IUL School of Social Sciences

Department of Social and Organizational Psychology

Microaggressive incidents towards women in the healthcare context. A qualitative and intersectional perspective

Elena Piccinelli

Dissertation report submitted as partial requirement for the conferral of
Master in Psychology of Intercultural Relations

Supervisor:
Dr. Christin-Melanie Vauclair, Invited Assistant Professor,
Instituto Universitário de Lisboa (ISCTE-IUL), CIS-IUL, Lisboa

Co-supervisor:
MSc, Sara Martinho, Assistant Researcher,
Instituto Universitário de Lisboa (ISCTE-IUL), CIS-IUL, Lisboa

September, 2019

IUL School of Social Sciences
Department of Social and Organizational Psychology

Microaggressive incidents towards women in the healthcare context. A qualitative and intersectional perspective

Elena Piccinelli

Dissertation report submitted as partial requirement for the conferral of
Master in Psychology of Intercultural Relations

Supervisor:
Dr. Christin-Melanie Vauclair, Invited Assistant Professor,
Instituto Universitário de Lisboa (ISCTE-IUL), CIS-IUL, Lisboa

Co-supervisor:
MSc, Sara Martinho, Assistant Researcher,
Instituto Universitário de Lisboa (ISCTE-IUL), CIS-IUL, Lisboa

September, 2019

Acknowledgments

First and foremost, my sincere thanks to all the wonderful women and activists I have met and interviewed during my research, for their collaboration and, more importantly, for the effort they make every day to be part of social change. They have been an enormous source of inspiration and an amazing example of humanity, commitment and dedication.

I would like to express my deep and genuine gratitude to my supervisor, Christin-Melanie Vauclair, for the guidance, support and encouragement she gave me, and to my co-supervisor, Sara Martinho, for her constant availability, her help and immensurable patience. I had the chance to work with two incredible women, that taught me a lot, both on the academic and personal level.

Thanks to my teachers and colleagues at ISCTE-IUL, for the two fantastic years we have spent and for all the opportunities we had to learn and maturate together.

Thanks to my parents, that always support me emotionally and financially. To my brother, who is my biggest source of joy and pride, to my grandparents, for everything they teach me every day, and to my all family, for the faith they always put in me.

To my friends that are distant, but close to my heart. To the friends that are near, for their company and their affection.

To my partner in life, Weber, with whom every day I grow up and learn how to see the world from a new, different perspective.

A last thanks goes to all women that who actively fight against oppression, whether silently or publicly, to those that study and research about how to reduce discrimination, and to all men that offer their support to the feminist cause.

Resumo

As microagressões são uma forma sutil de discriminação, expressas sob ofensas, insultos e invalidações e dirigidas a grupos sociais minoritários, marginalizados e discriminados. As microagressões são frequentemente perpetuadas de modo inconsciente, sendo socialmente normalizadas e naturalizadas. O presente estudo qualitativo incide sobre as situações de microagressão vividas por mulheres de diversas identidades interseccionais (mulheres brancas, mulheres negras, mulheres imigrantes, mulheres heterossexuais, mulheres LGBTQ+, e mulheres com diversidade funcional) no contexto de saúde português. A investigação foi conduzida através de entrevistas semiestruturadas, baseadas na *técnica de incidentes críticos*. Participaram dezassete mulheres que se identificaram como feministas, ativistas e/ou envolvidas em organizações não governamentais e outras organizações ativamente comprometidas em causas sociais. Foi usada análise temática e análise de conteúdo aos dados recolhidos com o objetivo de identificar, entender e analisar as diversas formas de microagressão (microinsultos, microinvalidações, microassaltos), níveis de manifestação (verbal, não-verbal/comportamental, ambiental) e temas das microagressões perpetuadas no contexto de saúde português. No fim da dissertação, e com base nas informações obtidas, foram criadas vinhetas exemplificando alguns incidentes críticos, tendo em vista a sua implementação em programas de intervenção e formação para a diversidade.

Palavras chave: Microagressões, Sistema de Saúde, Mulheres, Identidades Minoritárias, Interseccionalidade, Incidentes Críticos

Classificação nas categorias definidas pela American Psychological Association
(PsycINFO Classification Categories and Codes):
2900 Social Processes & Social Issues
    2970 Sex Roles & Women's Issues
3400 Professional Psychological & Health Personnel Issues
    3410 Professional Education & Training

Abstract

Microaggressions are subtle forms of discrimination, expressed in slights, insults, invalidations and indignities directed to minority, marginalized and discriminated groups. Microaggressions are often unconsciously perpetrated, socially normalized and naturalized. The present qualitative study aimed to analyze and understand the microaggressive incidents experienced by women with different intersectional identities (White women, women of Color, immigrant women, straight women, LGBTQ+ women, functionally diverse women) in the Portuguese healthcare context. Semi-structured interviews, centered around the Critical Incident Technique, were conducted. Seventeen women that self-identified as feminists, activists and/or that were engaged with NGOs and organizations actively committed to social causes, participated in the study. Content and thematic techniques for qualitative analysis were used in order to recognize the different microaggressive forms (microinsults, microinvalidations, microinvalidations), levels of manifestation (verbal, nonverbal/behavioral, environmental) and themes perpetrated in the healthcare context. At the end of the study, and based on the information collected, brief vignettes showcasing critical incidents were created with the potential of being implemented in diversity training programmes.

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

Classification as defined by American Psychological Association
(PsycINFO Classification Categories and Codes):
2900 Social Processes & Social Issues
    2970 Sex Roles & Women's Issues
3400 Professional Psychological & Health Personnel Issues
    3410 Professional Education & Training

Table of Contents

Table of Contents VI

Index of Tables VII

Introduction 1

Chapter I. Literature review 5

1.1 Microaggressions: a general overview 5

1.2 The development of minoritarian and activist identities 12

1.3 Microaggressions in the health care context 13

1.4 Research purposes 17

Chapter II. Methodology 19

2.1 Design 19

2.2 Participants 19

2.3 Data Collection 20

2.4 Methodological approach and data analysis 23

2.5 Ethical considerations 27

2.6 Procedures to ensure trustworthiness and study quality 27

Chapter III. Results 29

3.1 Content analysis 29

3.2 Thematic analysis 43

Chapter IV. Discussion 53

4.1 Limitations 59

4.2 Suggestions for future research 60

Chapter V. Critical Incidents 63

Bibliography 65

Appendices 73

Index of Tables

Table 2.1. Classification of NVivo cases based on participants' minoritarian identities.........24
Table 3.1. Frequencies per each typology of microaggression..30
Table 3.2. Relative frequencies of microaggressions for each group......................................31
Table 3.3 Absolute and relative frequencies for each typology of microaggression...............32
Table 3.4 Absolute frequencies for specific medical area or physical sections of healthcare facilities..33

Microaggressive incidents toward women in the healthcare context.

