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FROM BLACKER THE BERRY TO DARKER THE FLESH: GENDERED RACIAL MICROAGGRESSIONS, ETHNIC IDENTITY, AND BLACK WOMEN'S SEXUAL BEHAVIORS

Chelsie E. Dunn
Virginia Commonwealth University

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A thesis submitted in partial fulfillment of the requirements for the degree of
Master of Science at Virginia Commonwealth University

By: CHELSIE EVA DUNN
Master of Arts, Alliant International University, 2016
Master of Public Health, Charles R. Drew University of Medicine & Science, 2013
Bachelor of Arts, Wesleyan College, 2011

Director: Kristina Hood, Ph.D.
Assistant Professor of Health Psychology
Department of Psychology

Virginia Commonwealth University
Richmond, Virginia
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Abstract

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Race- and gender-related contextual factors influence Black women's sexual behaviors, attitudes, and outcomes. Contextual factors of Black women's sexual behaviors include stereotypes, microaggressions, ethnic identity, and self-concept. Little to no research has examined race- and gender-specific microaggressions (i.e., gendered racial microaggressions; GRM) impact on Black women's sexual health. Responsively, using an intersectional approach, this study hypothesized that ethnic identity's influence on the relationship between GRM and sexual behavior (i.e., condom use, lifetime sexual partners) is conditional on self-conceptualization moderated effect on ethnic identity and sexual behavior. Participants included 124 unmarried Black women, recruited from mTurk, a southeastern university and community. Moderated moderation analyses revealed the relationship between GRM and number of lifetime sexual

partners is conditionally based on one's level of ethnic identity and self-conceptualization. Findings could potentially enhance existing HIV interventions by increasing awareness of GRM and implementing coping strategies to combat GRM's effect on sexual behaviors.

Introduction

The compromised sexual health of Black adolescent and emerging adult women is an issue of grave public health significance (Centers for Disease Control and Prevention, 2016c; Kann et al., 2016). Center for Disease Control and Prevention (CDC) surveillance data highlight the disproportionate burden of risky sexual behaviors, practices, and outcomes among ethnic minority women in the United States (Kann et al., 2016). Despite recent decline of risky sexual behaviors compared to their White counterparts, Black women still represent some of the highest percentage of those engaging in sexual risk behaviors (i.e., early sexual debut, multiple sexual partners) and outcomes (i.e., STI/HIV) (Centers for Disease Control and Prevention, 2016b).

Sexual health disparities in the Black community may be contributed to access to equitable healthcare, lack of HIV services and education, lack of awareness of HIV status, sexual risk behaviors, discrimination, and negative perceptions associated with HIV testing among Blacks (Centers for Disease Control and Prevention, 2016a). Surveillance data gives little attention to the various environmental determinants (i.e., accessibility, affordability, quality of health services) that may contribute to the alarming statistics within the Black community. Race- and gender-related contextual factors influence Black women's sexual behaviors, attitudes, and outcomes (Belgrave, Van Oss Marin, & Chambers, 2000). Contextual factors of Black women's sexual behaviors include environmental factors (e.g., closed sexual networks, gender imbalance, stereotypes, microaggressions), ethnic identity, and self-concept. Of note, closed sexual networks refers to a set of individuals who share similar life experiences, risk circumstances, norms and values as a direct or indirect linkage through sexual contact (i.e., shared linkage of sexual partners; Adimora & Schoenbach, 2005; Amirkhanian, 2014)) – such an environment increases Black women's HIV risk due to increased gender imbalance and shared sexual partners.

Therefore, in order to holistically explore Black women's sexual health (i.e., behaviors, attitudes, outcomes), we must understand Black women's life experiences, with respect to their sexual health.

The lack of understanding of Black women's experiences and the environmental factors of Black women's sexual health may result in the perpetration of microaggressions (Sue et al., 2007) and Black women's internalization of microaggressions. Oftentimes these microaggressions are based on both gender and race – known as *gendered racial microaggressions*. These messages overemphasize Black women as having exotic body features (i.e., large hips, buttocks, breast) and enforces oversexualized stereotypes (e.g., Black women being portrayed as hypersexual in media - Jezebel stereotype; Lewis et al., 2013). These messages are detrimental to Black women's sexual health as scholars have shown that over-sexualized and demeaning stereotypes affect Black women's self-concept (i.e., self-esteem, self-worth), interpersonal relationships, and perception of their own sexuality (Stephens & Phillips, 2003; Townsend, Thomas, Neilands, & Jackson, 2010). This study sought to explore an environmental factor (i.e., gendered racial microaggressions) impact on Black women's sexual health (i.e., behavior). Here, sexual health refers to sexual risk and protective behaviors, sexual attitudes, and sexual outcomes (e.g., STI, HIV/AIDS). The purpose of this study is to use an intersectional lens to examine the impact gendered racial microaggressions (GRM) have on Black women's sexual behaviors, such as condom use and lifetime sexual partners.

Review of Literature

Sexual Health Disparities Among Black Women

Black women make up about 12% of the population (U.S. Census Bureau, 2014); yet, 44% of estimated new HIV diagnoses, among women in the United States, (Centers for Disease

Control and Prevention, 2016a) are reported to be Black women. Heterosexual Black women account for the majority of new HIV diagnoses when compared to heterosexual Black men, Hispanic/Latina women, and White women (4654, 2108, 1159, 1115, respectively; CDC, 2016a). Additionally, race/ethnicity and gender-specific data (Kann et al., 2016) revealed that Black adolescent girls have the highest percentage of reporting early sexual debut compared to their White counterparts (i.e., first sexual intercourse before age 13 years; 4.3% vs. 1.6%, respectively). Research has found that early age of sexual debut increased women's STI/HIV risk as a result of their engagement in behaviors associated with STI/HIV risk such as increased number of lifetime sexual partners, negative condom attitudes, and relationship solidity (Sandfort, Orr, Hirsch, & Santelli, 2008).

Despite recent decline of sexual risk behaviors compared to their White counterparts, Black adolescent girls still have the lowest percentage of birth control pills use before last sexual intercourse, nationally (25.4% vs. 9.0%, respectively); with White female students being about 2.8 times more likely than Black female students to use birth control pills (CDC, 2016b). Notably, CDC/NCHS data revealed that current condom use was slightly higher among Black women compared to White, and Hispanic/Latina women (9.4%, 9.3%, 8.6%, respectively; Daniels, Daugherty, & Jones, 2014). There is also a decline in unplanned pregnancies at a young age (13-18 years of age) among Black adolescent girls (Martinez, Daniels, & Chandra, 2012); with the mean age of first child birth for Black women being 20.9 years (Martinez et al., 2012). This may be attributed to Black women engaging less in unprotected sex (Beadnell et al., 2003).

Moreover, CDC surveillance data revealed that Black emerging adult women (age 20-24) have the highest reported cases of chlamydia and gonorrhea (CDC, 2016b). More specifically, 114,437 cases of chlamydia were reported for Black emerging adult women between the ages of

20-24, which is 3.9 times the rate among White women (106,961 cases); and 29,704 cases of gonorrhea was reported for Black women between the ages of 20-24, which is 8.9 times the rate among White women (12,051 cases). Researchers suggest that closed sexual networks increase Black women's risk of contracting a STI (Adimora & Schoenbach, 2005; Khan et al., 2009; Laumann & Youm, 1999). Closed sexual networks are a direct result of the residential segregation of Black communities; and the historical and persistent discrimination that contributes to gender imbalance (i.e., low male to female sex ratio) such as the mass incarceration of Black men and greater homogeneous sexual selection (i.e., selecting a partner with similar phenotypical features), when compared to other ethnic minority groups (Adimora & Schoenbach, 2005).

Black emerging adult women are disproportionately suffering the consequences (i.e., STIs, HIV) of engaging in sexual risk behaviors, even though they engage in sexual protective behaviors (i.e., condom use) more frequently than other racial and ethnic groups. Therefore, it is equally important to examine the risk and protective factors (i.e., personal and environmental) associated with Black women's sexual behaviors and outcomes. This includes, but are not limited to, racism, discrimination, sexism, stereotypes, microaggressions, self-concept, and ethnic identity impact on sexual behaviors, practices, attitudes, and outcomes.

Over-sexualized Stereotypes

Black women experience stigma based on negative stereotypes of both their gender and their race (Townsend et al., 2010). Historical stereotypical images (i.e., Jezebel, Mammy, Sapphire) of Black women are still present in modern day culture but in a different form (i.e., freaks, gold diggers, divas, and baby mamas). One of the most overtly stereotypical, sexual images of Black women would be the Jezebel stereotype – a seductive, highly sex driven woman

(Mitchell & Herring, 1998; West, 1995). The Mammy is viewed as an asexual Black woman who serves as a caregiver to others (e.g., nanny, housekeeper) (Mitchell & Herring, 1998; West, 1995). Lastly, Sapphire image is viewed as a Black women who is loud, argumentative, and devalues men (Mitchell & Herring, 1998; West, 1995). Overall, these stereotypical images are prevalent in Black women's sexuality and often influence how Black women view the exploitation of their sexuality (Stephens & Few, 2007; Stephens & Phillips, 2003; Townsend et al., 2010).

Over-sexualized and demeaning stereotypes affect Black girls and women's self-concept, cultural values, interpersonal relationships, and perception of their own sexuality (Stephens & Phillips, 2003; Townsend et al., 2010). Consequently, these experiences cause distress which may impact Black women's values and attitudes towards healthy relationships. This emotional and psychological distress may influence Black women to seek out unhealthy types of interpersonal relationships which may present itself as being a risky sexual relationship (Duvall et al., 2013). These types of relationships may place Black women in a position to engage in sexual risk behaviors such as unprotected sex, substance use during intercourse, and exploitation. Furthermore, these stereotypes may alter Black women's self-concept, worth, interpersonal relationships, and healthy behaviors. Most importantly, these stereotypes influence the way others value and interact with Black women (Stephens & Phillips, 2005), perpetrating the subtle forms of sexism (e.g., being sexually objectified) they experience.

Microaggressions

Covert racism and sexism is universal due to the constant perpetration of racist and sexist stereotypes in everyday conversation and socialization (Sue et al., 2007; Sue, Capodilupo, & Holder, 2008). An example of covert racism and sexism is commenting to a Black woman, in a

stunned tone, that *she is pretty for a dark skin woman*. Racial microaggressions is a concept based on covert racism. Back in 1977, Pierce, Carew, Pierce-Gonzalez, & Wills (1977) introduced the term racial microaggressions and defined it as "subtle, stunning, often automatic, and nonverbal exchanges, which are 'put downs' toward people of color" (p. 66). Later, Sue and colleagues (2007) added to this definition by stating racial microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (p.271). Furthermore, Sue & Capodilupo (2008) characterized gender microaggressions as a subtle form of sexism, ranging from women feeling as a second-class citizen to being sexually objectified. These experiences leads to Black Americans being treated inferiorly, denied equal access and opportunities as their White counterparts (Sue, 2003), and developing feelings of self-doubt and low self-esteem (Solorzano, Ceja, & Yosso, 2000).

Racial Microaggressions. Racial microaggressions are theorized to occur in three forms: microassaults, microinsults, and microinvalidations (Sue et al., 2007). *Microassault* is "an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions" (p. 274). One example is calling someone "colored" or discouraging interracial relationships. *Microinsult* is "characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity" (p. 274). This includes ascription of intelligence, assumption of criminal status, and second-class citizenship. And *microinvalidations* are "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (p. 274). Individuals who are perpetrators of racial color blindness and/or deny personal racism are engaging in

microinvalidations. Microassaults and microinvalidations are particularly risky given their potential ambiguity which in turn can be detrimental to one's psychological health. Sue, Capodilupo, and Holder (2008) found that Black Americans who experienced racial microaggressions described feeling powerless (i.e., "…having little control over stopping the continuing onslaught of microaggressions"), invisibility, and the stress associated with representing the Black community (i.e., "If I screw up, every Black woman after me, or every Black person after me, is going to have to take it, because I screwed up . . . so I carry that pressure with me.")

Racial microaggressions impact Black women's overall quality of life (i.e., physical and mental health, academic satisfaction, job satisfaction) and has been studied significantly over the past decade (Donovan, Galban, Grace, Bennett, & Felicié, 2012; McCabe, 2009; Sue, Nadal, et al., 2008). This is particularly true for Black women in the South who reported experiencing more racial microaggressions than Black women in any other region of the United States (Donovan et al., 2012). Perceptions of racial microaggression experiences effect one's psychological well-being. Consequently, these experiences are linked to substance abuse, lower self-concept, mental distress, and behavioral control (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Schoulte, Schultz, & Altmaier, 2011; W. A. Smith, Hung, & Franklin, 2011; Wong, Derthick, David, Saw, & Okazaki, 2014). These attributes can lead Black women to engaging in sexual risk behaviors such as early sexual debut, multiple sexual/causal partners, and unprotected sex. This may be due to low self-efficacy and self-worth to effectively negotiate condom use and control over sexual intercourse (Salazar et al., 2004). Fortunately, racial/ethnic identity may mediate the impact of racial microaggressions on one's self-esteem (Barnes, 2011).

Gender Microaggressions. Gender microaggressions as "brief and commonplace daily verbal, behavioral, or environmental indignities (whether intentional or unintentional) that communicate hostile, derogatory, or negative sexist slights and insults toward women. These microaggressions are often unconscious in that the perpetrator of the microaggressions may not realize that he is being hurtful in his statements or behaviors" ((Nadal, 2010; p. 158). Prior to a formal term to described insults based on gender, scholars explored the impact of complimentary stereotypes based on gender. Czopp & Monteith (2006) found that African American adults' internalization of complimentary stereotypes related to athleticism, musical ability, and sensuality/sexuality were associated with feelings of anxiety, stress, and perceived prejudice or discrimination. The constant use of these types of "complimentary" stereotypes, based on gender (e.g., "Women with large curves are good in bed…. more cushion for the pushing", "The best athletes are men"), lead to these stereotypes becoming *gender microaggressions* in everyday dialogue. Two years later, Sue & Capodilupo (2008) characterized such stereotypes as gender microaggressions, or a subtle form of sexism, ranging from women feeling as second-class citizens to being sexually objectified.

