism frequency or rated their gendered racism experiences as more stressful also reported higher levels of gendered racial centrality (i.e., that their identity as a Black woman was

very important). Finally, in this sample, gender centrality and gendered racial centrality were positively and significantly related (r (105) = .49, p = .00).

5.2. Simple Linear Regression Results

Hypothesis 1: There will be a positive relationship between gendered racism and depressive symptoms.

In the first regression (see Table 3), gendered racism frequency significantly predicted depressive symptom scores, accounting for 4% of the variance in those self-ratings, $F(1,110) = 4.21$, $p = .04$. Results from this model aligned with expectations that gendered racism would be positively related to depressive symptoms and, for every one point increase in gendered racism frequency, there was a .03 point increase in reported depressive symptoms.

In the second regression, the relationship between gendered racism stress appraisal and depressive symptoms was significant (see Table 4), with gendered racism stress appraisal accounting for 5% of the variance in depressive symptoms scores, $F(1,93) = 4.60$, $p = .04$. In this model, the direction of the observed relationship aligned with expectations and, for every one point increase in gendered racism stress appraisal, there was a .03 point increase in reported depressive symptoms. Thus, consistent with expectations, gendered racism frequency and gendered racism stress appraisal each evidenced significant predictive associations with depressive symptoms.

5.3. Hierarchical Multiple Regression Results

Hypothesis 2: Gender centrality will moderate the relationship between gendered racism and depression such that greater gender centrality will be related to higher levels of depressive symptoms.

In the first hierarchical multiple regression I conducted (see Table 5), gendered racism frequency and gender centrality were entered in Step 1, and the interaction term gendered racism frequency X gender centrality was entered in Step 2. The overall model was not significant, $F(3,94) = 1.75$, $p = .16$; neither gender centrality nor gendered racism frequency significantly predicted depressive symptoms. Overall, results from this regression did not align with expectations. However, in Step 1, gendered racism frequency trended toward significance ($p = .07$).

In the second hierarchical regression (see Table 6), gendered racism stress appraisal and gender centrality were entered in Step 1, with the interaction term gendered racism stress appraisal X gender centrality entered in Step 2. The overall model was not significant, $F(3,79) = 2.62$, $p = .06$; however, the first step of the model accounted for 7% of variance and significantly predicted depressive symptoms, $F(2, 80) = 3.18$, $p = .05$. In this model, neither gender centrality nor gendered racism stress appraisal met expectations and predicted depressive symptoms; however, in Step 1, gender racism stress appraisal trended toward significance ($p = .05$). While variables were centered to reduce multicollinearity, results for individual predictors may have still been affected by the relationships among the study's key constructs. That said, while multicollinearity reduces the power to detect significant results for individual predictors, it does not reduce the model's predictive power (Frazier et al., 2004).

Hypothesis 3: Gendered racial centrality will moderate the relationship between gendered racism and depression such that greater gender centrality will be related to higher levels of depressive symptoms.

The third hierarchical regression (see Table 7) tested the moderating effect of gendered racial centrality on the relationship between frequency of experiences of gendered racism and depressive symptoms. In Step 1, gendered racism frequency and gendered racial centrality were entered, followed by the interaction term of gendered racism frequency X gendered racial centrality in Step 2. In Step 1, gendered racism frequency significantly predicted depressive symptoms (p = .05) and, for every one point increase in perceived gendered racism frequency, there was a .03 point increase in reported depressive symptoms. Gendered racial centrality did not significantly predict depressive symptoms in Step 1 (p = .44). The interaction did not contribute to the model and the final model was not statistically significant, $F(3,104) = 1.45$, $p = .23$.