Introduction

> "There is this situation, with the same doctor [a private gynecologist]. We can start saying that I began my sexual life with a woman, and I had never been with a man, but him [the gynecologist] completely assumed my sexuality as heterosexual. And then, I had to do this exam, the Pap Test… and I couldn't do it. I was too nervous, for psychological reasons, and I couldn't do it. But he told me 'even old women do this exam, why don't you do it?'. It was the last time I went to this doctor." [Interviewee 6 from this Master Thesis Project]

Upon a first impression, this may seem a harmless incident occurred during a medical consultation. However, a deep look reveals that multiple discriminatory messages are hidden behind the attitude of the physician. First, he assumes *a priori* the patients' sexual orientation to be heterosexual. This biased attitude towards LGBTQI+ people is very common in the healthcare context and is cause of high levels of stress among patients (Morrison, 2012; Platzer & James, 2000; Marques, Nogueira, & de Oliveira, 2015). It invalidates the existence and identity of non-heterosexual people by communicating and legitimizing heteronormative values (Sue D. W., 2010). A second prejudiced message is hidden behind the sentence "even old women do this exam, why don't you do it?". In this case, the physician is displaying an ageist and sexist stereotype towards old women, seen as frail and vulnerable, and he is – probably unconsciously – using this stereotype to invalidate the worries and anxiety of his young patient, also showing a great lack of empathy and sensitivity towards her emotional and physical condition.

The slight invalidations and insults above presented are part of a greater category of discriminatory attitudes that take the name of "microaggressions" (Sue D. W., 2010). The term "microaggressions" was coined in 1970 (Pierce, 1970; Pierce, Carew, Pierce-Gonzalez , & Willis, 1978), with the aim to define and interpret the new, subtle "face" of racist attitudes. Microaggressions are perpetrated in every area of social interaction by well-intentioned people that are usually unaware of their biases, and target members of minority and historically oppressed social groups. These forms of discrimination are common in the everyday life of socially powerless individuals but remain invisible to the eyes of the powerful ones.

Since the concept of microaggressions was created, a major effort has been made by scholars in order to understand the perpetration of these messages and incidents in different social contexts, such as the organizational (Sue, Lin, & Riveira, 2009), educational (Gaisch, Chydenius, Preymann, Sterrer, & Aichinger, 2016) and psychological counseling ones (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), towards different minority groups, such as People of Color (Watkins, Labarrie, & Appio, 2010; Riveira, Forquer, & Rangel, 2010; Lin, 2010),

LGBTQI+ people, (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016), women (Capodilupo C. , et al., 2010) and people with disabilities (Keller & Galgay, 2010), and in relation to their impact on targets' mental and physical wellbeing (Sue D. W., 2010).

Sue (2010) proposed a categorization of microaggressions based on their different forms (microinsults, microinvalidations, microassaults) and levels (verbal, behavioral, environmental) of manifestation. Furthermore, many studies have focused on the understanding of the stereotypical themes and contents that underly microaggressions, such as those related to sexism, heterosexism, racism, ableism and ageism. In the last decade, theories about microaggressions have been complemented with the notion of intersectionality of identities (Nadal, et al., 2015) and expanded to new contexts. For example, some studies have analyzed microaggressions towards different minority groups in the healthcare context (Almond, 2017; Cruz, Rodriguez, & Mastropaolo, 2019; Freeman & Stewart, 2018; Snyder, Wang, & Truitt, 2018; Smith-Oka, 2015; Smith & Turell, 2017). However, studies about microaggressions in healthcare are still few and lack important answers, such as those regarding the existence of microaggressive themes specifically related to this context and the impact that these incidents have on patients, including physical and psychological consequences.

The present study was aimed at identifying and analyzing the different microaggressions that women experience in the healthcare context. Women are daily targets of a great number of microaggressions, related, for example, to hostile or benevolent forms of sexism (Glick & Fiske, 2001). The Developmental Model of Feminist Identity (Downing & Roush, 1985) shows that women develop awareness of subtle and blatant forms of discrimination through a troubled process made of consciousness-raising and social active commitment. Because this process is not engaged by all women, most of them may suffer from the psychological consequences of the continued exposure to microaggressions without being aware of it.

A particular focus was here made on women with intersectional identities. Women of Color, immigrant women, LGBTQI+ women and women with disabilities were involved in this study, in order to understand their experiences of microaggressions in the healthcare context, and to make a comparison with the ones lived by White, straight women.

This study aimed at answering the following questions: 1) Do women perceive microaggressions in the health care context?; 2) Which are the microaggressive forms, levels of manifestation and themes frequently perceived by women in the health context?; 3) Compared to White women, do women with intersectional identities (Women of Color,

immigrant, LGBTQ+, disabled) report a higher degree of microaggressive incidents?; 4) In the health care context, do women with different minoritarian identities report different forms, levels of manifestation and themes of microaggressive incidents?; 5) Which are the themes and contents related to microaggressions experienced by women in the healthcare context? Is there any theme that specifically targets women with intersectional identities?