Gender microaggressions influence interpersonal relationships, sexual violence among youth (Gartner & Sterzing, 2016), and mental health outcomes (i.e., depression, anxiety) of Blacks (Donovan et al., 2012). Duvall et al. (2013) found that African American women who endorsed "complimentary" stereotypes (e.g., "Black people have a unique quality of sexuality that most white people don't have.") were positively correlated with risky sexual behaviors and attitudes. More specifically, African American women who internalized the gender microaggressions had negative sexual attitudes; which in turn, increased their acceptability of having unprotected sex in order to strengthen their relationship (Duvall et al., 2013).

Furthermore, women in this sample were also more likely to have a greater number of sexual partners in the past year. The impact of stereotypes and microaggressions goes beyond "skin surface;" the ramifications of experiencing, perceiving, and/or being stressed due to racial- and gendered stereotypes and microaggressions impact Black women's overall quality of life (i.e., mental health, sexuality, and interpersonal relationships). Responsively, it is important to examine the intersectionality of race and gender, with respect to microaggressions and Black women's sexual health (e.g., sexual behavior and attitudes).

Gendered Racial Microaggressions. Gendered racial microaggressions (GRM) are defined as "subtle and everyday verbal, behavioral, and environmental expressions of oppression based on the intersection of one's race and gender" (Lewis & Neville, 2015). It is operationalized by the frequency and anxiety of microassaults, insults, and invalidations constructed on stereotypes, assumptions, and marginalization. The use of a combination of Black feminist and intersectionality theory allowed for a deeper understanding of the intersection of subtle and covert forms of gendered racism and microaggressions experienced by Black women.

Using an intersectional approach and building on Sue (2010) microaggressions theory, Lewis, Mendenhall, Harwood, & Huntt (2013) explored how college-aged Black women cope with gendered racial microaggressions. Results yielded five coping strategies associated with the stress of perceived GRM: (1) *Using One's Voice as Power* (resistance), (2) *Resisting Eurocentric Standards* (resistance), (3) *Leaning on One's Support Network* (collective), (4) *Becoming a Black Superwoman* (self- protective), and (5) *Becoming Desensitized and Escaping* (self-protective). Additionally, this study found that when faced with a GRM, Black women used cognitive decision-making strategies based on "if", "when", or "how" to respond to gendered racial microaggressions. Equally, this decision was based on (1) the power of the target in the

situation; (2) whether certain stereotypes would be perpetuated by the target's response; and/or (3) the overall impact on their mental health and well-being. Lewis et al.'s (2013) study demonstrates the awareness and resilience of Black women when faced with GRM.

Lewis and her colleagues' work on GRM is the product of an intersectionality framework being applied to Essed (1991) theory of gendered racism and Sue et al. (2007) model of racial microaggressions. As a result, Lewis & Neville (2015) developed the Gendered Racial Microaggressions Scale (GRMS). Now, researchers are able to assess the frequency of (GRMF)- and stress appraisal (GRMA) associated with experiences of GRM among Black women. The instrument consists of four subscales: (1) Assumptions of Beauty and Sexual Objectification, (2) Silenced and Marginalized, (3) Strong Black Woman, and (4) Angry Black Woman. Most importantly, GRMS was positively related to the Racial and Ethnic Microaggressions Scale (Nadal, 2011) and the Schedule of Sexist Events (Klonoff & Landrine, 1995); thus, supporting the effectiveness of the intersectional theory. Most recently, using a Black feminist theoretical framework, Lewis, Mendenhall, Harwood, & Huntt (2016) identified three core themes related to gendered racial microaggression – projected stereotypes (i.e., expectation of the Jezebel and Angry Black woman), silenced and marginalized (i.e., struggle for respect, invisibility), and assumptions about style and beauty (i.e., assumptions about communication styles, assumptions about aesthetics). This study also found that experiences of gendered racial microaggressions influence the way Black women feel and view themselves. That said, Black women felt sexualized based on the Jezebel stereotype (Lewis et al., 2016).

Building on these findings, the current study used the Assumptions of Beauty and Sexual Objectification subscale – sexualized stereotypes and assumptions physical appearance – in its final analyses of GRM stress appraisal. Here, the stress appraisal of Black women's experiences

is operationalized as feeling eroticized and/or sexualized. Black women being labeled as having more exotic body features (e.g., buttocks, hips, and breasts) is stereotypically associated with being more sexualized and pleasurable during sexual intercourse. Connectively, it suggests that gendered racial microaggressions may be associated with sexual risk behaviors among Black women as perceived stigmatization is associated with lower self-regard (Wong et al., 2014). Furthermore, this attribute can lead Black women to engaging in sexual risk behaviors; more specifically, unprotected sex, early sexual debut, and having multiple and/or casual sex partners. Peterson and colleagues (2007) found that perceived portrayal of sexual stereotypes, of young, attractive African American females in popular media (i.e., rap music videos), was associated with an increased likelihood of having multiple sexual partners – an act associated with increased STI/HIV risk.

Similar to oversexualized stereotypes (i.e., a subset of gendered racial microaggressions), experiences of gendered racial microaggressions with sexual objectification undertones may lead to deleterious sexual health outcomes (e.g., unplanned pregnancy, HIV/AIDS, STIs) because of engagement in aforementioned behaviors that increase risk (Duvall et al., 2013; Salazar et al., 2004). Fortunately, research has highlighted the various coping strategies (i.e., resistance, collective, self-protective) Black women employ when faced with GRM, given certain contextual factors (e.g., whether certain stereotypes would be perpetuated by the target's response). Alongside these coping strategies, research has uncovered the protective nature of ethnic identity and self-concept in protecting Black women from the effects of over-sexualized stereotypes and microaggressions, with respect to sexual behaviors and attitudes (Belgrave et al., 2000; Townsend, 2002).

Ethnic Identity

Ethnic identity (EI) has been shown to be influential in minimizing sexual risk behaviors and promoting positive sexual attitudes among Black adolescent girls and women (Beadnell et al., 2003; Belgrave et al., 2000; Townsend et al., 2010). Cokley (2007) defines *ethnicity* as the "characterization of a group of people who see themselves and are seen by others as having a common ancestry, shared history, shared traditions, and shared cultural traits such as language, beliefs, values, music, dress, and food (p. 225)." Accordingly, *ethnic identity* is described as a "subjective sense of belonging to a particular group or culture and encompasses cultural behaviors, values, and attitudes toward one's group" (Corneille, Fife, Belgrave, & Sims, 2012; Phinney & Ong, 2007). Furthermore, scholars have noted the difference in which ethnic identity is being operationalized within measures. Syed and colleagues (2013) proposed there are two dimensions of ethnic identity exploration (i.e., participation and search); and noted that Revised Multigroup Ethnic Identity Measure (MEIM) assesses *search* whereas Ethnic Identity Scale (EIS) assesses *participation*. *Searching* refers to the process by which the individual questions what it means to be a member of their ethnic group (e.g., "I think a lot about how my life will be affected by my ethnic group membership"). *Participating* refers to the process by which the individual learns about what it means to be a member of an ethnic group (e.g., "I have attended events that have helped me learn more about my ethnicity"; Syed et al., 2013). The findings from this study revealed that MEIM exploration was negatively associated with well-being (Syed et al., 2013); whereas EIS exploration was positively associated with well-being. Thus, for the purposes of this study, I will be examining MEIM exploration and how it relates to sexual risk and protective behaviors, GRM, and self-concept, where low MEIM exploration is hypothesized to be associated with less risky sexual behaviors.

Strong ethnic identity facilitates positive sexual behaviors, practices, and attitudes (Beadnell et al., 2003; Belgrave et al., 2000; Townsend et al., 2010). More specifically, higher ethnic identity was associated with strategies of abstinence, relationship monogamy (Beadnell et al., 2003), and greater condom use (Corneille et al., 2012). Conversely, those in supportive monogamous relationships tend to have a positive identity development (Corneille et al., 2012). Salazar et al. (2004) found that African American adolescent girls with positive ethnic identity and higher levels of self-esteem had higher frequency rate of refusing unprotected sex. Of note, cited research examining ethnic identity's relationship to sexual behavior operationalizes ethnic identity using the entire scale or affirmation/belongingness subscales. That said, higher levels of affirmation and belongingness to one's ethnic group was associated with less risky sexual attitudes.

Additionally, Belgrave et al. (2000) suggest that low ethnic identity may result in high dissonance which could trigger maladaptive beliefs and choices such as negative sexual attitudes. This may also be due to individuals exploring their ethnic group and their ethnic identity not being fully developed. According to Roberts and colleagues (1999), the exploration process is critical in the ethnic identity development as this is when individuals engage in activities to explore and learn more about their ethnic group. Scholars have investigated ethnic identity exploration, with respect to academic achievement, substance use, depression, and self-esteem (Rivas-Drake et al., 2014). Surprisingly, there is limited research examining ethnic identity exploration and sexual behaviors. To add to literature, this study sought to examine the relationship between individuals who are exploring their ethnic identity (as operationalized by MEIM) and sexual behaviors. Understanding ethnic identity in all of its components (i.e.,

exploration, affirmation) may result in changes in behavior and attitudes, which in return, may result in a decreased risk for STI and HIV.

Self-Concept

According to Harter (1988) and Spencer (1988), self-conceptualization is arranged into a hierarchy of self-components: *self-concept* (an image or perception of oneself; SC), *self- esteem* (the values or judgments one has of oneself), and *identity* (an awareness of one's group membership such as race and gender). Moreover, Harter (1988) suggested that self-conceptualization is strongly linked to behavior and may dictate whether a person engages in sexual risk behaviors (Townsend et al., 2006). Positive self-concept has been linked to reports of stronger partner communication attributes (i.e., sex-related discussion, self-efficacy of condom use negotiation) and more refusal of unprotected intercourse among African American adolescent females (Salazar et al., 2004). Furthermore, self-concept is negatively associated with body dissatisfaction (Fulton, 2016) which is associated with condom use self-efficacy (Blashill & Safren, 2015). While separately strong ethnic identity and positive self-concept serve as a buffer against engaging in sexual risk behaviors, the combined effect of self-concept and ethnic identity may serve as a buffer against Black women endorsing negative sexual attitudes and racial stereotypes (Townsend, 2002).

Nobles (1976) stated that the influence of ethnic identity on African Americans may be due to the link between ethnic identity and self-perceptions. Likewise, Townsend and colleagues (2010) suggested that Black girls' and women's self-concept is influenced by attitudes, knowledge, and beliefs surrounding their ethnic group. Studies have explored the combination of strong ethnic identity and strong self-concept on the internalization of negative stereotypes (Duvall et al., 2013; Phinney & Ong, 2007; Stephens & Few, 2007; Stephens & Phillips, 2005).

For example, Black women with strong ethnic identity and positive self-concept are less likely to endorse negative stereotypes (Townsend et al., 2010). This may be due to the Black individuals having positive attitudes/connections associated with their ethnic group, in addition to, high self-esteem which may apt them to detach and reframe negative stereotypes (Tynes, Umana-Taylor, Rose, Lin, & Anderson, 2012). Earlier research suggest that a strong ethnic identity and self-concept are essential for a healthy sense of self (Shorter-Gooden & Washington, 1996), which could be influential when faced with GRM. Researchers have highlighted that even with having a strong ethnic identity, African Americans could still engage in sexual risk behaviors if they accept the negative stereotypes of their own ethnic group (Espinosa-Hernández & Lefkowitz, 2009; Stephens & Few, 2007).

The current study explored self-concept and ethnic identity, with respect to the effects of GRM) because as suggested by previous literature in order for the negative effects of GRM to impact Black women ethnic identity and self-concept must be strong and experiences of GRM and/or negative stereotypes must not be internalized. Strong ethnic identity and self-concept can assist Black emerging adult women with a healthy sexual identity, behaviors, and attitudes. This, in turn, can assist with reducing the risk of HIV infection due to sexual risk behaviors and negative sexual attitudes (Townsend et al., 2010).

Theoretical Framework

Building on recent work's on racial and gender microaggressions, racial stereotypes, and Lewis et al. (2013) work on GRM, an intersectional analytic framework was used to explore the impact gendered racial microaggressions have on Black women's sexual behaviors (i.e., condom use in the past two months and number of lifetime sexual partners); and explain the role of ethnic identity and self-concept in the GRM-sexual behavior relationship. Viewing through an

intersectional lens removes the unitary approach of examining race and gender issues, separately. The exploration of the systems of oppression and social constructions of race, class, and gender was first conceptualized by a Black feminist and critical race theorist (Crenshaw, 1989) and later supported by Collins (1990). This is what we know of today as *intersectionality* (or intersectional theory).

Intersectionality is defined as "an analysis claiming that systems of race, economic class, gender, sexuality, ethnicity, nation, and age form mutually constructing features of social organization" (Collins, 1998). As highlighted in the literature review, empirical research has explored the intersection between racism and sexism, with respect to Black women's experiences, by examining oversexualized stereotypes. However, empirical research has not explored gendered racial microaggressions, specifically. While oversexualized stereotypes, which has been explored extensively, are a subset of gendered racial microaggressions (i.e., assumptions of beauty and sexual objectification), there is limited research examining the relationship between GRM and Black women's sexual health (i.e., sexual risk and protective behaviors). Based on intersectional theory, both GRM and oversexualized stereotypes sexually objectify Black women as an object and sexual being for others to view. In addition, previous research has found that societal stereotypes and beliefs about Black women based on racist and sexist perceptions of Black womanhood marginalize and objectify Black women, such as Jezebel and Manny stereotypes (Collins, 1990; Stephens & Phillips, 2003; Townsend et al., 2010). Therefore, it is important to note that scholars are confronting, head on, the realization of how multiple societal constructed realities (e.g., racism, sexism) impact Black women lives. At times, the harsh reality that Black women face, often daily, are not a result of only their race or gender, but a combination of both. Intersectionality theory allows us to recognize how race, gender, and

other dimensions of identity contribute to the interconnecting systems of oppressions for many marginalized groups and individuals. Now, we must move forward in efforts to have an impact, at the microsystem level (i.e., HIV interventions), by addressing the gap in literature through exploring how gendered racial microaggressions impact Black women's sexual health (e.g., sexual risk behaviors, sexual protective behaviors).