For the fourth regression (see Table 8), testing the moderating effect of gendered racial centrality on the relationship between gendered racism stress appraisal and depressive symptoms, I entered gendered racism stress appraisal and gendered racial centrality as the predictor into Step 1 and found that it trended toward significance, $F(2,89) = 3.08$, $p = .05$. In Step 1, gendered racial centrality was not significant, but gendered racism stress appraisal was a significant predictor (p = .02); for every .04 point increase in reported depressive symptoms, there was a .one point increase in gendered racism stress appraisal. In Step 2, the interaction term of gendered racism stress appraisal X gendered racial centrality was entered as a predictor and was not significant nor did it add to explanatory power, $F(3,88) = 2.04$, $p = .11$.

In sum, this study found that gendered racism frequency and stress appraisal predicted depressive symptoms; however, gender centrality and gendered racial centrality did not act as moderators in these relationships.

Chapter 6. Discussion

6.1. Review of Findings

This study set out to address three gaps in the literature by examining the relationship between gendered racism and depressive symptoms, and whether gender centrality and gendered racial centrality moderate this relationship. Results from this study provide evidence that when Black women report greater frequency of gendered racist events or stress experienced from those events, they endorse higher levels of depressive symptoms. This finding – that gendered racism positively predicted symptoms of depression – was consistent with expectations. However, the other study findings did not align with hypotheses. Specifically, although experiences of and stress appraisals related to gendered racism predicted depression among Black women in this sample, gender centrality and gendered racial centrality were not moderating factors in this relationship. Nevertheless, the findings of this study illustrate (a) the possible deleterious consequences of gendered racism, specifically related to depressive symptoms, and (b) the lack of influence that identity centrality appears to have on the relationship between gendered racism and depressive symptoms, at least in the context of this cross-sectional investigation.

6.1.1. Prior findings: Gendered racism and depression.

This study found that gendered racism related to higher levels of depressive symptoms. Multiple previous studies have found that racism related to worse psychological well-being and greater levels of depression (e.g., Clark et al., 1999; Graham et al., 2016; Harrell, 2000; Pieterse

et al., 2011). Other studies have found that sexism is related to greater psychological distress and depression (e.g., Borrell et al., 2010, 2011; Molix, 2014; Moradi & Funderburk, 2006; Moradi & Subich, 2004). A smaller set of studies examined the statistical interaction of racism and sexism but did not show that the interaction significantly contributed to psychological distress (Moradi & Subich, 2003; Stevens-Watkins et al., 2014). This study builds upon studies that have examined racism and sexism as unitary constructs by employing a measure of gendered racism and assessing the distinct experience Black women face in terms of the intersection of racism and sexism. Further, results from this study are consistent with results from previous studies that used a measure of gendered racism and found that gendered racism negatively contributes to psychological well-being (Lewis & Neville, 2015), as well as those from studies with that sought to capture gendered racism through separate measures of racism and sexism (Perry et al., 2013; Woods-Giscombé & Lobel, 2008).

6.1.2. Prior findings: Gender centrality. In this study, gender centrality did not moderate the relationship between gendered racism and depressive symptoms. Only one study that assessed the moderating effect of gender centrality was identified through the present review of the literature; however, that prior work focused on identity conflict related to women scientists' gender centrality (Settles, 2004) and, thus, holds minimal relevance to the objectives and results of the present study.

In fact, one reason for the inclusion of gender centrality in the present effort was the lack of attention the construct has received in the literature. Gender centrality has not been thoroughly examined empirically, and the importance of gender identity to an individual's self-concept may have deleterious results because identifying as a woman is

thought to be related to higher levels of depression (Kohn & Hudson, 2002). In their review, Kohn and Hudson (2002) discussed the potential for Black women to perceive their Black identity as protective in the relationship between discrimination and depression, but their identity as a woman as elevating the risk. This study's finding that gender centrality does not moderate the relationship between gendered racism and depressive symptoms does not support Kohn and Hudson's (2002) argument that one's identity as a woman may increase an individual's risk of depression. This null finding may suggest that gender centrality does not affect the relationship between gendered racism and depressive symptoms when operationalizing gendered racism as the total, cumulative effect of the intersection of racism and sexism. It is also possible that this study's findings reflect the fact that this study utilized the total score of the GRMS frequency and stress appraisal scales; results may have differed if the subscales of the gendered racism measure were used (e.g., silencing and marginalization frequency, angry Black woman stress appraisal). Because previous investigations tested the moderating effect of racial centrality on the relationship between discrimination and mental health outcomes and found that racial centrality acts as a protective factor (Caldwell et al., 2004; Schmitt et al., 2014; Seaton et al., 2011; Sellers et al., 2003; Sellers & Nicole, 2003), this study did not focus on testing that relationship.