A total of 17 women participated in semi-structured face-to-face interviews. Interviews were based on the Critical Incident Technique (Flanagan, 1954) and were aimed at collecting detailed descriptions of the microaggressive incidents experienced by participants in the above described context. To ensure that all participants had a good awareness of discrimination and microaggressions, all the interviewed women had to self-identify as feminists and/or activists, and/or be actively engaged with NGOs and other socially committed organizations. Qualitative data analysis was conducted according to the principles of content and thematic analysis (Vaismoradi, Turunen, & Bondas, 2013; Braun, Clarke, Hayfield, & Terry, 2018). These types of analysis allowed to answer the above-mentioned research questions, and to understand all the relational, social and psychological processes triggered by the experience of a microaggression, such as the participants' feelings, thoughts and reactions and the perceived short and long-term impact of the incident on participants' health and mental health.

At the end of the study and based on the information collected, some texts narrating critical incidents were created with the potential of being implemented in diversity training programmes for health care professionals. Narratives of critical incidents are commonly used as a tool to sensitize and raise awareness about diversity and discrimination (Wight, 1995). The texts were created based on the most common and exemplificative microaggressive incidents collected during the investigation. The codes created during the content and thematic analysis – presented in detail in the following chapters – were used as key points to create the narratives of the incidents.

In the context of this study, the use of the expressions "ethnicity" and "functional diversity" (and derivates) was preferred to the use of the respective terms "race" (with an exception for the word "racism") and "disability".

Microaggressive incidents toward women in the healthcare context.

Microaggressive incidents toward women in the healthcare context.

Chapter I. Literature review

1.1 Microaggressions: a general overview

Microaggressions are defined as “brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile derogatory or negative racial, gender, sexual orientation and religious slights or insults to the target person or group” (Sue D. W., 2010, p. 5). The term was coined by Chester M. Pierce in 1970, to refer to the everyday and often subtle attacks specifically directed at Black Americans (Pierce, 1970; Pierce, Carew, Pierce-Gonzalez , & Willis, 1978). Forms of discrimination as racism, sexism and heterosexism have assumed a “new face” in the last years (Dovidio & Gaertner, 1996): while their vintage and blatant manifestations are disappearing, new subtle – but not less dangerous – forms are arising. Sue (2010) conceptualized these forms as perceived microaggressions from the perspective of minority members. Microaggressions arise in different context and levels, assume different forms and are related to different themes. However, microaggression are characterized by some specific, constant elements: they are targeted at minority, historically oppressed or disadvantaged groups, are often unconsciously perpetrated, are socially normalized and naturalized, and assumed to produce severe consequences on targets’ physical and mental health and well-being (Sue D. W., 2010).

The fact that perpetrators of microaggressions often act unconsciously and unintentionally poses the first problem in the identification of such forms of discrimination. According to Sue (2010), as individuals tend to perceive themselves as non-prejudiced, well-intentioned and decent human beings, perpetrators of microaggressions often tend to deny that they are discriminating. Microaggressions are based on stereotypical contents and beliefs acquired by individuals during their whole-life socialization process, and may be committed by a variety of perpetrators, transmitted via interactions with members of dominant social groups, members of other marginalized groups or individuals with shared marginalized identities (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Furthermore, these subtle slights and insults are the expression and the reflection of societal mechanism and beliefs regarding privilege, oppression and meritocracy. It is important to observe that the prefix “micro-” does not refer to the intensity, frequency or severity of such aggressions, but only to their subtle and hardly recognizable feature (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016).

On the targets’ side, the exposure to microaggressions may lead to severe consequences. At the individual level, microaggressions “have the lifelong insidious effects of silencing, invalidating, and humiliating the identity and/or voices of those who are oppressed” (Sue D. W., 2010, p. 66). Microaggressions have shown to be related with negative effects on both

physical and mental health, such as increased susceptibility to illness, increased stress levels (Sue D. W., 2010), lowered self-esteem, increased prevalence of depressive symptoms, lowered levels of psychological well-being, negative emotional intensity, negative perception of one's own identity, etc. (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014). Furthermore, at the systemic and macro level, microaggressions reflect and reproduce societal stereotypes and prejudices, disparities and inequalities, affecting the quality of life and standard of living for marginalized groups (Sue D. W., 2010).

1.1.1. Forms and levels of manifestation of microaggressions

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

Microaggressions manifested at the verbal level are delivered through direct or indirect comments to targets, while nonverbal/behavioral microaggressions include the use of body language or physical actions. Additionally, environmental microaggressions are defined as "the numerous demeaning and threatening social, educational, political or economic cues that are communicated individually, institutionally or societally to marginalized groups" (Sue D. W., 2010, p. 25).

Microinsults refer to communications that reveal stereotypes, rudeness, insensitivity and intent to demean the target because of his or her race, gender, sexual orientation or identity. This form of microaggression consists of subtle insults, humiliations and insinuations, frequently unconsciously perpetrated (Sue D. W., 2010). Microinvalidations are communication and environmental cues that – often unconsciously – exclude, deny or nullify targets' thoughts, feelings or experiential reality. As Sue and colleagues have stressed, the power of a group resides in its ability to define reality: when a group is able to deny another group's experiences and reality, it imposes its own reality on the other group and consequently it affirms its social power (Sue D. W., Capodilupo, Nadal, & Torino, 2008). Finally, microassaults are characterized by conscious, deliberated and either subtle or explicit communications that are delivered with the intent to hurt, harm or attack the target's identity (Sue D. W., 2010). Examples of combination between each form of microaggression and level of manifestation will follow in the next paragraphs.

Microaggressive incidents toward women in the healthcare context.

1.1.2. Targets and contents of microaggressions

As already mentioned, microaggressions are directed at members of minority groups. Wirth (1945) defined a minority group as "any group of people who, because of their physical or cultural characteristics, are singled out from others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination" (Wirth, 1945, p. 347). According to Social Identity Theory (Tajfel & Turner, 1986), part of individuals' identity is related to their belonging to social groups. Individuals that identify with minority groups and are recognized to have minoritarian identities may suffer stigmatization and discrimination as direct consequences of intergroup bias. In other words, in every society some social groups are confined to the margins of social desirability, are forced to live at the edge of the cultural, social, political and economic systems and may experience exclusion, inequality and social injustice (Sue D. W., 2010). In this context, microaggressions are the reflection of societal power relations, "of marginality and worldviews of inclusion/exclusion, superiority/inferiority, desirability/undesirability, normality/abnormality" (Sue D. W., 2010, p. 14).