Purpose of the Study

Previous research has highlighted the impact stereotypes and microaggressions (i.e., gender and racial) have on Black girls' and women's overall quality of life (i.e., mental health, sexuality, and romantic relationships) and the protective nature of ethnic identity and self-concept. With regard to gendered racial microaggressions, there is little to no research available on the impact gendered racial microaggressions experiences have on Black emerging adult women's sexual behaviors (i.e., lifetime sexual partners, condom use). Exploration of gendered racial microaggressions occurring in Black emerging adult women's lives is important as emerging adulthood serves as a period where sexual risk behaviors peak, not adolescence or adulthood (Arnett, 2000). Consequently, using an intersectional approach, this study explored the GRM-sexual behavior relationship based on being an emerging adult Black woman. More specifically, this study sought to examine how emerging adult Black women's perceived stress associated with experiencing gendered racial microaggression(s) influence their sexual behaviors such as condom use and number of sexual partners in their lifetime, after controlling for body appreciation (BAS), sexual debut, and age. Body appreciation is the cognitive process to promote and protect positive views of one's body (Tylka & Wood-Barcalow, 2015). Controlling for body appreciation was imperative as scholars found that BAS is correlated with condom use among participants with more than one sexual partner (Winter & Satinsky, 2014).

Hypotheses

The study explored the association between stress-related to experiences of gendered racial microaggressions (GRMA) and sexual behaviors (i.e., condom use in the past two months, number of lifetime sexual partners). Additionally, it examined whether ethnic identity exploration (EIE) would moderate the GRMA-sexual behavior relationship, after controlling for BAS, sexual debut, and age. Lastly, the study examined self-concept (as operationalized by self-worth based on appearance; SCA) as a moderated moderator of the GRMA-sexual behavior relationship, after controlling for BAS, sexual debut, and age.

Hypothesis 1. GRMA will negatively predict condom use in the past two months and positively predict number of lifetime sexual partners. Lower GRMA will be associated with higher frequency of condom use in the past two months and fewer lifetime sexual partners among Black women.

Hypothesis 2. EIE will negatively predict condom use in the past two months and positively predict number of lifetime sexual partners. High EIE will be associated with higher frequency of condom use in the past two months and fewer lifetime sexual partners among Black women

Hypothesis 3. SCA will positively predict condom use in the past two months and negatively predict number of lifetime sexual partners. High SCA will be associated with higher frequency of condom use in the past two months and fewer lifetime sexual partners in their lifetime among Black women.

Hypothesis 4. EIE will moderate the relationship between GRMA and sexual behavior (i.e., condom use, lifetime sexual partners). Black women in the sample with low EIE will report

higher frequency of condom use in the past two months and fewer sexual partners in their lifetime when GRMA is high.

Hypothesis 5. SCA will moderate the relationship between EIE and sexual behavior (i.e., condom use, lifetime sexual partners). When SCA is high, higher frequency of condom use in the past two months and fewer sexual partners in their lifetime among Black women in the sample with low EIE.

Hypothesis 6. EIE influence on the relationship between GRMA and sexual behavior (i.e., condom use, lifetime sexual partners) is conditionally based on SCA effect on the relationship between EIE and sexual behavior (see Figure 1). Higher GRMA will be associated with higher frequency of condom use in the past two months and fewer sexual partners in their lifetime, when EIE is low and SCA is high, among Black women in the sample.

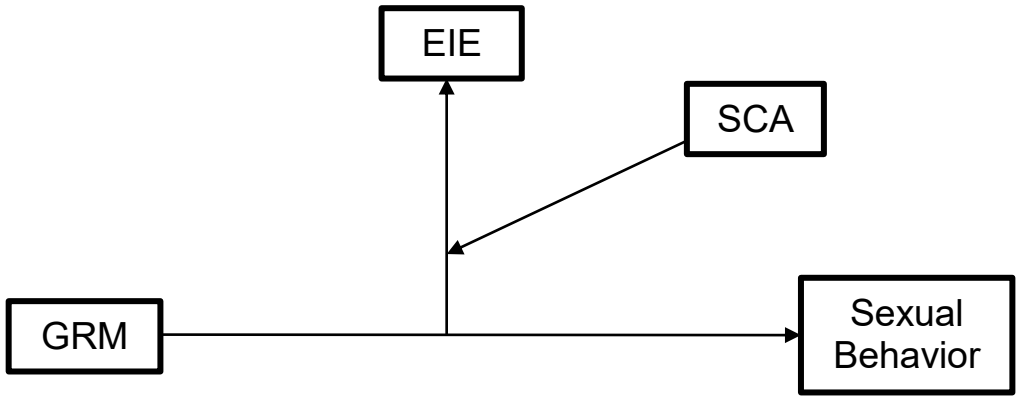

Figure 1. Moderated moderation model
GRM: Gendered racial microaggressions; EIE: Ethnic identity exploration; SCA: Self-Concept appearance; Sexual behavior: condom use and lifetime sexual partners

Method

A quantitative, cross-sectional study design was used to evaluate the impact ethnic identity exploration and self-concept have on the relationship between gendered racial microaggressions and Black women's sexual behavior (i.e., number of lifetime sexual partners, condom use in the past two months). This study used a self-selection sampling approach. The

study answered the following research questions: (1) is there a relationship between GRMA and sexual behaviors (i.e., condom use in the past two months, number of lifetime sexual partners)? (2) does EIE and/or SCA moderate the relationship between experiences of GRMA and sexual behaviors (i.e., condom use in the past two months, number of lifetime sexual partners)? and (3) does EIE moderate the relationship between GRMA and sexual behaviors due to SCA moderating the relationship between EIE and sexual behaviors (i.e., condom use in the past two months, number of lifetime sexual partners)?

Participants

One hundred and seventy-seven individuals (*N*=177) consented to participate in the study and were recruited from two primary outlets: Word of Mouth (i.e., social media and Craigslist - referred to as community sample, mTurk; *N*=141); and a large, urban university in the Southeast's SONA system (*N*=36). mTurk is an online recruitment tool powered by Amazon where participants complete a wide variety of surveys and questionnaires; and SONA is a web-based program the psychology department uses to manage recruitment, signup, credit management, and on-line surveys. One participant was excluded because she self-identified as White. An additional 30 were excluded for failing to complete the primary study variables (i.e., gendered racial microaggression, ethnic identity, self-concept, condom use, lifetime sexual partners) of the survey. Therefore, a total of 146 participants were included in the final dataset. G*Power Statistical Power Analysis was used to calculate the observed power when conducting a moderated moderation with the given sample size. Post-hoc power analyses revealed that the observed power for sample of 95 (condom use as outcome variable sample size) was .40 (α = .05, effect size of .05); and the observed power for a sample of 124 (lifetime sexual partners as outcome variable sample size) was .52 (α = .05, effect size of .05).

The sample consisted of women from throughout the United States with the majority (93.8%) residing in the Southern region of the United States. The mean participant age was 19.03 (*SD* = 1.65). The majority of the sample (95.2%) was enrolled in a two or four-year university. About 34% characterized their hometown as suburban. Thirty-eight percent of the sample were in a committed relationship while 29.8% were single and currently looking. Majority of the sample (63.2%) had first voluntary sexual intercourse with a man before 18 years of age, with a mean age of 16.81 (*SD*=1.57). About 75.3% stated that the suggestion of condom use at first intercourse was recommended by both parties involved.

Inclusion Criteria. This study consisted of participants who self-identified as being (1) woman; (2) Black; (3) between the ages 18 and 24; and (4) single or in a relationship. Black women who reported (1) never having voluntary vaginal sexual intercourse; (2) having a child(ren); (3) being engaged, married, or divorced; (4) being pregnant or attempting to become pregnant; (5) self-identifying as bi-racial or mixed race; and (6) self-identifying as gay or lesbian were excluded from this study. The study population consisted of Black women between the ages of 18-24 (also referred to as emerging adults, a distinctive period in the life stages of individuals; Arnett, 2000). Furthermore, data has shown that people in this age group are at increased risk for HIV infection (CDC, 2016). In 2015, African American between the age of 15-24 accounted for 28% of new diagnoses of HIV infection among African Americans (CDC, 2016).

Measures

The online questionnaire assessed demographics, sexual health behaviors, body appreciation, gendered racial microaggressions experiences, ethnic identity, and self-concept. The measures have been used in previous research examining the impact of stereotypes,

discrimination, racism, sexism, ethnic identity, and self-concept on Black women's sexual health. Therefore, to assess my hypotheses, these measures were administered to all participants who were eligible and who chose to participate.

Sexual Behaviors. Sexual risk behavior items were created from items used in studies by DePadilla, Windle, Wingood, Cooper, & DiClement (2011) and DiClemente & Wingood (1995) These authors used a self-report survey to assess sexual risk and protective behaviors in the past two months and last sexual act. Additionally, this measure assessed future intentions to use condoms in the next 2-3 months. HIV testing history and intentions were also assessed. Items are both open-ended and force choice. Question such as "in the past 2 months, how many times have you had vaginal intercourse" and "what is the probability out of 100 that you will use a condom the next time you have sex?" were asked. For the purpose of this study, responses to items "In the past 2 months, how many times have you had vaginal intercourse;" "In the past 2 months, when you had sex how many times was a condom used;" and "Number of Lifetime partners?" were used to analyze sexual risk behaviors. Of note, this study calculated the ratio of "In the past 2 months, when you had sex how many times was a condom used?" to "In the past 2 months, how many times have you had vaginal intercourse?" Lifetime sexual partners were coded as 1="1-3 sexual partners"; 2="4-10 sexual partners"; and 3="more than 10 sexual partners."

Gendered Racial Microaggressions (GRM). The Gendered Racial Microaggressions Scale (GRMS; Lewis & Neville, 2015) is a 26-item measure used to assess the frequency of- and stress appraisal associated with experiences of GRM among Black woman. The measure consists of four subscales: (1) Assumptions of Beauty and Sexual Objectification, (2) Silenced and Marginalized, (3) Strong Black Woman, and (4) Angry Black Woman. For the purposes of this

study, Assumptions of Beauty and Sexual Objectification subscale was used. Additionally, stress appraisal of Assumptions of Beauty and Sexual Objectification was used as the primary predictor variable. Questions, such as "Someone objectified me based on my physical features as a Black woman," are measured on a 5-point scale: 1 = *None*, 2 = *Less than once a year*, 3 = *A times a year*, 3 = *About once a month*, 4 = *A few times a month*, and 5 = *Once a week or more*. Higher scores are indicative of perceiving more experiences of GRM. For both, Stress Appraisal (GRMA) and Frequency (GRMF) of Assumptions of Beauty and Sexual Objectification subscale, Cronbach's α = .90 indicated a strong reliability for both GRM stress appraisal and GRM frequency.

Ethnic Identity (EI). The Revised Multigroup Ethnic Identity Measure (MEIM-R; Roberts et al., 1999) is a 15-item self-report instrument used to assess an individual's level of ethnic identity based on two subscales, Exploration and Affirmation/Belonging. Twelve-items are measured on a 4-point Likert scale (1 = *Strongly disagree*, 2 = *Disagree*, 3 = *Agree*, 4 = *Strongly agree*). Items included statement such as, "*I think a lot about how my life will be affected by my ethnic group membership*" and "*I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs*." Three items are used for identification such as "My ethnicity is?" and "My father's ethnicity is?" Higher scores on MEIM-R indicate strong ethnic identity. Higher scores on subscales indicate either a stronger connection with ethnic identity search or affirmation, belonging, and commitment. Of note, low scores of EIE indicates high EI and is associated with positive well-being. Based on previous research, this study used the Exploration (EIE) subscale as moderator. The MEIM exploration subscale had moderately high reliability, Cronbach's α = .74.

Self-Concept (SC). The Contingencies of Self-Worth Scale (CSWS; Crocker, Luhtanen, Cooper, & Bouvrette, 2003) is a 35-item self-report instrument used to assess seven subscales of self-esteem in college students: Others' Approval, Appearance, Competition, Academics, Family Support, Virtue, and God's Love. Responses to each item are measured on a 7-point Likert scale (1 = *Strongly Disagree* to 7 = *Strongly Agree*, with 4 = *Neutral*). Items included statements such as, "My self-esteem depends on the opinions others hold of me." and "My sense of self-worth suffers whenever I think I don't look good." Higher scores on subscales indicate self-worth not being contingent on one's appearance or stronger self-worth/self-concept. For the purposes of controlling for co-variates and operationalizing self-concept, this study used the Appearance (SCA) subscale as a moderated moderator. The use of appearance subscale is appropriate as it accurately measures self-concept (i.e., an image or perception of oneself) as defined by Harter (1988). Based on Cronbach's alpha coefficient, there was an acceptable reliability of the CSWS subscale appearance, Cronbach's $\alpha = .68$.

Demographic Characteristics. Information was collected on a variety of demographics variables including race/ethnicity, gender, age, sexual orientation, academic level, hometown, relationship status, and sexual debut. For the purposes of this study, sexual debut and age were the only demographics variables used in final data analysis. The other variables were used to determine study eligibility.

Body Appreciation. Body appreciation was measured using the Body Appreciation Scale (BAS; Avalos, Tylka, & Wood-Barcalow, 2005). Thirteen items are measured on a 5-point Likert scale ranging from 1 (i.e., never) to 5 (i.e., always) to assess the level of body appreciation. Participants choose a number that closely represented their level of agreement on questions regarding their body (e.g., "Despite its flaws, I accept my body for what it is."). Higher

scores indicate higher body appreciation. For the purposes of this study, BAS was used as a control variable. The total BAS had high reliability, Cronbach's $\alpha = .90$.

Procedure

SONA and Community Sample. Either through advertisement or SONA website (a web-based program the psychology department uses to manage recruitment, signup, credit management, and on-line surveys), participants were directed to Qualtrics where they had access to the pre-screening and full study survey. Here, participants had access to view the pre-screen consent form. If they indicated consent, they were directed to complete a pre-screening survey to assess if they met the inclusion criteria. If participants did not meet the criteria, they were thanked for their time and told they were not eligible to participate in the study. Participants did not receive compensation for completing the pre-screen survey.

If they met the inclusion criteria, they were directed to a full description of the study and informed consent. To ensure confidentiality, participants did not provide any identifiable information in Qualtrics such as, but not limited to, name, email address, and social security number. Each participant was identified by a unique Study ID. After indicating consent, participants began the online survey. Participants in these two samples either received 1.5 SONA credit or were entered into a drawing for a chance to win one of four VISA gift cards (community sample). Of note, community sample consist of participants who were recruited from social media, Craigslist, hair salons, and/or churches.

mTurk sample. Through mTurk (an online recruitment tool powered by Amazon where participants complete a wide variety of surveys and questionnaires), participants were directed to Qualtrics where they had access to the pre-screening and full study survey. Here, participants had access to view the pre-screen consent form. If they indicated consent, they were directed to a pre-

screening survey to assess if they met the inclusion criteria. If participants did not meet the criteria, they were thanked for their time and told they did not eligible to participate in the study. Participants received $0.25 for completing the pre-screen survey.