6.1.3. Prior findings: Gendered racial centrality. Gendered racial centrality did not act as a moderator in the relationship between gendered racism and depressive symptoms in this study. This result mirrors Szymanski and Lewis' (2016) finding that, in a sample of Black women, gendered racial identity centrality did not moderate the relationship between gendered racism and psychological distress, except through

detachment coping strategies in situations in which moderate or high levels of identity centrality were reported. Viewed in the context of the null findings from the present study, Szymanski and Lewis' (2016) results may suggest that gendered racial centrality does not moderate the relationship between the total, cumulative experience of gendered racism and depressive symptoms in all situations. Specifically, gendered racial centrality may influence the relationship between gendered racism and depressive symptoms when individuals employ particular coping mechanisms (e.g., detachment coping, social support, spirituality), but the moderating effect of gendered racial centrality itself may not be strong enough to detect on its own. Thus, taken together, the findings of Szymanski and Lewis (2016) and those from this study suggest that examining identity centrality on its own may not afford adequate precision to uncover the specific nature of the experience of gendered racism and the protective or risk-conferring role(s) of identity centrality.

6.1.4. Contributions of this study to the literature. Findings from this study demonstrated a relationship between gendered racism and depressive symptoms but did not show that gender centrality or gendered racial centrality acted as a moderator in this relationship. While two of the study's hypotheses were not supported, this study builds on and extends the literature in several ways. First, this study examined the intersection of racism and sexism by using a measure that captured the experience of gendered racism rather than the separate experiences of racism and sexism. Previous studies have examined the intersection of racism and sexism by creating a statistical interaction term (i.e., racism X sexism) and analyzing the main effects of racism and sexism. These studies did not find a relationship between this interaction term and mental health

outcomes (e.g., psychological distress; Moradi & Subich, 2003; Stevens-Watkins et al., 2014). By employing a measure of gendered racism, the present study was better able to assess the intersection of racism and sexism, and findings indicate that gendered racism was positively related to depressive symptoms in Black women. These findings also support qualitative studies and reviews that have suggested that gendered racism is associated with mental health challenges, including depression (Kohn & Hudson, 2002; Watson & Hunter, 2015).

The positive relationship between gendered racism and depressive symptoms found in this study suggests that Black women who frequently experience gendered racism and/or have experiences of gendered racism that elicit a great deal of stress are more likely to report higher levels of depressive symptoms. These results complement previous research that has found a negative association between racism and psychological well-being (Clark et al., 1999; Graham et al., 2016; Harrell, 2000; Pieterse et al., 2011) as well as between sexism and psychological well-being (Borrell et al., 2010, 2011; Molix, 2014; Moradi & Funderburk, 2006; Moradi & Subich, 2004). The present findings also add to the growing gendered racism literature, which has suggested that stress from the cumulative effect of gendered racism is related to poor mental health outcomes (Perry et al., 2013).

6.2. Limitations

Although this study fills a gap in the literature regarding the relationship between Black women's experiences of gendered racism and depressive symptoms, and the potential role of identity centrality in this relationship, several limitations bear mention. For instance, examining gendered racism as a total score rather than using subscale scores

to understand a complex phenomenon may have contributed to a reductive view of this experience. Consistent with this possibility, various theoretical works have suggested that all experiences of racism do not necessarily lead to racism-related stress (e.g., Clark et al., 1999). In turn, because experiences of racism can contribute to differential stress responses, it is likely that the various domains of gendered racism may also contribute to differential stress responses. As one case in point, research suggests that the stereotype of a strong Black woman can have disparate effects on psychological well-being. For example, in their empirical study, Lewis and Neville (2015) found that Black women rated experiences of the strong Black woman stereotype as less stressful compared to other domains of gendered racism (e.g., sexual objectification), while Watson and Hunter (2015) found, in their qualitative study, that Black women's identification as a strong Black woman created tension that may contribute to psychological distress.