In identifying a minority group, the presence of discrimination is a fundamental factor (Hacker, 1951). Examples of social minorities are some specific ethnic groups (such as Africans, Brazilians, Indians, Chinese and Roma in Portugal), women, LGBTQ+ people, people with functional diversity, low-income people, etc. Racism is the form of discrimination against ethnic groups and related to the belief of the existence of *races*. Sexism is the form of discrimination against women. Heterosexism, homophobia, biphobia and transphobia are forms of discrimination against homosexuals, bisexuals, transsexuals and genderqueer people. Ableism and disablism refer to the discrimination against people with functional diversity, and classism refers to the discrimination against low-income people.

Such forms of discrimination are the basis of microaggressions: for example, racial microaggressions often contain racist beliefs, gender microaggressions contain sexist beliefs, and sexual orientation microaggression contain heterosexist beliefs (Sue D. W., 2010). In other words, prejudiced and stereotypical beliefs determine the contents and themes of microaggressions. Racial microassaults often communicate that the target group or person is "less human", unworthy, or are not the "right kind of people" and consist, for example, in the use of racial epithets or in telling ethnic or racial jokes (verbal), in intentionally ignoring the target or forbidding inter-ethnic marriage (nonverbal/behavioral) or in creating an hostile environment to the targeted minority (environmental). According to the thematic taxonomy presented by Sue (2010), racial microinsults contain the following themes: ascription of

intelligence (stereotypical perception of one's intelligence based on his or her ethnicity), second-class citizenship (treatment as a "lesser" person or group), pathologizing of cultural values/communication styles (valuing as abnormal the cultural values and communication styles of people of color) and assumption of criminal status (stereotypical perception of one's criminality and danger based on his or her ethnicity). Racial microinvalidations include the themes of: alien in own land (belief that visible ethnic minorities are foreigners), color-blindness (denial or pretense that ethnicities do not exists or are not seen by White people), myth of meritocracy (belief that ethnicity plays a minor role in life success) and denial of individual racism (denial of personal racism or one's role in its perpetrations) (Sue, Capodilupo, & Holder, 2008; Sue D. W., 2010).

Similarly, to racial microassaults, gender and sexual orientation microassaults (verbal, nonverbal/behavioral, environmental) express the belief that the targeted person or group is inferior, unworthy, undesirable (e.g. through the use of sexist/heterosexist humor and jokes). Women are often targets of sexual objectification (perception of the female body as an object for the pleasure of men), differential treatment (invisibility, second-class citizenship), use of sexist language (general use of masculine nouns and pronouns, use of sexist language assumptions) and assumptions of inferiority (belief that women are intellectually, temperamentally and physically inferior). Sexist microaggressions can also occur through the prescription of restrictive gender roles, denial of the reality of sexism, denial of individual sexism (Gaisch, Chydenius, Preymann, Sterrer, & Aichinger, 2016; Sue & Capodilupo, 2008). According to this classification, sexual orientation microaggressions are often related to the belief of centrality of sex in the life of a LGBTQ+ person (oversexualization), to beliefs that homosexuality is contagious (homophobia), that is a sin or a crime (sinfulness), that is an illness or an abnormal condition (assumption of abnormality). Other heterosexist microaggressions are perpetrated through the use of heterosexist language/terminology, the denial of individual heterosexism, and the endorsement of heteronormative culture and behaviors (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; Sue D. W., 2010).

Some studies (Keller & Galgay, 2010; Conover, Israel, & Nylund-Gibson, 2017) propose a thematic taxonomy for ableist microaggressions. People with functional diversity often live situations in which their personal identities are ignored, minimized or denied (denial of identity), in which they are infantilized (patronization), desexualized and "helped", "saved" or "rescued" when they do not need to (helplessness). Perpetrators of ableist microaggressions often assume that individuals affected by disability possess some special "gift" or ability (spread effect), feel to have the right to ask about disability-related information (denial of

privacy) and expect for recognition and reward when they interact with disabled persons (secondary gain).

The notions of racial, gender and sexual orientation microaggression are related and conceptually similar to many other sociological and psychological theories, such as: Aversive Racism (Dovidio & Gaertner, 1996), Minority Stress Theory (Meyer, 2003) Everyday Sexism (Swim, Hyers, Cohen, & Ferguson, 2001), Objectification Theory (Fredrickson & Roberts, 1997), Sexual Harassment (Leung, 2017), and Anti-gay Harassment (Burn, Kadlec, & Rexer, 2005). An important link to the theoretical foundations of microaggressions is represented by the definition of Ambivalent Sexism, given by Glick and Fiske (2001). According to the authors, gender stereotypes can be conceptualized on the two axes of a Cartesian diagram, characterized by status and warmth-relevant cluster traits, that respectively define attitudes of hostile and benevolent sexism. On the one hand, women that are perceived as challenging men's power and social positions are punished by attitudes of hostility and antipathy. On the other hand, women that enact conventionally to gender roles are rewarded with benevolent and caring attitudes. Looking at the thematic categorization of microaggressions, it is possible to notice that most of the sexist themes reflect the ambivalent sexism dichotomy, oscillating between dominative (e.g. restrictive gender roles) and protective paternalism (e.g. assumption of inferiority), or between heterosexual hostility (e.g. use of sexist language) or intimacy (e.g. sexual objectification) (Glick & Fiske, 2001). Attitudes and ideas reflecting benevolent and hostile sexism may manifest as gender microaggressions (Capodilupo C. , et al., 2010). Furthermore, Nadal and colleagues (2013) highlight that, besides the conceptual similarity, there are some differences between microaggressions and the above-mentioned theories on discrimination. For example, research on microaggressions stresses the idea of unintentionality or unconsciousness of perpetrators, presents a redefined categorization based on several forms and levels of manifestation, and focuses on target's perception of discrimination.