If they met the inclusion criteria, they were directed to a full description of the study and informed consent. To ensure confidentiality, participants did not provide any identifiable information in Qualtrics such as, but not limited to, name, email address, and social security number. Each participant was identified by a unique Study ID. After indicating consent, participants began the online survey. The questionnaire consisted of six main sections. The six main sections are demographics, sexual history (i.e., behaviors), body appreciation, GRM experiences, ethnic identity, and self-concept. As mentioned previously, participants were asked to complete a series of surveys to assess their stress appraisal of experiences of GRM (for assumption of objectification and beauty), sexual behavior, and level of body appreciation, ethnic identity, and self-concept. Finally, participants were debriefed and compensated for their participation. Participants received $1.25 disbursed into their mTurk Worker account.

Data Analytic Plan

SPSS 24 and SPSS 24 with PROCESS macro v2 16.3 (Hayes, 2013) were used for all analyses. Preliminary analyses were conducted to screen data for outliers and violations of assumptions of multiple regressions including linearity, normality, and homogeneity of variance. Descriptive analyses (i.e., mean and standard deviations) were computed to describe the sample. Next, bivariate correlational and hierarchical linear regression analyses were computed, using SPSS, to examine associations among variables and to test study hypotheses. Lastly using SPSS 24 with PROCESS macro v2 16.3, moderation and moderated moderation analyses were

computed to test study hypotheses. Of note, in all analyses, independent variables and interaction terms were centered.

Results

Descriptive Statistics

for assumptions of normality, linearity, and homoscedasticity were performed. Skewness and Kurtosis for predictor variables, moderator variable, and control variables were between -1 and 1 meaning normality was close to 0 and are considered acceptable. Therefore, assumptions of normality were met for all predictor, moderator, and control variables. Also, assumptions of linearity and homoscedasticity were met. Of note, sample size for condom use outcome variable is relatively lower compared to lifetime sexual partner outcome variable due to participants omitted to answer the questions used to assess condom use in the past two months.

Descriptive statistics for the primary variables of interest are presented in Table 1. Based on their sexual activity in the past two months, 48.6% of the sample reported a ratio of condom use to number of times having vaginal intercourse less than 50/50 ratio. About 36.9% of the sample reported having two or more sexual partners in the past 2 months. Additionally, 32.2% of the sample reported a 50% or lower probability of using a condom next time they have sex. More than half of the sample tested negative for an STI or HIV in their lifetime (60.7% and 75.2%, respectively), with 19.3% and 24.1% (respectively) never being tested.

The mean on gendered racial microaggressions (stress appraisal) scale was 3.43 (*SD* = 1.68), with a range from 1 to 7, with higher score indicating higher stress related to experiencing beauty/sexual objectifications. Additionally, the mean on gendered racial microaggressions (frequency) scale was 3.03 (*SD*=1.27), with a range of 1 to 6, with higher scores indicating higher frequency of experiencing beauty/sexual objectifications. Participants reported a mean of

1.83 (*SD* = 0.50) on the Revised Multigroup Ethnic Identity Measure for exploration, with a range from 1-3.17, with higher score indicating stronger connection with ethnic identity search. Lastly, participants reported a mean of 4.84 (*SD*=1.07) on the Contingencies of Self-Worth scale (appearance subscale), with a range from 1-7, with higher scores indicating self-worth being contingent on physical appearance (which indicates low self-concept).

Table 1.
Descriptive statistics

Variable	*N*	*M*	*SD*	*Observed Range*
Condom Use	109	.50	.45	(0-1)
Lifetime Sexual Partners	146	1.44	.63	(1-3)
GRM: Appraisal (GRMA)	127	2.25	1.63	(0-5)
GRM: Frequency (GRMF)	142	2.03	1.27	(0-5)
MEIM: Exploration (EIE)	146	1.83	.50	(1-3.17)
Self-Concept: Appearance (SCA)	146	3.16	1.07	(1-6)
Body Appreciation (BAS)	145	3.84	.70	(2-5)
Sexual Debut	144	16.81	1.57	(13-23)
Age	145	19.03	1.58	(18-24)

Correlational analyses were conducted to see if there were any potential covariates and if any variables of interest were highly correlated (see Table 2). Results from the correlational analyses revealed that EIE was significantly and positively correlated with number of lifetime partners [r (146) = 0.19, p<.05]. Those with lower levels of EIE were more likely to have fewer sexual partners in their lifetime compared to those with higher levels of EIE. Lower scores of EIE indicates high ethnic identity and is negatively associated with well-being outcomes. Correlational analyses also revealed that BAS was not correlated with condom use and lifetime sexual partners [r (108) = -0.61, p=.53; r (145) = -0.42, p=.62, respectively]. However, scholars have found that BAS is correlated with condom use among participants with more than one sexual partner (Winter & Satinsky, 2014). BAS was negatively correlated with GRMA and

positively correlated with SCA [r (126) = -3.91, p=.00; r (145) = 3.10, p=.00, respectively]. Those with high BAS reported less stress-related to experiencing GRM and higher self-concept.

Given the disproportionate rates of early sexual debut among Black adolescents the relationship between sexual debut and sexual behaviors among Black emerging adult women was examined. Correlational analyses revealed that sexual debut was significantly and negatively correlated with number of lifetime sexual partners [r (144) = -0.40, p<.01]. Individuals with an earlier sexual debut reported greater number of sexual partners in their lifetime. Age was significantly correlated with both condom use in the past two months and number of lifetime partners [r (109) = -0.20, p<.01; r (145) = 0.31, p<.01, respectively]. Older participants were more likely to report lower condom use in the past two months and having a greater number of sexual partners in their lifetime. Therefore, BAS, sexual debut, and age were included in final analyses as covariates.

Table 2.
Study variables' means, standard deviations, and bivariate correlations

	Condom Use	Lifetime Sexual Partners	GRM: Appraisal	MEIM: Exploration	SW: Appearance	Body Appreciation	Sexual Debut	Age
Condom Use	1	-.18	-.12	.00	-.06	-.06	.16	-.20*
Lifetime Sexual Partners		1	-.07	.19*	-.08	-.04	-.40**	.31**
GRM: Appraisal			1	-.24**	-.30**	-.39**	.20*	.09
MEIM: Exploration				1	-.01	.03	-.03	.12
Self-Worth: Appearance					1	.31**	.10	-.07
Body Appreciation						1	-.058	-.086
Sexual Debut							1	.260**
Age								1

*p < .05; **p < .01

Test of Main Hypotheses for Condom Use in the Past Two Months

The purpose of the current study was to test whether EIE influence on the relationship between GRMA and condom use in the past two months is conditionally based on the level of SCA, after controlling for BAS, sexual debut, and age. GRMA scores were regressed onto condom use, the interaction between GRMA and EIE, the interaction between GRMA and SCA, the interaction between EIE and SCA, and the interaction between GRMA, EIE, and SCA. Hypothesis 1 investigated how well GRMA predicts condom use, after controlling for BAS, sexual debut, and age, by computing a hierarchical linear regression. When BAS, sexual debut, and age was entered, they significantly predicted condom use, $F(3, 91) = 5.46$, $p < .01$, $R^2 = .153$. As indicated by R^2, 15.3% of the variance in condom use could be predicted by knowing the participant's BAS, sexual debut, and age. When GRMA was added into the model, it marginally improved the prediction, $\Delta R^2 = .035$, $\Delta F(1, 90) = 3.82$, $p = .054$; contributing 3.5% of additional variance in condom use, beyond the variance accounted for by BAS, sexual debut, and age. Although hypothesis 1 was not fully supported, there was marginal support

To investigate how well EIE predicts condom use after controlling for BAS, sexual debut, and age, a hierarchical linear regression was computed to test hypothesis 2. When BAS, sexual debut, and age was entered, it significantly predicted condom use, $F(3, 104) = 3.62$, $p < .05$, $R^2 = .095$. As indicated by R^2, 9.5% of the variance in condom use could be predicted by knowing the participant's BAS, sexual debut, and age. When EIE was added into the model, it did not significantly improve the prediction, $\Delta R^2 = .002$, $\Delta F(1, 103) = .072$, $p = .789$. Hypothesis 2 was not supported.

Hypothesis 3 examined how well SCA predicts condom use. Therefore, a hierarchical linear regression was performed to test how well SCA predicts condom use after controlling for

BAS, sexual debut, and age. When BAS, sexual debut, and age was entered, it significantly predicted condom use, $F(3, 104) = 3.62$, $p < .01$, $R^2 = .095$. As indicated by R^2, 9.5% of the variance in condom use could be predicted by knowing the participant's BAS, sexual debut, and age. When SCA was added into the model, it did not significantly improve the prediction, $\Delta R^2 = .00$, $\Delta F(1, 103) = .061$, $p = .805$. Based on these results, hypothesis 3 was not supported.

Hypothesis 4 predicted that EIE would moderate the relationship between GRMA and condom use, after controlling for BAS, sexual debut, and age. In other words, those with low EIE would report a higher frequency of condom use when GRMA is high. Findings yielded that EIE did not significantly moderate the relationship between GRMA and condom use in the past two months among Black women in the sample, $b = -.10$, $SE = .06$, $p = .14$. Hypothesis 5 predicted that SCA would moderate the relationship between EIE and condom use in the past two months. That is, those with high SCA would report a higher frequency of condom use in the past two months when EIE is low. Analysis revealed that SCA did not moderate the relationship between EIE and condom use in the past two months among Black women in the sample, $b = .07$, $SE = .10$, $p = .47$. Thus, hypothesis 4 and 5 was not supported (see Table 3).

Hypothesis 6 predicted that EIE influence on the relationship between GRMA and condom use in the past two months is conditionally based on the level of SCA. That is, after controlling for BAS, sexual debut, and age, higher GRMA would be associated with higher frequency of condom use in the past two months, when EIE is low and SCA is high, among Black women in the sample. The model was significant [$F(10, 94) = 11.38$, $p < .01$] and explained 27% of the variance in condom use scores. However, moderated moderation analysis was not statistically significant, $b = -.09$, $t(84) = -1.44$, $p = .15$; meaning, there is no evidence of a three-way interaction between condom use and GRMA at varying levels of EIE and SCA. In

other words, the relationship between GRMA and condom use in the past two months is not conditionally based on one's level of EIE and SCA.

Table 3.

Moderated moderation analysis predicting condom use from GRMA, EI exploration, and SC appearance

	b [95%*CI*]	*SE*	*t*	*p*
Constant	1.22 [-.02, 2.27]	.58	1.95	.05
GRM: Appraisal	-.07 [-.14, -.00]	.03	-2.10	.04*
EI: Exploration	-.02 [-.22, .17]	.10	-.25	.80
SC: Appearance	-.06 [-.16, .03]	.05	-1.39	.17
GRMA x EI Exploration	-.10 [-.22, .03]	.06	-1.49	.14
GRMA x SC Appearance	.09 [.03, .15]	.03	3.17	.00*
EI Exploration x SC Appearance	.07 [-.13, .27]	.10	.73	.47
GRMA x EI Exploration x SC Appearance	-.09 [-.21, .03]	.06	-1.44	.15

R^2= .27 (p<.01)

*p < .05; **p < .01

However, findings did reveal that SCA moderated the relationship between GRMA and condom use in the past two months, b= .09, SE= .03, p= .00 (see Table 3), after controlling for BAS, sexual debut, and age. Further inspection of the relationship between GRMA and condom use indicates a significant moderating effect of SCA. As shown in Figure 2, when SCA is high, condom use is significantly higher among those who experience low GRMA compared to those who experience high GRMA. When SCA is low, condom use consistency does not significantly differ among those experience high GRMA compared to those who experience low GRMA.

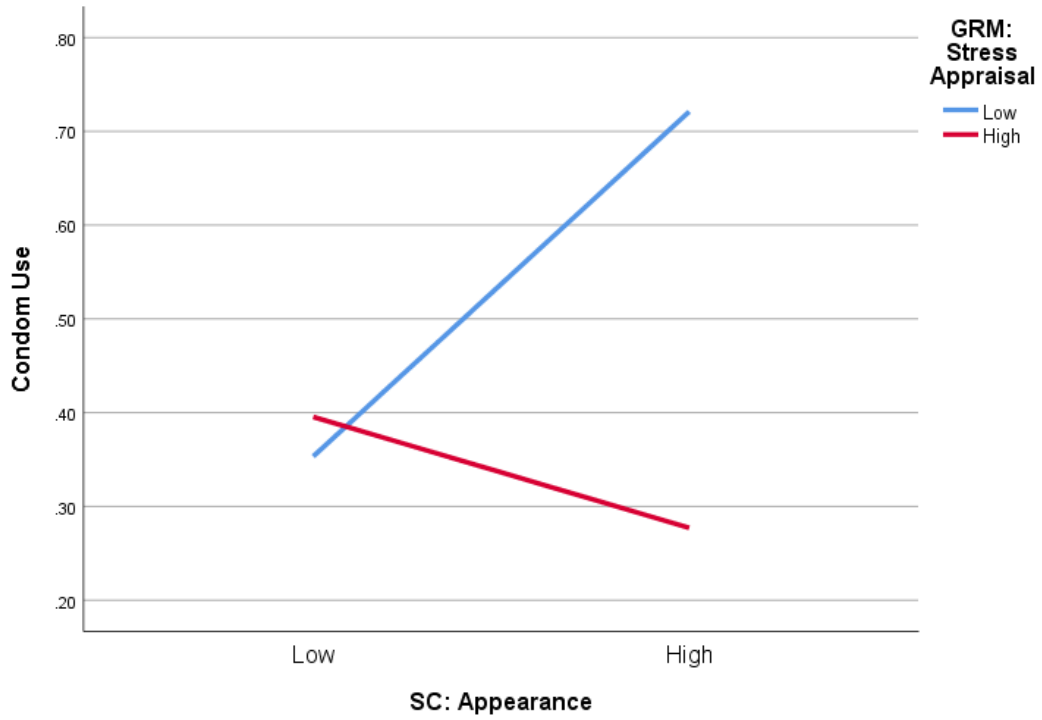

Figure 2. Simple slopes equations of the regression of condom use on GRMA at two levels of SCA.