The study's primary focus on identity centrality may also be a limitation because identity centrality may not be able to explain fully the complex relationship between gendered racism and psychological well-being. Szymanski and Lewis' (2016) exploration of the relationship between gendered racism, psychological distress, and gendered racial identity centrality in the context of individuals' coping style demonstrates that more complex analyses can help to elucidate this experience. A more complex analysis that takes coping style and other potentially-relevant factors (e.g., social connectedness and support, rumination, counterspace involvement, vigilance) into account may be necessary to understand the effects of gendered racism in the current sample.

This study was also limited by the small sample size. Missing data substantially reduced the sample size and decreased the ability to detect smaller effects. The large amount of missing data reflect the perception that the set of measures was experienced as too time-consuming and/or confusing due to the use of multiple, similar measures (i.e., GRMS frequency and stress appraisal; MIBI-G and MIBI-GR). In particular, the GRMS frequency and stress appraisal measures were presented next to one another online and utilized the same items; however, one set of items asked about frequency of specific experiences while the other set assessed the level of stress perceived as related to each experience. It is possible that some participants only responded to the frequency items because those items and response options were presented first (i.e., on the left of the screen, with stress appraisal items on the right). This possibility is supported by the varying sample sizes (i.e., $n = 113$ for frequency, $n = 96$ for stress appraisal). In addition, the gender centrality and gendered racial centrality measures were identical except the former referred to experiences as a woman and the latter referenced experiences as a Black woman. The gendered racial centrality measure was presented to participants first and it is possible that participants did not respond the gender centrality measure because they believed they were providing duplicate data; this possibility is supported by the differences in sample size (i.e., $n = 129$ for gendered racial centrality, $n = 108$ for gender centrality). Future research that utilizes these measures should include clear instructions that each measure assesses different constructs and, to maximize the potential usefulness of their insights, participants should respond carefully to each item. Future research should also considered using measures that are less similar in order to reduce the rate of missing data.

Low reports of depressive symptoms in this sample may also have influenced results. On average, participants scored 12.00 on the study's measure of depressive symptoms (possible range = 7-28), and participants whose scores indicated depressive symptoms at levels that were considered severe or extremely severe were outliers. In this sample, the depressive symptoms variable was transformed into a logarithmic variable in order to address the skewness, and results may have differed within a sample that reported a greater range and variability in depressive symptoms.

While the design of this study is similar to other quantitative studies assessing sexism, racism, and gendered racism, its cross-sectional nature and reliance on retrospective reports are also limitations. Given the hypothesized roles of identity-relevant constructs, prospective-longitudinal methodologies may be necessary to shed light on the specific mechanisms involved in the hypothesized relationships. Furthermore, the study's cross-sectional approach was best suited for capturing data at a specific point in time. Therefore, although the measures of gendered racism asked participants to respond to items reflecting possible lifetime events and the other measures (e.g., gendered racial centrality, depressive symptoms) do not specify a time period for reflection, recent events may be easier for participants to recall and negative events may be more salient. In a similar vein, if individuals have time to reflect and cope with their experiences of gendered racism, they may interpret and retroactively report these experiences differently than they would have at the time of the event.