Microaggressions and intersectionality

In the social realm, a specific condition is experienced by those who identify with two or more minority groups. The possession of different minoritarian and intersectional identities may expose individuals to microaggressions of different nature (Nadal, et al., 2015; Sue D. W., 2010). Intersectionality is defined as "the interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage" (Oxford University Press, 2019). According to the theory of intersectionality, individuals need to be seen as multidimensional, yet uniquely whole, beings, because the interlocking of their identities

defines specific layers and levels of oppression and privilege, characterizing their social experience as unique (Samuels & Ross-Sheriff, 2008). In other words, people with different minoritarian identities do not only experience discrimination based on the separated social groups they belong to, neither experience the sum of these forms of discrimination, but they are subjected to specific forms of oppressions related to the intersection of their identities (Lewis & Neville, 2015) .

Recent studies stressed the need to consider microaggressions towards people with intersectional identities as a specific phenomenon, using multisystemic and multidimensional approaches (Samuels & Ross-Sheriff, 2008). For example, Nadal et. al (2015) demonstrated that microaggressions towards people with intersectional identities contain themes that are new to the classic literature about microaggressions: women of color described themes as exotization, exclusion and isolation, biased compliments on appearance, assumption of inferior status; lesbian women and gay men are particularly exposed to gender-based stereotypes (e.g. the belief that all gay men are feminine and all lesbian women are masculine); LGBT individuals with ethnic or religious identity reported a conflict between their sexual orientation and their ethnicity or religion (in many cultures and religions homosexuality and transsexuality are abomined); Muslim men and women experienced the exposure to specific gender-expectations (women are seen as conservative, objectified and submissive, joyless, men are seen as traditional and “inhumane”).

Based on the intersectional notion of “gendered racism” Lewis and Neville (2015) proposed a Microaggressions Scale for Black Women. Their study highlighted some microaggressive themes uniquely experienced by black women: assumptions of beauty and sexual objectification (sexualization of the black body, existence of “standards of beauty” for black women), silence and marginalization at work, school and other settings; stereotypes that configure black women as strong and angry. Similarly, Balsam and colleagues (2011), examined the specific microaggressive stressors to which LGBT-People of Color are exposed, being simultaneously targets of racism within the LGBT communities, of heterosexism within their ethnic minorities, and of other specific discriminatory beliefs related to the intersection of their oppressing identities.

1.1.3. Consequences of microaggressions on targets

To understand, analyze and categorize microaggressions it is necessary to consider: the interaction between the involved actors, the historical and cultural context in which such interaction occurs, the words used to perpetrate the microaggression, the multiple hidden meanings and messages that the microaggression contains. Such meanings and messages reveal

specific beliefs, stereotypes and prejudices about the target, and are often in contradiction with each other (Sue D. W., 2010). Due to contradictions of these messages and meanings, four psychological dilemmas arise from experiences of microaggression: clash of realities (refers to the double perception of microaggressions: harmful for the target, harmless for the perpetrator), invisibility of unintentional bias (refers to the difficulty of detecting hidden biases, because such biases are learnt by individuals through socialization), perceived minimal harm of microaggressions (many people, specifically historically privileged groups, may see microaggressions as unimportant and unworthy of discussion, because the specific incidents are innocuous and minor), catch-22 of responding to microaggressions (the same incident may trigger different reactions in different individuals, and each individual may react based on personal availability of energy, time, and fear of repercussion) (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; Sue D. W., 2010).

After many studies on microaggressions, Sue and colleagues (Sue, Capodilupo, & Holder, 2008; Sue D. , Lin, Torino, Capodilupo, & Rivera, 2009) have finally proposed a Microaggression Process Model. According to the Model, the impact of microaggression can be summarized in five phases: Incident, Perception, Reaction, Interpretation, and Consequence (Sue D. W., 2010). In the first phase, a specific incident triggers a chain of psychological events and reactions in the targeted individual. In the second phase, the individual attempts to determine whether the incident was motivated by prejudiced assumptions. This phase includes the process of "questioning", in which the individual tries to decode the multiple messages hidden in the microaggression, asking himself or herself about the causes and motivations of such messages. The third phase explains the reaction processes: recipients of microaggressions may experience different reactions, such as the "healthy paranoia", "sanity check", or/and the empowerment and validation of the self. In the fourth phase, the individual interprets the meanings and themes contained in the microaggressive message. Finally, the fifth phase is related to the consequences of the microaggressive incident, including physical, cognitive, behavioral and emotional processes. Among the short-term consequences of microaggressions were identified: powerlessness, invisibility, forced compliance, loss of integrity and the pressure to represent one's own group. Long-term consequences imply the continued exposure to microaggressive incidents and the need to constantly deal with microaggressive stress. Microaggressive stress was found to be related with lowered physical and mental health (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), lowered subjective well-being and self-esteem, to produce cognitive effect as disruption, and behavioral effects as hypervigilance, skepticism, rage, anger and fatigue. Phases of the Microaggression Process Model are not always

sequentially experienced, but may be cyclical or interact in a more complex manner (Sue D. W., 2010).

Women's reactions to microaggressions

A specific study has been conducted to explore and understand women's reactions to microaggressions (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013). As expected by the Microaggressions Process Model, women were found to process and react to microaggressions on three different levels: emotional, behavioral and cognitive. At the emotional level are located the emotions felt at the moment of the microaggressive incident. Emotional reactions may be based on internalized emotions (internal processes, often unexpressed, that women struggle with) or externalized emotions (in which women react in order to take protective measures for themselves). Behavioral reactions were classified on a continuum, ranging from passivity to confrontation. Finally, the cognitive processes involved in the reaction to microaggressions were related to resiliency, acceptance and resistance.