Test of Main Hypotheses for Number of Lifetime Sexual Partners

The purpose of the current study was to test whether EIE influence on the relationship between GRMA and number of lifetime sexual partners is conditionally based on the level of SCA, after controlling for BAS, sexual debut, and age. GRMA scores were regressed onto Lifetime sexual partner, the interaction between GRMA and EIE, the interaction between GRMA and SCA, the interaction between EIE and SCA, and the interaction between GRMA, EIE, and SCA. Hypothesis 1 sought out to investigate how well GRMA predicts lifetime sexual partners, after controlling for BAS, sexual debut, and age, by computing a hierarchical linear regression. When BAS, age and sexual debut was entered, it significantly predicted lifetime sexual partners, $F(3, 120) = 25.23$, $p < .01$, $R^2 = .361$. As indicated by R^2, 36.1% of the variance in lifetime sexual partners could be predicted by knowing the participant's BAS, sexual debut, and age.

When GRMA was added into the model, it did not significantly improve the prediction, ΔR^2 = .001, $\Delta F(1, 119) = .232$, $p = .631$. Based on these results, hypothesis 1 was not supported; meaning, there is no evidence to infer that the addition of GRMA accounts for incremental variance in number of lifetime sexual partners, even after controlling for BAS, sexual debut, and age.

To investigate how well EIE predicts number lifetime sexual partners after controlling for BAS, sexual debut, and age, a hierarchical linear regression was computed to test hypothesis 2. When BAS, sexual debut, and age was entered, it significantly predicted lifetime sexual partners, $F(3, 138) = 25.23$, $p < .001$, $R^2 = .355$. As indicated by R^2, 35.5% of the variance in lifetime sexual partners could be predicted by knowing the participant's BAS, sexual debut, and age. When EIE was added into the model, it marginally improved the prediction, $\Delta R^2 = .016$, $\Delta F(1, 137) = 3.55$, $p = .06$; contributing 1.6% of additional variance in lifetime sexual partners if we include EIE, beyond the variance accounted for by BAS, sexual debut, and age. Based on these results, hypothesis 2 was not supported; however, there is marginal evidence to infer that the addition of EIE accounts for incremental variance in lifetime sexual partners, even after controlling for BAS, sexual debut, and age.

Hypothesis 3 stated that SCA predicts number of lifetime sexual partners. Therefore, a hierarchical linear regression was performed to test how well SCA predict number of lifetime sexual partners after controlling for BAS, sexual debut, and age. When BAS, sexual debut, and age was entered, it significantly predicted lifetime sexual partners, $F(3, 138) = 25.23$, $p < .01$, $R^2 = .354$. As indicated by R^2, 35.4% of the variance in lifetime sexual partners could be predicted by knowing the participant's BAS, sexual debut, and age. When SCA was added into the model, it did not significantly improve the prediction, $\Delta R^2 = .001$, $\Delta F(1, 137) = .177$, $p = .674$. Based on

these results, hypothesis 3 was not supported; meaning, there is no evidence to infer that the addition of SCA accounts for incremental variance in lifetime sexual partners, even after controlling for BAS, sexual debut, and age.

Hypothesis 4 predicted that EIE moderates the relationship between GRMA and lifetime partners (see Table 4). Findings yielded that EIE did not significantly moderate the relationship between GRMA and number of lifetime sexual partners among Black women in the sample months, b= .11, SE= .07, p= .15, after controlling for BAS, sexual debut, and age. Therefore, hypothesis 4 is not supported. Hypothesis 5 predicted that SCA would moderate the relationship between EIE and lifetime partners, meaning, when SCA is high, fewer sexual partners in their lifetime will be reported among those with low EIE. Analysis revealed that SCA moderated the relationship between EIE and number of lifetime sexual partners among Black women in the sample, b= -.23, SE= .09, p= .01, after controlling for BAS, sexual debut, and age. Therefore, hypothesis 5 is supported (see Figure 3). Further inspection of the relationship between EIE and number of lifetime sexual partners indicates a significant moderating effect of SCA. As shown in Figure 2, when SCA is high, number of lifetime sexual partners is significantly lower among those with low EIE compared to those with high EIE. However, when SCA is low, there are no significant differences in number of lifetime sexual partners among those with high EIE compared to those with low EIE.

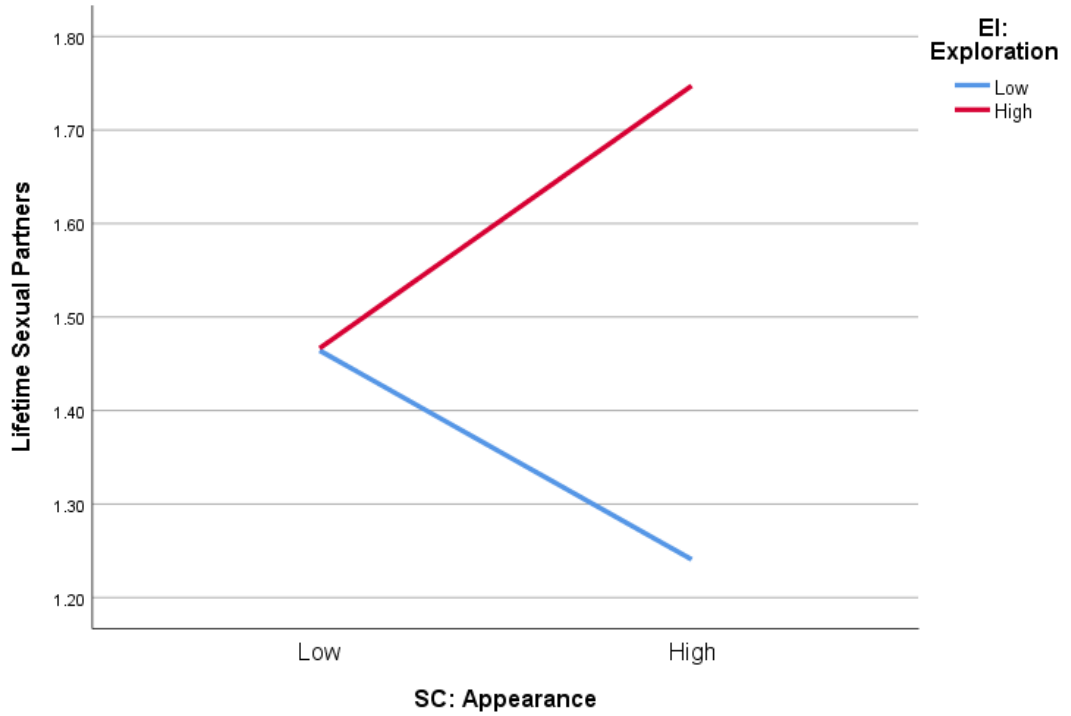

Figure 3. Simple slopes equations of the regression of lifetime sexual partners on EIE at two levels of SCA.

Hypothesis 6 predicted that EIE influence on the relationship between GRMA and number of lifetime sexual partners is conditionally based on the level of SCA. That is, higher GRMA will be associated with fewer number of lifetime sexual partners, when EIE is low and SCA is high among Black women in the sample. The model was significant [R^2 = .45, F(10, 113) = 9.10, p < .01] and explained 45% of the variance in number of lifetime partners. The moderated moderation analysis (see Table 4) was statistically significant, b= - .15, t(113)= -2.36, p= .02; meaning, there is evidence of a three-way interaction between the lifetime sexual partners and GRMA among EIE and SCA. In other words, the magnitude of the moderating effect of EIE on the relationship between GRMA and lifetime sexual partners depends on one's level of SCA. Therefore, hypothesis 6 was supported; and the three-way interaction explained an additional 2.7% of variance in the relationship, ΔR^2= 0.027, F(1, 113)= 5.57, p<.05.

Further inspection (see Figure 4) of the conditional relationship between GRMA and number of lifetime sexual partners indicated a significant moderating effect of EIE and SCA. Such that, there is a significant difference in number of sexual partners based on one's level of SCA. That is, when SCA is low, there is no evidence to support the relationship between GRMA and lifetime sexual partners is moderated by EIE (b = -.05, 95% CI [-.24, .14], t = -.53, p = .59). However, findings did reveal that when SCA is high, the relationship between GRMA and lifetime sexual partners is moderated by EIE (b = .27, 95% CI [.06, .47], t = 2.59, p = .01). More specifically, when SCA is high and GRMA is high, number of lifetime sexual partners is significantly lower among those with low EIE compared to those with high EIE. Conversely, when SCA is high and GRMA is low, there are no significant difference in number of lifetime sexual partners based on one's level of EIE.

Table 4.

Moderated moderation analysis predicting lifetime sexual partners from GRMA, EI exploration, and SC appearance

	b [95%*CI*]	*SE*	*t*	*p*
Constant	2.65 [.64, 4.66]	1.02	2.61	.01
GRM: Appraisal	.01 [-.07, -.09]	.04	.32	.75
EI: Exploration	.25 [.03, .46]	.11	2.24	.03*
SC: Appearance	-.01 [-.14, .11]	.06	-.22	.83
GRMA x EI Exploration	.11 [-.04, .25]	.07	1.46	.15
GRMA x SC Appearance	-.05 [-.14, .04]	.04	-1.09	.28
EI Exploration x SC Appearance	-.23 [-.41, -.06]	.09	-2.60	.01*
GRMA x EI Exploration x SC Appearance	-.15 [-.28, -.02]	.06	-2.36	.02*

R^2= .45 (p<.01)

*p < .05; **p < .01

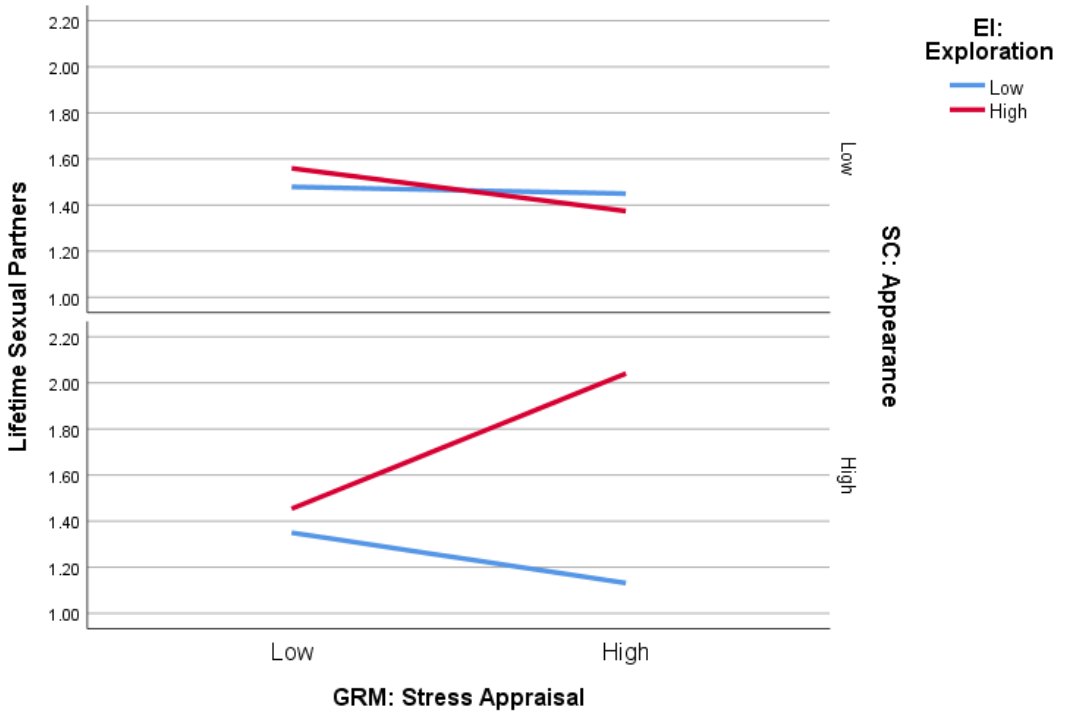

Figure 4. Simple slopes equations of the regression of lifetime sexual partners on GRMA at two levels of EI exploration by two levels of SC appearance.

Discussion

Guided by intersectionality theory, this study explored the GRM-sexual behavior relationship based on being a Black woman. While previous research has examined the impact racial or gender microaggressions has on Black women's sexual attitudes, self-concept, behavior control, and psychological distress (Donovan et al., 2012; Duvall et al., 2013; Nadal et al., 2014), little to no research has examined the impact of microaggressions, based on both gender and race (i.e., GRM), have on Black women's sexual behaviors or the combined impact ethnic identity (i.e., exploration) and self-concept (i.e., self-esteem, self-worth) have on the GRM-sexual behavior relationship. Therefore, this study's purpose was to determine if ethnic identity exploration (EIE) influence on the relationship between stress-related to gendered racial microaggressions (GRMA) and sexual behavior (i.e., condom use in the past two months, number of lifetime sexual partners) is conditionally based on the level of self-concept appearance

(SCA). More specifically, the study investigated if higher GRMA will be associated with higher frequency of condom use in the past two months and fewer sexual partners in their lifetime, when EIE is low and SCA is high, among Black women in the sample. Moderated moderation analyses revealed findings were statistically significant for number of lifetime sexual partners as an outcome variable but not for condom use as an outcome variable, among Black emerging adult women in the sample.

Hypothesis 1-3: GRMA, EIE, SCA, and Sexual Behaviors

The first hypothesis predicted that higher GRMA would be associated with lower frequency of condom use in the past two months and greater number sexual partners in their lifetime among Black women in the sample. Given the lack of research examining the relationship between GRM and sexual behaviors, among Black women, this hypothesis explored this relationship and builds on the works that examine racial microaggressions and gender microaggressions' impact on Black women's sexual health (Donovan et al., 2012; Wong et al., 2014). While hypothesis 1 is not fully supported for both outcome variables, there was marginal evidence to support the argument that higher stress related to GRM experiences is associated with less frequent use of condoms in the past two months. The lack of statistical significance, at $\alpha = .05$ level, may be due to small sample size and low power. With respect to GRMA and lifetime sexual partner finding, one potential reason for the lack of significant is due to majority of the sample reported having between 1-3 lifetime sexual partners. That is, the measure used to assess number of lifetime sexual partners were forced choice which resulted in less sensitivity and accounted for little variability within the sample. The study should be replicated using a lifetime partner item that allows women to enter the number of sexual partners rather than

choosing a restricted range response the in order to determine the magnitude of protection or risk GRMA, as well as EIE and SCA, have on lifetime sexual partners.