6.3. Directions for Future Research

Despite its limitations, this study helps to address a gap in the burgeoning gendered racism literature. This study offers quantitative results demonstrating that, for

Black women, the frequency of experiencing gendered racism and the appraisal of the level of stress resulting from those experiences are positively related to depressive symptoms. In addition, the present results suggest that identity centrality (i.e., gender, gendered racial) is not a salient contributing factor in this relationship. These findings hold relevance in the context of the gendered racism literature and demonstrate the need to further investigate the impact of gendered racism on mental health outcomes and the factors that contribute to these relationships. Future research should examine other predictors of depressive symptoms and analyze the subscales of the GRMS measure of gendered racism as well as the total score. Analyzing the GRMS's four subscales will help to elucidate the relationship between gendered racism and depression by determining how different dimensions of gendered racism (e.g., assumptions of beauty and sexual objectification, strong Black woman stereotype) contribute to depressive symptoms.

Future studies should seek to enhance understanding of the complexity of the relationship between gendered racism and psychological distress by exploring other factors (e.g., coping style, rumination, social connectedness, counterspace involvement) that may contribute to this association. Such work could replicate and extend the finding by Szymanski and Lewis (2016) related to detachment coping by also examining other types of coping such as spirituality as well as individual and relational resources.

Another future direction for research is to continue to examine identity centrality in the relationship between gendered racism and psychological well-being; however, other aspects of identity should be considered. Scholars have previously advocated for research examining multiple identities (e.g., gender identity, race/ethnicity, sexual

orientation, religion, socioeconomic status) in order to more fully understand individuals as multi-dimensional as well as how they navigate holding various identities at once (e.g., Collins, 2015, Crenshaw, 1991; Hancock, 2007; Hankivsky, 2012; Kohn & Hudson, 2002). Future research might also provide individuals with the option of endorsing some identities as more important than others in order to approach the measurement of identity centrality in a different way and work to facilitate understanding of how individuals manage and experience their multiple identities. In sum, given the lack of empirical attention to this area, constructs of identity and identity centrality warrant further exploration, with particular emphasis on individuals' multiple identities. Such efforts would be consistent with the growing interest in and emphasis on intersectionality.

Other research areas related to intersectionality and perceived discrimination have also been underexplored. For example, Purdie-Vaughns and Eibach (2008) put forth the theoretical model of intersectional invisibility, which asserts that individuals who have multiple marginalized identities (e.g., Black women) are less likely to experience overt discrimination but, instead, experience marginalization and oppression through their erasure in history, culture, and policy. The current review did not identify any empirical tests of this notion; investigations of the theory of intersectional invisibility could yield value in enhancing knowledge about the linkages between individuals' identities and their experiences of oppression. Critically, such work would necessitate a substantially larger and more diverse sample to support the objectives of comparing differential experiences across varied intersecting identities. Of note, by focusing on less overt forms of discrimination and attending to feelings of invisibility and erasure in the larger societal

context, future research may be able to uncover different aspects of discrimination and better understand the impact of discrimination on mental health.

Those designing future research should also consider utilizing a longitudinal approach and, specifically, employing such methods as daily diaries to help address limitations of a cross-sectional, retroactive response approach. Brondolo and colleagues (2009) utilized diaries in their study and had participants complete questionnaires related to discrimination and affect in order to understand pathways through which perceived discrimination affects mental health (Brondolo et al., 2009). Because the relationship between gendered racism and psychological distress can be impacted by coping style (Szymanski & Lewis, 2016), it might be important to capture reactions from experiences of discrimination as they happen before individuals can process and react to those experiences. Utilizing a longitudinal approach may also be better suited for capturing the long-term effects of gendered racism and how pervasive discrimination may have a cumulative impact on psychological distress and well-being.

Finally, future research should focus on a broader range of outcomes. Previous research in this area has focused heavily on psychological distress (Hurst & Beesley, 2013; Moradi & Subich, 2004; Stevens-Watkins et al., 2014; Szymanski & Lewis, 2016; Thomas et al., 2008), which is why depressive symptoms were chosen as the outcome variable in this study. Future research should continue using depression as an outcome variable but should also broaden the focus on other mental health outcomes, such as anxiety, stress, psychological well-being, self-efficacy, self-competence, and hope.