1.2 The development of minoritarian and activist identities

Individuals' awareness of discrimination shall not be taken for guaranteed, especially when such discrimination is expressed in subtle forms as microaggressions. The literature about prejudice and discrimination suggests that all individuals may learn and acquire stereotypes and biases during their whole-life socialization process (Dovidio & Gaertner, 1996). As explained by the psychological dilemma of "invisibility of unintentional bias" (Sue D. W., 2010), not only perpetrators, but also recipients of microaggressions may be unaware of the discrimination in course. The Microaggression Process Model (Sue D. W., 2010) suggests that recipients of microaggressions make a sever effort to understand the intentionality, motivation and content of a microaggression. The body of research about feminist identity development (Downing & Roush, 1985), Black identity development (Cross, 1978), and homosexual identity development (Cass, 1979), suggests that resources and the ability to interpret microaggressive incidents are related to specific phases of the minoritarian identities development. For example, the Feminist Identity Development Model proposed by Downing and Roush (1985), identifies five stages through which women develop an actively committed identity. In the first stage, named "passive acceptance", the woman is unaware or denies any form of prejudice and discrimination against her, accepting sex-role stereotypes and gender-biased beliefs. The second stage, "revelation", is characterized by a series of crises in which the awareness of discrimination arises, resulting in a questioning process of Self and roles and in feelings of anger and guilt. The third stage, "embeddedness/emanation" is characterized by connectedness with other selected woman, by the strengthening of a new identity and, at the

end of the stage, the arising of a relativistic thinking. In the fourth stage, "synthesis", the woman has developed a truly feminist identity and has acquired a new flexibility in the perception of the world. Finally, the fifth stage "active commitment" is characterized by identity consolidation and active commitment to meaningful actions, to a non-sexist world. According to the Model these phases are not linear, can be experienced cyclically and often more than one time, but most women do not experience the last two phases (Downing & Roush, 1985). Models of Black and homosexual identity development (Cross, 1978; Cass, 1979) are conceptually similar to the Model of Feminist Identity Development, suggesting that awareness of discrimination does not arises in all individuals and that it is related with active social commitment.

1.2.1. Microaggressions and feminist identity

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

1.3 Microaggressions in the health care context

Microaggressions may be perpetrated in many contexts and by many perpetrators, in all social environments, from family to school or work, restaurants and public places, health and mental health contexts (Sue D. W., 2010). An environment of particular interest is the health care context, specifically in relation to microaggressions perpetrated by health providers towards patients. In this context, the relation health provider-patient is characterized by a strong interdependence, in which, on one side, patients tend to be in a particularly vulnerable state when seeking medical provision and, on the other side, health providers occupy a position of social power and authority (Saha, Beach, & Cooper, 2008; Cruz, Rodriguez, & Mastropaolo, 2019). This power disparity may be strengthened or overlap with other disparities related to

the social relationship between dominant and minority groups. For example, according to Vissandjée and colleagues (2001), the power differential between patient and physician is "reinforced for female clients as result of stereotypes and misperceptions about women and their health issues" (Vissandjée, M., Dupéré, & Abdool, 2001). Among others, immigrant women face a triple jeopardy in the health-care system, because of their intersectional identity as women, members of ethnic minorities, and immigrants (Vissandjée, M., Dupéré, & Abdool, 2001). Furthermore, by way of their education, medical language and training, physicians tend to form a more homogeneous group than the patients they serve (Almond, 2017).

In this context, the application of a patient-centered approach is fundamental to the creation of positive patient-provider relationships (Cruz, Rodriguez, & Mastropaolo, 2019). According to Lipkin and colleagues, patient-centeredness "approaches the patient as a unique human being, with his own story to tell, promotes trust and confidence, clarifies and characterizes patient's symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness, and creates the basis for an ongoing relationship" (Saha, Beach, & Cooper, 2008). On the patients' side, this approach has been found to be related to improved medical outcomes, adherence to prescription and treatment, satisfaction and trust (Taylor, 2009). Furthermore, scholars suggest that patient-centeredness is associated and shares many aspects with cultural competence, as, for example: the understanding and the interest in the patient as a unique person; the exploration and respect of the patient's beliefs, values, meanings of illness, preferences and needs; the creation of a relationship of trust; the awareness of one's own biases and assumptions; the ability to maintain an unconditional positive regard; the provision of information and education tailored to the patient's level of understanding (Saha, Beach, & Cooper, 2008). According to this conceptualization, the application of a culturally competent patient-centeredness may be related to prejudice reduction and, consequently, to the decrease of microaggressions (Cruz, Rodriguez, & Mastropaolo, 2019).

On the other side, many studies (Cruz, Rodriguez, & Mastropaolo, 2019; Almond, 2017; Hobson, 2001; Franks, Fiscella, & Meldrum, 2005; Feagin & Bennefield, 2014) showed the presence of different forms of discrimination and microaggressions in the healthcare context. Healthcare microaggressions can be defined as "implicit discrimination within the healthcare setting, whereby treatment providers who are in positions of authority inadvertently marginalize members of minority groups through culturally insensitive interactions" (Cruz, Rodriguez, & Mastropaolo, 2019, p. 2). Freeman and Stewart (2018) proposed a new taxonomy for microaggressions in the healthcare context. Starting by the assumption that Sue's (2010)

taxonomy is enactor-centered, the authors introduced three new target-based forms of microaggressions: epistemic microaggressions (consisting in the devaluation and invalidation of the patient as knower, and in providers' tendency to view themselves as experts over patients' bodies), emotional microaggressions (the providers' failure in taking seriously patients' emotional status and experience) and self-identity microaggressions (providers' attitudes that undermine and jeopardize the consequences that often accompany experiences of illness). Each one of these microaggressions can cause a specific harm to targets.

1.3.1. Racism in the healthcare context

According to Feagin and Bennefield (2014) systemic racism in the healthcare context needs to be addressed starting by the racist history of medical experiments. Hobson and colleagues (2001) found that many Black Americans perceived racial discrimination in the health care context: from perceived differential treatment (in comparison with White patients), perceived negative attitudes, being treated as dumb, being made to wait or being ignored, to the infliction of unnecessary pain, harassment and the use of racial slurs and remarks. Other studies (Franks, Fiscella, & Meldrum, 2005; Feagin & Bennefield, 2014) found that, compared to White patients, Black patients have less recommendations for Pap Tests, rectal exams, smoking cessation, and are less likely to receive pharmacological therapy, diagnostic of angiography, catheterization and other treatments, suggesting that Black patients are treated differently by health providers. Some studies used specific scales – such as the Microaggressions Health Care Scale (MHCS) (Cruz, Rodriguez, & Mastropaolo, 2019) and the Racial Microaggressions in Medical Practice Scale (RMMPS) (Almond, 2017) – to understand the perpetration and impact of racial microaggressions in the healthcare context. Findings show that People of Color and ethnic minorities face a high number of microaggressions, especially in cross-racial interactions, and that there is a strong correlation between the experience of microaggressions and the occurrence of anxiety and depressive symptoms (Walls, Gonzalez, Gladney, & Onello, 2015; Almond, 2017; Cruz, Rodriguez, & Mastropaolo, 2019). Snyder, Wand and Truitt (2018), found that health providers often make mistaken assumptions about patients' ethnic identity (mistaken identity), family kinship (mistaken relationships) and income class or degree of education (pervasive stereotypes) based on their skin color or physical attributes, that providers often make inappropriate questions about patients' race and ethnicity (entitled examiners), that patients often suffer from intersectional forms of microaggressions (intersectionality) and encounter difficulties in identifying with one exclusive ethnic or racial category between those mentioned in clinical forms (fixed forms).