The second hypothesis concerned the relation between EIE and sexual behaviors (i.e., condom use in the past two months; number of lifetime sexual partners) among Black women. A substantial body of work in ethnic identity literature found that strong ethnic identity facilitates positive sexual behaviors (Beadnell et al., 2003; Belgrave et al., 2000; Townsend et al., 2010). Research found that higher ethnic identity affirmation was associated with greater condom use (Corneille et al., 2012). Notably, majority of the research examining ethnic identity focused primarily on affirmation/belongingness. To add to the literature on ethnic identity and sexual health, hypothesis two sought to explore ethnic identity exploration (EIE). Exploration is an important part of identity formation as this is the period where individuals learn more about their ethnic group. Hypothesis two predicted that lower EIE would be associated with higher frequency of condom use in the past two months and fewer sexual partners in their lifetime. Hypothesis 2 was marginally supported for number of lifetime sexual partners; however, it was not supported for condom use in the past two months. There is marginal support to suggest that Black women who explored of their ethnic group less were more likely to report fewer sexual partners in their lifetime. This may be due in part to a lower dissonance with one's ethnic group which in turn serves as a protection against maladaptive behaviors. These findings are loosely consistent to Belgrave and colleagues (2000) who suggested that low ethnic identity affirmation may result in high dissonance which could trigger negative sexual attitudes. Therefore, previous research and hypothesis two's findings suggest that the role of ethnic identity on Black women's sexual behaviors depends on individual's level of exploration, affirmation, or overall ethnic identity – with low exploration serving as a protective factor for sexual risk behaviors.

Furthermore, the marginal findings are loosely supported by Syed and colleagues (2013) who found that low MEIM exploration (referred to as low EIE in the present study) was associated with greater self-esteem, eudaimonic well-being, subjective well-being, and satisfaction with life. It is suggestive that this is due to individuals with low EIE having lower general identity confusion. Thus, it is important to explore ethnic identity exploration, as low levels of EIE serve as a protective factor against maladaptive behaviors.

The third hypothesis examined the relation between SCA and sexual behaviors among Black emerging adult women. Scholars have found that some of the constructs of self-concept; more specifically, self-esteem is associated with sexual debut, number of sexual partners, condom use, and STD status (Gardner, Frank, & Amankwaa, 1998; Kowaleski-Jones & Mott, 1998; MacDonald & Martineau, 2002; Salazar et al., 2005). Based on previous research, hypothesis 3 predicted high self-concept would be associated with higher frequency of condom use in the past two months and fewer sexual partners in their lifetime among Black women in the sample. Interestingly, hypothesis 3 was not supported for both condom use and lifetime sexual partners. One potential reason for the non-statistically significant findings and inconsistency with previous literature is the measure used to operationalize self-concept. The scale used to assess self-concept in this study, was designed to assess overall self-esteem in college (i.e., CSWS); even though it has a subscale that measures the main component of self-concept (i.e., appearance subscale.). As aforementioned, Harter (1988) suggested, self-concept and self-esteem are two different constructs – self-esteem is based on the values or judgements one has of oneself. Therefore, this measure may not have been sensitive enough to detect self-concept given the measure was designed to assess self-esteem in college.

Hypotheses 4-5: Moderated Effect of EIE and SCA

Moderation analyses of the fourth hypothesis involved examining the moderating effect of EIE on the GRMA and sexual behavior (i.e., condom use, lifetime sexual partners) relationship. Hypothesis four predicted that Black women in the sample with low ethnic identity exploration would report a higher frequency of condom use in the past two months and fewer sexual partners in their lifetime when their stress associated with experiencing GRM is high. It was found that the effects of Black emerging adult women's stress associated with GRM experiences on their condom use and number sexual partners in their lifetime does not change across different levels (or stages) of them exploring (or searching) their ethnic group. Therefore, hypothesis four was not supported. The lack of moderating effect of EIE on the GRMA-sexual behavior relationship may be due to low variability among participants EIE scores and low statistical power of the overall study.

Moderation analyses were performed to test hypothesis five. The fifth hypothesis examined the moderating effect of SCA on the EIE and sexual behavior (i.e., condom use in the past two months, lifetime sexual partners) relationship. Hypothesis five was supported for lifetime sexual partners but was not supported for condom use. That is, the effects of Black women exploring their ethnic group on the number of sexual partners in their lifetime changes across different levels of one's self-concept. Hence, when self-concept is high, number of lifetime sexual partners was significantly lower among Black women in the sample with low EIE compared to those with high EIE. These findings are consistent with previous literature as scholars have extensively studied the significant relationship between self-esteem and ethnic identity and their relationship with sexual risk behaviors among Black women (Carlson, Uppal, & Prosser, 2000; E. P. Smith, Walker, Fields, Brookins, & Seay, 1999; Turnage, 1999). More

specifically, interventions, such as Sisters Informing Sisters about Topics on AIDS (SISTA), have demonstrated how adding components of both self-esteem and ethnic identity is instrumental in the reduction of sexual risk behaviors. (i.e., increase in condom use).

Additional analyses revealed that SCA moderates the relationship between GRMA and condom use in the past two months among Black women in the sample, after controlling for BAS, age, and sexual debut. More specifically, findings yielded that when GRMA stress appraisal is low, condom use was higher for Black women who reported higher self-concept than for those who reported lower self-concept. Regardless of self-concept, those who have high GRMA are less likely to use condoms. This provides evidence that more research is needed to further explore the impact self-concept has on the GRMA and condom use relationship by examining potential moderators, mediators, and control variables. Additionally, while not significant, a trend emerged, in the analysis, reflecting that Black women display high self-concept, they tend to use condoms less frequently due to high stress they experience after a GRM event. This trend provides marginal support that self-concept alone is not entirely protective against unsafe safe sex practices (i.e., condom use), with respect to Black emerging adult women who endorse high stress appraisal associated with experiencing a GRM. Overall, the unexpected findings will better inform future research in this area and assist with revising the current study' hypotheses and research questions tailored toward Black emerging adult women's condom use. Therefore, we should continue to explore the impact different levels of self-concept have on condom use when the stress Black women experience as a direct result of a GRM event.

Though the moderated effect of SCA was statistically significant for lifetime sexual partners, the impact of self-concept on ethnic identity exploration and condom use frequency was not supported by the findings. Although scholars and interventionists have demonstrated the

importance of self-concept and ethnic identity, as core components of HIV intervention, in increasing sexual protective behaviors (DiClemente & Wingood, 1995; Dixon, Schoonmaker, & Philliber, 2000; Salazar et al., 2004), the current study's findings revealed there was no evidence to support that SCA moderated the relationship between EIE and condom use, after controlling for BAS, sexual debut, and age. The relatively small sample size may have contributed to these non-statistically significant findings and low statistical power as previous research has demonstrated a relationship between self-concept and refusal of unprotected sex among African American females (Salazar et al., 2004).

Hypothesis 6: Moderated Moderation Analyses

Moderated moderation analyses were performed to test the study's primary hypothesis. Hypothesis six explored if EIE influence on the relationship between GRMA and sexual behavior (i.e., condom use in the past two months, number of lifetime sexual partners) is conditionally based on SCA effect on the relationship between EIE and sexual behavior. The sixth hypothesis was supported for lifetime sexual partner, but not support for condom use. That is, there was no evidence to suggest a three-way interaction between condom use in the past two months and GRMA among EIE and SCA. The lack of significance may be due to low power coupled with the relatively small sample size (N=95) and multiple interactions terms entered into the model (GRMA x EIE, GRMA x SCA, EIE x SCA, GRMA x EIE x SCA). Another potential reason for these findings is how the study operationalized condom use. Perhaps, if condom use was assessed by asking about frequency of condom use in current relationship, findings would have been statistically significant. This would have allowed for participants to more accurately endorse their condom use rather than asking about condom use in the last 2 months and number

of times engaging in sexual intercourse in the past two months; which was used to calculate the condom use ratio in the past two months.

As aforementioned, hypothesis 6 is supported for lifetime sexual partners as there is evidence to support a three-way interaction between number of sexual partners in one's lifetime and GRMA among EIE and SCA. In other words, the effect of stress-related to experiencing a GRM on number of lifetime sexual partners changes across different levels of Black women's self-concept and exploration of their ethnic group. Nonetheless, the interaction between exploring one's ethnic group and self-concept is influential in combating the negative effects stress induced as a result of GRM have on Black emerging adult women's sexual behaviors, such as number of lifetime sexual partners. These findings demonstrated that when self-concept is high and high stress appraisal associated with experiencing GRM event is exhibited, number of lifetime sexual partners is significantly lower among Black women who are less active in exploring their ethnic group compared to Black women who are actively exploring (or searching) their ethnic group. However, the moderating effect of exploring your ethnic group on the relationship between stress-related to GRM event and sexual partners in one's lifetime was not significant when Black women reported having lower self-concept. It's important to note that for those with high self-concept, this is where less emphasis on exploring (or searching) one's ethnic group is truly protective in combating the negative effects of stress-induced due to GRM event – lifetime sexual partners. The findings also revealed differences in the impact of stress-related to experiences of GRM have on Black women's sexual behaviors (i.e., lifetime sexual partner). If Black women do not have the protection of higher ethnic identity and positive self-concept when the GRM experience is considered stressful, these experiences are associated with higher numbers of lifetime partners.

Broadly, these findings have implications in that it sheds light on the combined protective nature of exploring one's ethnic group and self-concept on Black women's sexual behaviors as Shorter-Gooden & Washington (1996) suggested that ethnic identity and self-concept are essential for a healthy sense of self. Townsend and colleagues (2010) found that Black women with strong ethnic identity and positive self-concept tend to not endorse negative stereotype based on Black women. Furthermore, scholars have expressed the combined relationship ethnic identity exploration and self-concept have with one another. As previous research has demonstrated, high ethnic identity alone does not protect Black women from engaging in sexual risk behaviors as a direct result of endorsing negative societal stereotypes of Black women (Duvall et al., 2013; Phinney & Ong, 2007; Stephens & Few, 2007; Stephens & Phillips, 2005). Therefore, by having only one of these components (i.e., ethnic identity or self-concept), African Americans can still engage in sexual risk behaviors if they accept negative stereotypes of their ethnic group (Espinosa-Hernández & Lefkowitz, 2009; Stephens & Few, 2007); it is through the interaction between ethnic identity exploration and self-concept where we see behavior change.

Supported by intersectional theory (Collins, 1990), these findings highlight how societal stereotypes and beliefs about Black women based on racist and sexist perceptions of Black womanhood (Stephens & Phillips, 2003; Townsend et al., 2010) and stress related to experiencing GRMs can influence Black women's sexual risk behaviors (i.e., lifetime sexual partners). Based on previous research and the present findings, there is an established connection between oversexualized stereotypes, a subset of gendered racial microaggressions (i.e., assumptions of beauty and sexual objectification), and sexual behaviors. The adverse effects of oversexualized stereotypes (Duvall et al., 2013; Stephens & Phillips, 2003; Townsend et al., 2010) and GRMs result in similar engagement of sexual risk behaviors among Black emerging

adult women. Through an intersectional lens, emerged from these findings was the potential protective nature of the combined effect of ethnic identity and self-concept on high stress related to GRM and its impact on sexual behaviors (i.e., lifetime sexual partners). As separate constructs, ethnic identity exploration and self-concept did not change effects of GRMA on lifetime sexual partners, but ethnic identity exploration & self-concept combined weaken the effects of GRMA on lifetime sexual partners. Collectively, the study hypotheses and findings can better inform future research and HIV interventions. Now, GRM researchers have a basis to build on by further examining the impact GRM has on Black emerging adult women's sexual behavior. Additionally, HIV intervention work can incorporate ethnic identity exploration, self-concept, and GRMA into their program curriculum as it provides knowledge on how different levels of two vital components (i.e., ethnic identity and self-concept) buffer the negative effects stress-related to experiences of GRM have on Black emerging adult women's number of lifetime sexual partners.

Limitations

Despite the contributions the present study makes to the GRM literature, it is important to address the limitations. Therefore, the current study's outcomes should be considered in light of several limitations. The relatively small sample size served as a limitation and may have also contributed to lack of statistical significance in my findings due to low statistical power as a direct result of sample size. Furthermore, majority of the sample residing in the Southern region of the United States; this is due in part to changes in recruitment strategy and utilizing a convenience sample (i.e., large southeastern university's SONA system). As a result, the use of Black emerging adult women residing primarily in the South limits the generalizability of the findings. However, the findings can be applied to Black emerging adult women residing in the

Southern part of the United States. Another limitation is the sample consisted of predominately college students and did not represent a full range of Black women at risk of HIV. Meaning, majority of the sample had some form of college education and access to HIV services and resources. Thus, variability in the sample was limited along the measure of condom use, lifetime sexual partners, and GRM frequency and stress appraisal as a result of sample characteristics.

Another limitation that resulted in limited variability in the sample was due to measure structure. More specifically, the use of a force-choice item to measure lifetime sexual partners resulted in less sensitivity and decrease variability among scores. Thus, to assess the magnitude and increase variability, open-ended questions assessing lifetime sexual partners is highly recommended. Additionally, the reliance on self-report measures for all primary study variables served as another limitation. This may have introduced the concern of response bias as respondents may not have accurately endorsed their self-concept, ethnic identity, and sexual behaviors. More specifically, social desirability biases may have influenced women's responses to questions, regarding sexual behaviors, so they answer questions in a manner that will be viewed favorably by others. Therefore, the use of two measures to assess the primary study variables would have assisted in capturing response bias. Furthermore, the measure used to assess self-concept may not have been sensitive enough to detect self-concept given it was designed to assess self-esteem in college. And as previous researcher, Harter (1988) suggested, self-concept and self-esteem are two different constructs – self-esteem is based on the values or judgements one has of oneself. Collectively, this may have contributed to some non-statistically significant findings

Another limitation in this study was cross-sectional design which limits the determination of cause and effect. I was unable to establish whether Black women who are less active in

exploring their ethnic group also have fewer sexual partners when they report high self-concept and high stress associated with experiencing a gendered racial microaggression event. Therefore, use of a longitudinal study with both college and non-college emerging adult Black women may provide more information as to directionality of associations and if the interaction between ethnicity identity and self-concept serve as a protective factor against the adverse impact of gendered racial microaggressions on sexual risk behaviors. Furthermore, because of the study design, I was unable to determine if the stress related to the experience of the GRM was reflective of how they feel now thinking about the GRM experience(s) or was it reflective of how they felt then. For example, it is possible that the reported stress associated with the GRM is due to stress they are experiencing now recalling the event (or other stress such as academics, social media) and processing what occurred at that point in time. To address this issue, with still employing a cross-sectional design, adding a question within the GRM scale to assess when the GRM experience(s) occurred will assist with capturing more accurate stress appraisal associated with the GRM experience(s). Furthermore, within the scale assess if there are other stressors occurring in the immediate past of the participant and if it is microaggression, discrimination, sexism, or racism related.