Chapter 7. Conclusion

Findings from the present study support the extensive literature emphasizing the relevance of discrimination for mental health outcomes, including depression. Focusing on the unique experience of gendered racism felt by Black women helps to further elucidate the effects of discrimination on mental health. While this study found that identity centrality did not moderate the relationship between gendered racism and depressive symptoms, it is important for future research to enhance understanding of the factors and processes that underlie the mechanisms by which discrimination affects psychological well-being. Overall, it appears that higher levels of depressive symptoms may have a significant effect on the lives of Black women and it is important to understand how gendered racism contributes to this experience because this area of research is underexplored and findings may inform future prevention and treatment efforts.

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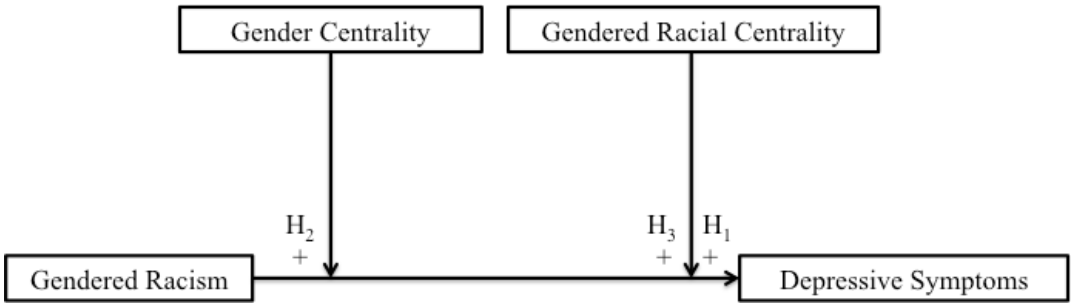

Figure 1. Study model of hypothesized relationships.

Table 1. Sample demographics

Variables	*n*	%
1. Marital Status	135	
Single/Never Married		65.0
In a Committed Relationship		28.5
Married		3.6
Divorced/ Separated		1.5
2. Annual Family Income	101	
Less than $5,000		4.0
$5,000- 11,999		2.0
$12,000- 15,999		5.0
$16,000- 24,999		4.0
$25,000- 34,999		9.9
$35,000- 49,999		20.8
$50,000- 74,999		17.8
$75,000- 99,999		15.8
Greater than $100,000		20.8

Table 2. Key study variables and demographics: Descriptive statistics and zero-order correlations

Variables	*n*	*M*	*SD*	1	2	3	4	5	6	7	8
1. Gendered Racism Frequency	113	2.89	1.07	--	0.81**	0.10	0.34**	0.15	-0.03	-0.07	-0.11
2. Gendered Racism Stress Appraisal	96	2.97	1.10		--	0.11	0.32**	0.20	0.08	-0.01	-0.07
3. Gender Centrailty	108	43.84	7.53			--	0.49**	-0.09	0.14	0.06	0.11
4. Gendered Racial Centrality	129	42.02	9.38				--	0.01	0.07	0.04	-0.09
5. Depressive Symptoms	128	12.00	4.82					--	-0.03	-0.10	-0.11
6. Age	130	21.35	5.34						--	0.54**	0.21*
7. Marital Status	135	1.41	0.64							--	-0.02
8. Annual Household Income	101	6.51	2.12								--

Note. * $p < 0.05$, ** $p < 0.01$.

Table 3. Gendered racism frequency as a predictor of depressive symptoms (n = 111)

Variables	*b*	*SE*	R^2
(Intercept)	1.04**	.02	
Gendered Racism Frequency	.03*	.01	.04*

Note. * $p < 0.05$, ** $p < 0.01$.

Table 4. Gendered racism stress appraisal as a predictor of depressive symptoms (n = 94)

Variables	*b*	*SE*	R^2
(Intercept)	1.05**	.02	
Gendered Racism Stress Appraisal	.03*	.02	.05*

Note. * $p < 0.05$, ** $p < 0.01$.