Microaggressive incidents toward women in the healthcare context.

1.3.2. Sexism in the healthcare context

Sexism in the health-care context is not an issue to underestimate. Many health providers see women's physical complaints as psychosomatic or related to neurotic disorders. Disparities between women and men in healthcare treatment begin at the research level: women's health issues are less researched than men's ones, women are less included in trials for medicines and in medical research samplings (Travis, Howerton, & Szymanski, 2012). Women are commonly believed to be highly emotional and anxious, and this often leads to the assumption that they are too hypochondriac and unreliable in describing their health issues (Halas, 1979). For example, women are less screened for colon cancer than men, are less likely to receive proactive treatment after a disease is diagnosed, and in case of arthritis are less likely to undergo arthroplasty (Travis, Howerton, & Szymanski, 2012).

Furthermore, gender role stereotypes acquired during the socialization process of both women and men, patients and doctors, exacerbates the already existing paternalization of patients (Taylor, 2009), configurating women as passive recipients of care from authoritarian doctors (Halas, 1979). Expectations of pain are also related to gender roles: women are commonly considered less able to endure pain and more willing to report it (Robinson, et al., 2001). Obstetric violence is considered by some authors a form of gender violence (in some cases compared to rape), for being a gendered phenomenon related to the objectification of pregnant women and the paternalization of mothers (Shabot, 2016). Smith-Oka (2015), conceptualized obstetric violence as a new form of microaggressions, called "corporeal microaggressions": providers justify verbal indignities and violent physical treatment and interventions as a necessary reaction to the perceived non-cooperation and non-compliance of pregnant women during consultations and childbirth.

1.3.3. Heterosexism in the healthcare context

Health providers often assume that their patients are heterosexual (Morrison, 2012; Platzer & James, 2000; Marques, Nogueira, & de Oliveira, 2015), and may have reactions of surprise, excessive curiosity, shock, discomfort, judgment, and avoidance, when their patients disclose their sexual identity (Dean, Victor, & Guidry-Grimes, 2016; Lee & Kanji, 2017). LGBTQI+ patients may encounter various forms of overt and subtle discrimination in the healthcare context: providers are often unprepared to treat homosexual, transgender, genderqueer and intersexual patients and their knowledge is often based on stereotypes and clichés (e.g., seeing homosexuality as a mental illness). Moreover, same-sex affective partners are likely to not be recognized as family members during visiting hours (Lee & Kanji, 2017). This and other microaggressions can influence LGBTQI+ patients' decisions about their health

Microaggressive incidents toward women in the healthcare context.

(Saulnier, 2002) and can represent an important barrier in seeking for healthcare services (Lee & Kanji, 2017). A study about lesbians' experiences in the healthcare context (Platzer & James, 2000) showed that these women tend to receive less screenings and prevention information for sexually transmitted diseases in comparison to heterosexual women, and, when disclosing their sexual identity, they can be recipients of homophobic reactions, ranging from the questioning of their sexual practices to verbal, non-verbal and physical sexual abuse (Platzer & James, 2000). Therefore, an important issue is here represented by lesbians' fear and avoidance to disclose their sexual orientation, with important consequences for their own physical and mental health (Marques, Nogueira, & de Oliveira, 2015; Gregg, 2018). Lesbian mothers can be considered a particularly vulnerable category, being likely to experience forms of heterosexist invalidation (e.g. the belief same-sex couples are unnatural, uncapable of parenting) and exclusion (e.g. non-biological or co-mothers are often excluded from care), expression of overt homophobia and disgust, refusal of services (Dahl, Fylkesnes, Sørlie, & Malterud, 2013; Gregg, 2018). According to a study about LGBTQI+ microaggressions in healthcare (Smith & Turell, 2017), homosexual, bissexual and transsexual patients identified microaggressions in non-welcoming environments and in providers' heteronormative assumptions, discomfort with sexual health conversations, lack of knowledge of LGBTQI+ health needs and unfamiliarity with appropriate terms of address, inappropriate targeting of sexual health needs.

1.3.4. Ableism in the healthcare context

People with functional diversity are also likely to experience negative ableist attitudes in the healthcare context, like objectification and paternalization. These forms of discrimination may find their origin in the medical model of disability, according to which disability is an individual and medical condition, that needs to be overcome through rehabilitation (Scullion, 1999). The lack of sensitivity of nurses and other health professionals, the lack of appropriate health provision, the building of an hostile environment and the use of discriminatory, unappropriated or highly technical language, are some of the factors responsible for shaping ableist discrimination in the healthcare context (Scullion, 1999). Dehumanization and abuse of people with functional diversity emerge in the invalidation of their physical sensations, in the invasion of their privacy (especially regarding disabled women), in the excessive curiosity for their personal condition or in forcing them into humiliating situations (Swain & French, 2001).

1.4 Research purposes

In the last years, many studies were conducted about microaggressions in different sectors and toward different populations. These studies addressed specificities related to

context, perpetrators and targets' identity. However, little was done to understand the microaggressions that women live in the healthcare context.

The main purpose of this study was to conduct a qualitative analysis in order to identify, analyze and understand microaggressive incidents towards different groups of women in the healthcare context. The study aimed at creating a new link between the literature about sexism, heterosexism, racism and ableism in the healthcare context and the definition, taxonomy and thematic classification of microaggressions, by answering to the following questions: Do women perceive microaggressions in the health care context? Which are the microaggressive forms, levels of manifestation and themes frequently perceived by different groups of women (White, Women of Color, immigrant, heterosexual, LGBTQ+, functionally diverse) in this context?