Additionally, the use of a cross-sectional study design also introduced the potential of retrospective memory bias through the questions used to assess sexual behaviors. This can be problematic when reporting sexual risk behaviors as participants may not accurately recall how many "one-night stands" they have had throughout their lifetime or how many times they have unprotected sex over the past two months. Participants may be prone to remember sexual encounters instances where desirable behaviors, such as condom use, was performed because of embarrassment or guilt associated with those experiences where condoms were not used (Fenton,

Johnson, McManus, & Erens, 2001; Schroder, Carey, & Vanable, 2003). Of note, numerous studies assess the occurrence of sexual risk behaviors, retrospectively, during the past two months to one's lifetime (Minton, Mittal, Elder, & Carey, 2016; Nesoff, Dunkle, & Lang, 2016; Steiner, Liddon, Swartzendruber, Rasberry, & Sales, 2016) which is the model the current study followed.

To address retrospective memory bias, it is recommended that using a study design almost similar to Grov, Golub, Mustanski, & Parsons (2010) and Mustanski (2007) by utilizing daily diary methods where currently sexually active participants (i.e., at least 3 sexual partners in the past 90 days) report their sexual behaviors only within the last 24 hours for 30 days. However, to reduce the burden of having to record sexual activity via physical diary, the proposed study could utilize EMA and send daily text message to participants to ask about number of sexual encounters, number of sexual partners, and if a condom was used. Another alternative, aside from daily diaries and EMA, would be to assess condom use through a variety of questions – "The last time you had sex did you use a condom?" "In the past 2 months, how many times have you had unprotected vaginal intercourse?" and "In your current relationship, how frequently do you use condoms?" Overall, the use of a daily diary, EMA, and/or multiple questions to assess condom use would assist in accurately capturing condom use and decreasing the impact of retrospective memory bias.

Future Directions

Future research could further explore the influence gendered racial microaggressions (GRM) have on Black adolescent girls' and emerging adult women's sexual health. Lewis and colleagues (2013; 2016; 2017) have extensively studied GRM among Black women, with respect to mental and physical health outcomes. Advancements in this area of research could help

researchers and interventionists pinpoint contextual factors (i.e., GRM) that negatively impact Black girls and women's sexual behaviors, outcomes, and attitudes. Broadly, through understanding the unique experiences of Black women, scholars are able to better inform interventions that promote sexual protective behaviors and prevent sexual risk behaviors within the Black community. Overall, it is important to study GRM's impact on Black women's sexual health will shed light on another contextual factors and system of oppression that may be contributing to the alarming rates of HIV/STI rates in the Black community.

Future researchers should replicate this study using a more representative sample of Black emerging adult women in the United States. This would include having a more variability in geographical region of residence (i.e., South, Mid-West, West, Northeast) among study participants. Also, increasing variability in educational status would assist with generalizability. Furthermore, a replication study would assist with increasing the sample size; thus, increasing statistical power and answering the current studies research questions. With increase sample variability and size as well as increased statistical power, the findings can be generalizable and interrupted with low caution. Such replication would provide greater support for the relationship between GRM and sexual behaviors such as condom use and number of sexual partners in one's lifetime.

Building on the unexpected interaction found between GRMA, SCA, and condom use, researchers should further explore this interaction. Given Black women with high self-concept engaged in safe sex practices (i.e., condom use) at higher rates among those who endorsed lower stress as a result of experiencing a GRM compared to those who reported higher stress appraisal. This interaction sheds light on the impact self-concept have on the relationship between GRM stress and condom use. Furthermore, it is consistent with previous literature examining

stereotypes and self-concept which found that Black girls who reported high self-concept had low sexual intentions if they did not internalize sexual stereotypes of Black women (i.e., Jezebel stereotype; Townsend et al., 2010). Therefore, through further examination of this interaction, researchers can replicate these findings and provide further justification of the findings. Implication of future research, examining the moderating effect of SCA on the relationship between GRM stress and condom use, is it will further explore the protective nature of self-concept on sexual behaviors, with respect to GRMA, and better inform sexual risk reduction programs that addressing oversexualized stereotypes, a subset of GRM.

Future work should also focus on examining how GRM impact sexual attitudes and body appreciation. Understanding how GRM impact more cognitive components of sexual behaviors and outcomes would allow researchers to further understand the impact stress-related to experiences of GRM have on sexual behaviors by way of sexual attitudes and body appreciation. Additionally, researchers should consider exploring the impact the frequency of GRM have on sexual behaviors and attitudes. For instance, while high GRM stress is associated with low condom use in the past two months, it may be due to Black women experiencing GRM more frequently (or not often) that is moderating this relationship. Therefore, future studies should examine the moderating effect of GRMF on the GRMA-condom use relationship.

Lastly, the development of HIV interventions tailored towards addressing GRM is imperative as it will address a contextual factor that impacts sexual risk and protective behaviors. Proposed HIV interventions can model *Media Aware* program, a mobile health HIV intervention with a media literacy component, which has been shown to reduce older adolescents' self-reported sexual risk behaviors; positively affect condom knowledge, attitudes, normative beliefs, and intentions related to sexual health; and increasing media skepticism (Scull, Malik, &

Kupersmidt, 2017). Through adaption, proposed HIV interventions can address the cultural, oversexualized stereotypes and gendered racial microaggressions faced by Black women in the media by increasing participants' understanding of sexual scripts that media tell and their sources. Another intervention incorporated media literacy in a social justice project and found that when students were faced with visual microaggressions such as films, they were able to use learned skills (i.e., educational navigation) to combat its effects (Yosso, 2002). Together this evidence suggests that the inclusion of a media literacy component in HIV intervention programs may be effective in addressing the impact of GRM on sexual risk and protective behaviors. Additionally, as suggested by the findings, proposed interventions should include in their core components aspects of ethnic identity and self-concept similar to *SISTA* curriculum. As it is the combined interaction between ethnic identity and self-concept that assist in reducing sexual risk behaviors and increasing sexual protective behaviors. Overall, culturally-responsive HIV interventions are needed to assist in decreasing the disproportionate rates of HIV among Black emerging adult women as these findings shed light on a contextual factor (i.e., GRM) and protective nature of ethnic identity and self-concept, combined, that is understudied.

Conclusion

Black emerging adult women's sexual health (i.e., behaviors, outcomes) is an issue of grave public health significance. The current study explored if ethnic identity exploration's influence on the relationship between stress-related to experiences of gendered racial microaggressions and sexual behavior (i.e., condom use in the past two months, number of lifetime sexual partners) is conditional on self-concept (i.e., appearance) moderated effect on ethnic identity exploration and sexual behavior. After controlling for body appreciation, sexual debut, and age, the main study hypothesis was supported for number of lifetime partners as an

outcome variable but not for condom use as an outcome variable. Little to no research, to my knowledge, has explored the impact experiences of gendered racial microaggressions have on Black emerging adult women's sexual behaviors. That said, these findings should be further explored as understanding contextual and protective factors that impact sexual behaviors are beneficial to the effectiveness of HIV intervention and efforts to reduce sexual health disparities among Black emerging adult women.

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APPENDIX A: Sexual Behaviors Questionnaire

SEXUAL RISK AND PROTECTIVE BEHAVIORS

1. **In the past 2 months, how many times have you had vaginal intercourse?**

   _____ (# of times in past 2 months)

   _____ I have not had sex in past 2 months.

2. **In the past 2 months, when you had sex how many times was a condom used?**

   _____ (# of times used a condom in past 2 months)

   _____ I have not had sex in past 2 months.

3. **In the past 2 months, how many sexual partners have you** had?

   _____ (# of men in past 2 months)

   _____ I have not had sex with a man in past 2 months.

4. **In the past 2 months, how many times have you had unprotected vaginal intercourse?**

   _____ (# of unprotected sex acts in past 2 months)

   _____ I have not had sex in past 2 months.

5. **The last time you had sex did you use a condom?** YES NO ___I've never had sex.

6. **The next time you have sex do you plan to use a condom?** YES NO

7. **In the next 3 months, do you plan on using a condom if you have sex?** YES NO

8. **In the next 2 months, do you plan on using a female condom?** YES NO

9. In the past 2 months, did you attempt to use the female condom? YES NO

10. In your lifetime, have you ever been tested for HIV? YES NO

11. In the past month, have you been tested for HIV? YES NO

12. Was a condom used during your last sexual encounter? YES NO _____I've never had sex.

13. What is the probability out of 100 that you will use a condom the next time you have sex?
_____

14. How likely are you to use a condom the next time you have sex?

- ○ Very Unlikely
- ○ Unlikely
- ○ Somewhat Unlikely
- ○ Neither Likely Nor Unlikely
- ○ Somewhat Likely
- ○ Likely
- ◉ Very Likely

15. My last sexual encounter was …

SPONTANEOUS PLANNED NO PREVIOUS SEXUAL ENCOUNTERS

16. In your current relationship, how frequently do you use condoms?

a. Always
b. Usually
c. Rarely
d. Never

17. Are you currently in a monogamous relationship? In other words, are you romantically involved with someone to the exclusion of all other romantic interests?

_____Yes

_____No, I am involved with more than one person currently.

_____No, I am not currently involved with anyone.

18. In the past, how likely were you to discuss safe sex practices with your partner before engaging in any type of sexual activity (oral, vaginal, anal, etc.)?

_____ I never discuss safe sex practices with my partner beforehand

_____ I discussed safe sex practices with my partner beforehand less than half the time

_____ I discussed safe sex practices with my partner beforehand about half the time

_____ I discussed safe sex practices with my partner beforehand more than half the time

_____ I always discuss safe sex practices with my partner beforehand

_____ Not applicable

19. How many of your sexual partners have revealed their STI/HIV status to you?

____All of them

____Most of them

____Some of them

____None of them

APPENDIX B: Gendered Racial Microaggressions Scale

Note: Scale used with permission from creator, Dr. Jioni Lewis.

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: Ethnic Identity Scale

MULTIGROUP ETHNIC IDENTITY MEASURE

In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic, Black, Asian-American, Native American, Irish-American, and White. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____
Use the numbers below to indicate how much you agree or disagree with each statement.
(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.
2- I am active in organizations or social groups that include mostly members of my own ethnic group.
3- I have a clear sense of my ethnic background and what it means for me.
4- I think a lot about how my life will be affected by my ethnic group membership.
5- I am happy that I am a member of the group I belong to.
6- I have a strong sense of belonging to my own ethnic group.
7- I understand pretty well what my ethnic group membership means to me.
8- To learn more about my ethnic background, I have often talked to other people about my ethnic group.
9- I have a lot of pride in my ethnic group and its accomplishments.
10- I participate in cultural practices of my own group, such as special food, music, or customs.
11- I feel a strong attachment towards my own ethnic group.
12- I feel good about my cultural or ethnic background.
13- My ethnicity is

(1) Asian or Asian American, including Chinese, Japanese, and others
(2) Black or African American
(3) Hispanic or Latino, including Mexican American, Central American, and others
(4) White, Caucasian, Anglo, European American; not Hispanic
(5) American Indian/Native American
(6) Mixed; Parents are from two different groups
(7) Other (write in): _____

APPENDIX D: Self-Conceptualization Scale

CONTINGENCIES OF SELF-WORTH SCALE

Use the numbers below to indicate how much you agree or disagree with each statement.

(1) Strongly Disagree (2) Disagree (3) Somewhat Disagree (4) Neutral (5) Somewhat Agree (6)Agree (7)Strongly Agree

1. I don't care what other people think of me.*
2. What others think of me has no effect on what I think about myself.*
3. I don't care if other people have a negative opinion about me.*
4. My self-esteem depends on the opinions others hold of me.
5. I can't respect myself if others don't respect me.
6. My self-esteem does not depend on whether or not I feel attractive.*
7. My self-esteem is influenced by how attractive I think my face or facial features are.
8. My sense of self-worth suffers whenever I think I don't look good.
9. My self-esteem is unrelated to how I feel about the way my body looks.*
10. When I think I look attractive, I feel good about myself.
11. Doing better than others gives me a sense of self-respect.
12. Knowing that I am better than others on a task raises my self-esteem.
13. My self-worth is affected by how well I do when I am competing with others.
14. My self-worth is influenced by how well I do on competitive tasks.
15. I feel worthwhile when I perform better than others on a task or skill.