Table 5. Moderated regression analysis with gender centrality and gendered racism frequency predicting depressive symptoms (n = 97)

Variables	b	SE	R^2	ΔR^2
Step 1			.05	
(Intercept)	1.04**	.02		
Gendered Racism Frequency	.03	.02		
Gender Centrality	.00	.00		
Step 2			.05	.00
(Intercept)	1.04**	.02		
Gendered Racism Frequency X Gender Centrality	.00	.00		

Note. ** $p < 0.01$.

Table 6: Moderated regression analysis with gender centrality and gendered racism Stress appraisal predicting depressive symptoms (n = 82)

Variables	*b*	*SE*	R^2	ΔR^2
Step 1			.07*	
(Intercept)	1.04**	.02		
Gendered Racism Stress Appraisal	.03	.02		
Gender Centrality	.00	.00		
Step 2			.09	.02
(Intercept)	1.05**	.02		
Gendered Racism Stress Appraisal X Gender Centrality	.00	.00		

Note. * $p < 0.05$, ** $p < 0.01$.

Table 7: Moderated regression analysis with gendered racial centrality and gendered racism frequency predicting depressive symptoms (n = 107)

Variables	b	SE	R^2	ΔR^2
Step 1			.04	
(Intercept)	1.04**	.02		
Gendered Racism Frequency	.03*	.02		
Gendered Racial Centrality	.00	.00		
Step 2			.04	.00
(Intercept)	1.04**	.02		
Gendered Racism Frequency X Gendered Racial Centrality	.00	.00		

Note. * $p < 0.05$, ** $p < 0.01$.

Table 8: Moderated regression analysis with gendered racial centrality and gendered racism stress appraisal predicting depressive symptoms (n = 91)

Variables	b	SE	R^2	ΔR^2
Step 1			.07	
(Intercept)	1.04**	.02		
Gendered Racism Stress Appraisal	.04*	.02		
Gendered Racial Centrality	.00	.00		
Step 2			.07	.00
(Intercept)	1.04	.02		
Gendered Racism Stress Appraisal X Gendered Racial Centrality	.00	.00		

Note. * $p < 0.05$, ** $p < 0.01$.

APPENDIX A: DEMOGRAPHIC INFORMATION

1. What is your age (in years)? _____

2. What is your gender? □ Female □ Male □ Transgender

3. What is your marital status?
   - □ Single/never married
   - □ In a committed relationship
   - □ Married
   - □ Divorced/Separated
   - □ Widowed

4. Were you born in the United States? □ Yes (SKIP TO QUESTION 7) □ No

5. Where were you born? _____

6. How many years have you lived in the US? _____

7. How many hours do you work per week?
   - □ not employed
   - □ 0-15
   - □ 15-20
   - □ 20-35
   - □ 35+

8. What is your total annual family income before taxes (include income from main wage-earners)?
   - □ Less than $5,000
   - □ $5000 to $11,999
   - □ $12,000 to $15,999
   - □ $16,000 to $24,999
   - □ $25,000 to $34,999
   - □ $35,000 to $49,999
   - □ $50,000 to $74,999
   - □ $75,000 to $99,999
   - □ $100,000 and greater
   - □ I don't know

9. **Think of this ladder as representing where people stand in the United States**

At the **top** of the ladder are the people who are best off—those who have the most money, the most education and the most respected jobs. At the **bottom** are the people who are the worst off—who have the least money, least education, and the least respected jobs or no job. The higher up on the ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.

Where would you place yourself on this ladder?

Where would you place yourself on this ladder?

Please place a large **"X"** on the rung where you think you stand at this time in your life, relative to other people in the United States.

10. **Think of this ladder as representing where people stand in their communities**

People define communities in different ways; please define it in whatever way is most meaningful to you. At the **top** of the ladder are the people who have the highest standing in their community. At the bottom are the people who have the lowest standing in their community.