APPENDIX E: Demographics Questionnaire

DEMOGRAPHICS

1. **I am _____ years old**
   - 18
   - 19
   - 20
   - 21
   - 22
   - 23
   - 24

2. **Which best describes your relationship status?**
   - Single and not looking (1)
   - Single and looking (2)
   - Casually dating (3)
   - Committed relationship (4)

3. **Are you currently employed?**
   - Yes (1)
   - No (2)

4. **Are you currently enrolled in a two or four-year university?**
   - Yes (1)
   - No (2)

5. **My university is primarily? (If yes to Q4)**
   - White (1)
   - Black (2)
   - Hispanic/Latino (3)
   - Asian (4)
   - Diverse (e.g., even representation of varies ethnicities/races) (5)
   - Unknown/Not sure (6)
   - Not listed (7), please specify: _____ (7)

6. **How would you characterize your hometown?**
   - Rural (unincorporated) (1)
   - Small town (village or town) (2)
   - Suburban (metropolitan area of a large city) (3)
   - Small city (population < 30,000) (4)
   - Medium-sized city (population 30,000 - 100,000) (5)
   - Large city (population > 100,000) (6)

7. **What region of the United States do you currently reside in?**
   - Northeast Region (i.e., Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York and Pennsylvania) (1)
   - Midwest Region (i.e., Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota) (2)
   - South Region (i.e., Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma and Texas) (3)
   - West Region (i.e., Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, Alaska, California, Hawaii, Oregon and Washington) (4)

8. **Where were you born?**
   - In the United States
   - Outside of the United States. Please specify: _____
   - Not sure

9. **Where was your biological mother born?**
   - In the United States
   - Outside of the United States. Please specify: _____
   - Not sure

10. **Where was your biological father born?**
    - In the United States
    - Outside of the United States. Please specify: _____
    - Not sure

11. **Did your middle or high school offer sex education courses or programs?**
    - Yes (1)
    - No (2)

12. **How old were you when you first had voluntary vaginal sexual intercourse with a man?**
    - Please write in (1) _____

13. **How old was your first voluntary male partner?**
    - Please write in (1) _____

14. **Was your first voluntary vaginal sexual partner a:**
    - Man (1)
    - Transgender (2)
    - Don't know/Don't remember (3)

15. **What was your relationship with your first vaginal sexual partner? Was he:**
    - Boyfriend or steady date (1)
    - A casual acquaintance (2)
    - A friend (3)
    - A relative (4)
    - A stranger (5)
    - Other (Please describe) (6) _____

16. **What kind(s) of sexual activities did you engage in during your first sexual encounter with a male? (Please provide an answer for EACH).**

	Yes (1)	No (2)	Don't Remember (3)
Vaginal sex with a condom (1)	❍	❍	❍
Unprotected anal sex (2)	❍	❍	❍
Anal sex with a condom (3)	❍	❍	❍
Unprotected oral sex performed on you (4)	❍	❍	❍
Oral sex performed on you with a condom or other barrier method (i.e. , plastic wrap) (5)	❍	❍	❍
Unprotected oral sex performed on your male partner (6)	❍	❍	❍
Oral sex performed on your partner with a barrier method (i.e., dental dam, plastic wrap) (7)	❍	❍	❍

17. **The first time you had voluntary sex, did either of you suggest using condoms?**
    - o I did (1)
    - o My partner did (2)
    - o We both did (3)
    - o Neither of us did (4)

18. **Are you currently sexually active?**
    - o Yes (1)
    - o No (2)

19. **Number of Vaginal Sexual Partners Past 6 Months**
    - o 0-1
    - o 2
    - o more than 2

20. **Number of Lifetime Sexual**
    - o 1—3
    - o 4—10
    - o more than 10

21. **Have you ever tested positive for a STI?**
    - o Yes (1)
    - o No (2)
    - o Prefer not to answer (3)
    - o Never was tested. (4)

22. Have you ever tested positive for a HIV?

- Yes (1)
- No (2)
- Prefer not to answer (3)
- Never was tested. (4)

23. Have you ever had an unplanned pregnancy?

- Yes (1)
- No (2)
- Prefer not to answer (3)

APPENDIX F: Body Appreciation Scale

BODY APPRECIATION SCALE

Please indicate whether the question is true about you (1) never, (2) seldom, (3) sometimes, (4) often, or (5) always

1. I respect my body.
2. I feel good about my body.
3. On the whole, I am satisfied with my body.
4. Despite its flaws, I accept my body for what it is.
5. I feel that my body has at least some good qualities.
6. I take a positive attitude toward my body.
7. I am attentive to my body's needs.
8. My self-worth is independent of my body shape or weight.
9. I do not focus a lot of energy being concerned with my body shape or weight.
10. My feelings toward my body are positive, for the most part.
11. I engage in healthy behaviors to take care of my body.
12. I do not allow unrealistically thin images of women presented in the media to affect my attitudes toward my body.
13. Despite its imperfections, I still like my body.

APPENDIX G: Informed Consent Forms

RESEARCH SUBJECT INFORMATION AND CONSENT FORM: Non-mTurk Participants

TITLE: Microaggressions, Identity, and Sexual Health

VCU IRB NO: HM20009530

INVESTIGATOR: Chelsie Dunn & Kristina Hood

If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may take time to think about or discuss this study with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this research study is to explore individuals' sexual behaviors and how their identity, self-concept, and personal experiences (such as stereotypes and discrimination) relate to their sexual behaviors.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT
If you decide to be in this research study, you will be asked to consent by selecting "I agree to participate" below.

In this study, you will be asked to complete a series of questionnaires related to identity and self-concept, personal experiences, and sexual health history. You will be asked a number of questions regarding your identity and self-concept, such as ethnicity and self-esteem; and your personal experience in society (such as microaggressions). You will also complete a questionnaire that assess your sexual health history such as behaviors, attitudes, and outcomes.

The survey should take about 30 minutes but no longer than sixty (60) minutes to complete. Please be forewarned that several of the questions are related to sensitive material. Please complete this study in private, as others may be able to view your answers if you are in a public place.

RISKS AND DISCOMFORTS
This study is no greater than minimal risk. Reading and thinking about some of the topics covered in this study may cause people to become uncomfortable or upset. If you experience any adverse effects, we will provide you with a list of emotional and mental health resources to use if you need. We will also provide you with our contact information so you may ask any questions you may have after participation.

BENEFITS TO YOU AND OTHERS
There is no guarantee of direct benefit for participating in this study. Overall, you may feel good knowing you are helping to advance social science, sexual health knowledge, and possible even public health intervention programs.

COMPENSATION FOR PARTICIPATION
You will be entered into a drawing for a chance to win either $100, $200, $300, or $400 VISA Gift Card. You will be entered into the drawing only once. This will occur immediately after participating in this study. The drawing will take place at the conclusion of data collection. Winners will be notified via email or phone; and compensation will be disbursed via certified mail. Of note, completion of the entire survey is needed to receive compensation. No partial compensation will be given.

CONFIDENTIALITY
Potentially identifiable information about you will consist of indirect identifiers such as your regional location, age, race, gender, etc. Data is being collected only for research purposes. Your data will be identified by randomly assigned, unique ID numbers, not names. All data will be stored in password-protected files on locked computers. Access to all data will be limited to study personnel. Of note, we will not tell anyone the answers you give us; however, information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized
officials of the Department of Health and Human Services or other federal regulatory bodies.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Your participation in this study is voluntary. You may decide to not participate in this study. Your decision not to take part will involve no penalty or loss of benefits to which you are otherwise entitled. If you do participate, you may freely withdraw from the study at any time. Additionally, you may skip any question(s) that may make you feel uncomfortable in answering. Your decision to with draw will involve no penalty or loss of benefits to which you are otherwise entitled.

If you leave the study before the completion of the survey, you will not be granted your compensation.

If you decide to withdraw, data collected up to the point of withdrawal will be used for the research analyses.

It can be difficult answering the questions that were included in this study, and your willingness to respond is greatly appreciated. If you feel distressed about anything mentioned in this study, please contact one of the resources listed below:

- National Suicide Prevention Lifeline (1-800-273-8255) http://suicidepreventionlifeline.org
- National Domestic Violence Hotline (1-800-331-8453)
- National STD Hotline (1-800-227-8922)
- National AIDS Hotline (1-800-342-AIDS (2437)
- American Social Health Association (1-800-772-8500

QUESTIONS
If you have any questions, complaints, or concerns about your participation in this research, contact:

Chelsie Dunn, MA, MPH
Virginia Commonwealth University
Department of Psychology
Email: **dunnce@vcu.edu**

Kristina Hood, PhD
Virginia Commonwealth University
Department of Psychology
Email: **hoodkb@vcu.edu**

The researcher/study staff named above is the best person(s) to call for questions about your participation in this study.

If you have any general questions about your rights as a participant in this or any other research, you may contact:

Office of Research
Virginia Commonwealth University
800 East Leigh Street, Suite 3000
P.O. Box 980568
Richmond, VA 23298
Telephone: (804) 827-2157

Contact this number to ask general questions, to obtain information or offer input, and to express concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk with someone else. General information about participation in research studies can also be found at
http://www.research.vcu.edu/human_research/volunteers.htm.

CONSENT
I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. My selection of the first option below says that I am willing to participate in this study.

- **I agree to participate**
- **I do NOT agree to participate**

RESEARCH SUBJECT INFORMATION AND CONSENT FORM: SONA Participants

TITLE: Microaggressions, Identity, and Sexual Health

VCU IRB NO: HM20009530

INVESTIGATOR: Chelsie Dunn & Kristina Hood

If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may take time to think about or discuss this study with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this research study is to explore individuals' sexual behaviors and how their identity, self-concept, and personal experiences (such as stereotypes and discrimination) relate to their sexual behaviors.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT
If you decide to be in this research study, you will be asked to consent by selecting "I agree to participate" below.

In this study, you will be asked to complete a series of questionnaires related to identity and self-concept, personal experiences, and sexual health history. You will be asked a number of questions regarding your identity and self-concept, such as ethnicity and self-esteem; and your personal experience in society (such as microaggressions). You will also complete a questionnaire that assess your sexual health history such as behaviors, attitudes, and outcomes.

The survey should take about 30 minutes but no longer than sixty (60) minutes to complete. Please be forewarned that several of the questions are related to sensitive material. Please complete this study in private, as others may be able to view your answers if you are in a public place.

RISKS AND DISCOMFORTS
This study is no greater than minimal risk. Reading and thinking about some of the topics covered in this study may cause people to become uncomfortable or upset. If you experience any adverse effects, we will provide you with a list of emotional and mental health resources to use if you need. We will also provide you with our contact information so you may ask any questions you may have after participation.

BENEFITS TO YOU AND OTHERS
There is no guarantee of direct benefit for participating in this study. Overall, you may feel good knowing you are helping to advance social science, sexual health knowledge, and possible even public health intervention programs.

COMPENSATION FOR PARTICIPATION
For participating in this study, you can either receive **1.5 SONA credit** or be entered into a drawing for a chance to win either **$100, $200, $300, or $400 VISA Gift Card** (with a probability of winning equally a 1% chance)**. You must choose only one of these options.** If you choose the gift card drawing, you will be entered into the drawing only once. This will occur immediately after participating in this study. The drawing will take place at the conclusion of data collection. Winners will be notified via email or phone; and compensation will be disbursed via certified mail. Of note, completion of the entire survey is needed to receive compensation. No partial compensation will be given.

CONFIDENTIALITY
Potentially identifiable information about you will consist of indirect identifiers such as your regional location, age, race, gender, etc. Data is being collected only for research purposes. Your data will be identified by randomly assigned, unique ID numbers, not names. All data will be stored in password-protected files on locked computers. Access to all data will be limited to study personnel. Of note, we will not tell anyone the answers you give us; however, information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized
officials of the Department of Health and Human Services or other federal regulatory bodies.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Your participation in this study is voluntary. You may decide to not participate in this study. Your decision not to take part will involve no penalty or loss of benefits to which you are otherwise entitled. If you do participate, you may freely withdraw from the study at any time. Additionally, you may skip any question(s) that may make you feel uncomfortable in answering. Your decision to with draw will involve no penalty or loss of benefits to which you are otherwise entitled.

If you leave the study before the completion of the survey, you will not be granted your compensation.

If you decide to withdraw, data collected up to the point of withdrawal will be used for the research analyses.

It can be difficult answering the questions that were included in this study, and your willingness to respond is greatly appreciated. If you feel distressed about anything mentioned in this study, please contact one of the resources listed below:

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- American Social Health Association (1-800-772-8500

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Virginia Commonwealth University
Department of Psychology
Email: **dunnce@vcu.edu**

Kristina Hood, PhD
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Department of Psychology
Email: **hoodkb@vcu.edu**

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CONSENT
I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. My selection of the first option below says that I am willing to participate in this study.

- **I agree to participate**
- **I do NOT agree to participate**

RESEARCH SUBJECT INFORMATION AND CONSENT FORM: mTurk Participants

TITLE: Microaggressions, Identity, and Sexual Health

VCU IRB NO: HM20009530

INVESTIGATOR: Chelsie Dunn & Kristina Hood

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BENEFITS TO YOU AND OTHERS
There is no guarantee of direct benefit for participating in this study. Overall, you may feel good knowing you are helping to advance social science, sexual health knowledge, and possible even public health intervention programs.

PAYMENT FOR PARTICIPATION
You will receive $1.25 disbursed to your Amazon Mechanical Turk Worker account immediately after participating in this study. Of note, completion of the entire survey is needed to receive compensation. No partial compensation will be given.

CONFIDENTIALITY
Potentially identifiable information about you will consist of indirect identifiers such as your regional location, age, race, gender, etc. Data is being collected only for research purposes. Your data will be identified by randomly assigned, unique ID numbers, not names. All data will be stored in password-

protected files on locked computers. Access to all data will be limited to study personnel. Of note, we will not tell anyone the answers you give us; however, information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized
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CONSENT
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- **I agree to participate**
- **I do NOT agree to participate**

APPENDIX H: Debrief Form

Microaggressions, Identity, and Sexual Health

Thank you for participating in the Microaggressions, Identity, and Sexual Health study. Please read the following statement, carefully.

The purpose of this investigation is to understand if ethnic identity, self-concept, and gendered racial microaggressions impact the sexual risk and protective behaviors of Black women such as condom use and number of sexual partners. Previous research has found that experiences of racial and gender microaggressions impact Black women's self-concept, sexual attitudes and sexual behaviors (Duvall et al., 2013; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Schoulte, Schultz, & Altmaier, 2011; Smith, Hung, & Franklin, 2011; Wong, Derthick, David, Saw, & Okazaki, 2014). Fortunately, strong ethnic identity and self-concept have shown to be protective factors against negative stereotypes towards Black women and increase self-efficacy of condom use (Belgrave, Van Oss Marin, & Chambers, 2000; Townsend et al., 2010). It is therorized that gendered racial microaggressions may be a predictor variable of sexual risk and protective behaviors (such as condom use and number of sexual partners). Therefore, this stidy seeks to explore this theory.

As stated in the consent form, your participation is confidential; therefore, nothing that you reported in the study will ever be traced back to you. Because of this, we ask that you do not share anything about this study with anyone. If future participants hear about the content of the study, the data can become biased and cannot be included in any analyses.

It can be difficult answering the questions that were included in this study, and your willingness to respond is greatly appreciated. If you feel distressed about anything mentioned in this study, please contact one of the resources listed below:

- National Suicide Prevention Lifeline (1-800-273-8255)
  http://suicidepreventionlifeline.org
- National Domestic Violence Hotline (1-800-331-8453)
- National STD Hotline (1-800-227-8922)
- National AIDS Hotline (1-800-342-AIDS (2437)
- American Social Health Association (1-800-772-8500

Again, thank you for your participation in the study today. If you have any further questions, or if you would like to hear the results of this study in the future, you can contact the primary investigator at dunnce@vcu.edu.

Do wish to be entered into the drawing for a chance to win one of four VISA gift cards?

- Yes (please click next)
- No

Vita

Chelsie Eva Dunn was born on July 21, 1989, in Jefferson Parrish, Louisiana. She graduated from The Heritage School, Newnan, Georgia in 2007. She received her Bachelor of Arts in Psychology from Wesleyan College, Macon, Georgia in 2011. She received a Master of Public Health in Urban Public Health from Charles R. Drew University of Medicine and Science, Los Angeles, California in 2013; and subsequently received her Master of Arts in Clinical Psychology from Alliant International University, Alhambra, California in 2016.