Where would you place yourself on this ladder?

Please place a large **"X"** on the rung where you think you stand at this time in

Think of this ladder as representing where people stand in their communities.

People define community in different ways; please define it in whatever way is most meaningful to you. At the **top** of the ladder are the people who have the highest standing in their community. At the **bottom** are the people who have the lowest standing in their community.

APPENDIX B: GENDERED RACISM

Gendered Racial Microaggressions Scale

Directions. Please think about your experiences **as a Black woman**. Please read each item and think of how often each event has happened to you **in your lifetime**. In addition, please rate how stressful each experience was for you. Stressful can include feeling upset, bothered, offended, or annoyed by the event.

Frequency

0	*1*	*2*	*3*	*4*	*5*
Never	Less than once a year	A few times a year	About once a month	A few times a month	Once a week or more

Appraisal

0	*1*	*2*	*3*	*4*	*5*
This has never happened to me	Not at all Stressful	Slightly stressful	Moderately Stressful	Very stressful	Extremely stressful

Based on my experiences as a Black woman...

Item	Frequency	Appraisal
1. Someone accused me of being angry when I was speaking in a calm manner.		
2. Someone assumed that I did not have much to contribute to the conversation.		
3. I have been told that I am too independent.		
4. Someone has made me feel unattractive because I am a Black woman.		
5. In talking with others, someone has told me to calm down.		
6. My comments have been ignored in a discussion in a work, school, or other professional setting.		
7. I have been told that I am too assertive.		
8. Someone has made a sexually inappropriate comment about my butt, hips, or thighs.		
9. I have been perceived to be an "angry black woman."		
10. Someone has challenged my authority in a work, school, or other professional setting.		
11. Someone made a negative comment to me about my skin color/skin tone.		
12. Someone made me feel exotic as a Black woman.		
13. Someone has imitated the way they think Black women speak in front of me (for example, "g-i-r-l-f-r-i-e-n-d").		

14. I have been disrespected by people in a work, school, or other professional setting.		
15. Someone made me feel unattractive because of the size of my butt, hips, or thighs.		
16. I have been assumed to be a strong Black woman.		
17. Someone has assumed that I should have a certain body type because I am a Black woman.		
18. I have felt unheard in a work, school, or other professional setting.		
19. I have received negative comments about my hair when I wear it in a natural hairstyle.		
20. I have been told that I am sassy and straightforward.		
21. Someone objectified me based on my physical features as a Black woman.		
22. I have felt someone has tried to "put me in my place" in a work, school, or other professional setting.		
23. Someone assumed I speak a certain way because I am a Black woman.		
24. I have felt excluded from networking opportunities by White co-workers.		
25. I have received negative comments about the size of my facial features.		
26. Someone perceived me to be sexually promiscuous (sexually loose).		

APPENDIX C: GENDER CENTRALITY

1. Overall, being a woman has very little to do with how I feel about myself. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

2. In general, being a woman is an important part of my self-image.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

3. My destiny is tied to the destiny of other women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

4. Being a woman is unimportant to my sense of what kind of person I am. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

5. I have a strong sense of belonging to women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

6. I have a strong attachment to other women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

7. Being a woman is an important reflection of who I am.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

8. Being a woman is not a major factor in my social relationships. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

APPENDIX D: GENDERED RACIAL CENTRALITY

1. Overall, being a Black woman has very little to do with how I feel about myself. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

2. In general, being a Black woman is an important part of my self-image.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

3. My destiny is tied to the destiny of other Black women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

4. Being a Black woman is unimportant to my sense of what kind of person I am. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

5. I have a strong sense of belonging to Black women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

6. I have a strong attachment to other Black women.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

7. Being a Black woman is an important reflection of who I am.

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

8. Being a Black woman is not a major factor in my social relationships. (R)

1 = strongly disagree 2 3 4 = neutral 5 6 7 = strongly agree

APPENDIX E: DEPRESSION

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3