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

Microaggressive incidents toward women in the healthcare context.

Chapter II. Methodology

2.1 Design

In the present exploratory qualitative study, the conceptualization and operationalization of microaggressions proposed by Derald Wing Sue (2010) were adopted and employed to understand the experiences of different groups of women in the Portuguese healthcare context. Data were collected through semi-structured interviews based on the Critical Incident Technique (Flanagan, 1954; Chell & Pittaway, 1998; Edvardsson & Roos, 2001; Spencer-Oatey, 2013) and analyzed in order to answer to the following research questions:

1) Do women perceive microaggressions in the health care context?

2) Which are the microaggressive forms, levels of manifestation and themes frequently perceived by women in the health context?

3) Compared to Perceived as Portuguese, Straight women, do women with intersectional identities (Perceived as non-Portuguese, LGBTQ+, functionally diverse) report a higher degree of microaggressive incidents?

4) In the health care context, do women with different minoritarian identities report different forms, levels of manifestation and themes of microaggressive incidents?

5) Which are the themes and contents related to microaggressions experienced by women in the healthcare context? Is there any theme that specifically targets women with intersectional identities?

This study involved women belonging to different minority groups. To ensure that they possessed the awareness and ability necessary to recognize subtle discrimination, all recruited participants had already overstepped the first stage of the Feminist Identity Development Model (Downing & Roush, 1985), the “passive acceptance”. During the data analysis, the different forms of discrimination presented in the above chapter and their related contents were used to understand and define the themes underlying each reported microaggressive incident.

2.2 Participants

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

Snowball sampling (Robinson O. C., 2014) was chosen as a strategy to reach and recruit participants, starting by some contacts that the research team already had. Inclusion criteria (Robinson O. C., 2014) consisted of: self-identification with women population, self-identification as a feminist and/or an activist and/or engagement with NGOs and organizations

actively committed to social causes. According to Downing and Rush's Model (1985), the identification as "feminist" and the active commitment in social causes are indicators of a developed feminist identity.

The principle of saturation (Saunders, et al., 2018) was reached after interviewing 17 participants, which constituted the sample of the study. Four groups of analysis were created based on participants' minoritarian identities:

1. Perceived as Portuguese, straight women;
2. Perceived as foreigners (immigrant and/or non-Caucasian), straight women;
3. Perceived as Portuguese, LGBTQ+ women;
4. Disabled, perceived as Portuguese, straight women.

The initial project of this study included a fifth group: perceived as foreigners (immigrant and/or non-Caucasian), LGBTQ+ women. However, despite the research team's numerous efforts, it was very difficult to enter in contact with this population, and even those who were contacted refused to participate. A possible explanation should be retrieved in the high vulnerability of this minority group, as it is indicated, for example, by the high rates of mental health problems and suicidality (Sutter & Perrin, 2016).

Participants' age ranged from 23 to 59 years (mean age: 38). Sixteen of them identified with feminine gender, one participant identified with non-binary gender. All participants had Portuguese nationality, three of them also had a second nationality. All participants identified as activists and/or feminists. Fourteen of them defined themselves as "formal activists" (meaning that they usually engage in activities with associations, organizations and other entities that openly work with activism), while three of them defined themselves as "informal activists" (intending activism as an "every-day contribution" through interpersonal relations, work activities, research activities, etc.). As activists, participants expressed their interest in different forms of activism, such as feminism, ethnic activism, activism for LGBTQI+ people's rights, activism for functionally diverse people's rights, and intersectional forms of activism.

2.3 Data Collection

2.3.1. The Critical Incident Technique

This qualitative study was conducted through interviews based on the Critical Incident Technique. The Critical Incident Technique (CIT) has been defined by Chell (1998) as "a qualitative interview procedure, which facilitates the investigation of significant occurrences (events, incidents, process or issues), identified by the respondent, the way they are managed, and the outcomes in terms of perceived effects. The objective is to gain an understanding of the incident from the perspective of the individual, taking into account cognitive, affective and

behavioral elements" (Chell & Pittaway, 1998). This technique aims to retrieve some specific critical (i.e. that is considered "extreme" and/or that deviates significantly from what is normal or expected) incidents (i.e. observable human activities that are sufficiently complete in themselves to permit inferences and predictions to be made about the person performing the act) from participants' memory (Spencer-Oatey, 2013).

Flanagan (1954) analyzed the various ways and techniques to compile Critical Incidents, establishing guidelines for any step of the investigation: choice of the type of interview (personal, focus group, questionnaire), preparation of the interview (guideline divided in points of interest, such as the cause, course and results of the critical incident), presentation of the topic to participants, conduction of the interview, transcription and data analysis. The CIT method can be used to obtain the respondents' perspective, in their own words, allowing them to define which incidents were more critical for the investigated phenomenon, and to provide as many details as possible (Gremler, 2004). This technique has been largely used in the area of organizational psychology, especially to identify criticalities in the relationship between organizations and clients (Edvardsson & Roos, 2001).

As critical incidents take the shape of remembrances, scholars should pay a special attention to the relationship between human memory and time: many factors may influence the way interviewees will remember the incident, such as its weight (positive and negative incidents require different types of cognitive appraisals, and therefore are diversely stored in memory), availability in memory and time passed since the incident. Furthermore, the memory of one incident often triggers the memory of similar incidents (Edvardsson & Roos, 2001).

2.3.2. Interview guide

The development of the semi-structured interview guide relied on previous literature about microaggressions and discrimination in the health care, as well as on the Flanagan's guidelines (1954) and other studies about the Critical Incident Technique. The structure of the guide was also coherent with the one proposed by Capodilupo et al. (2010). It included an introduction, containing the definition of microaggressions (similar to the one presented at the beginning of this thesis) and followed by some examples (carefully selected to avoid participants' bias). At the end of the introduction, the text asked participants to:

> "[…] try to remember of some situations [of microaggressions], that, as a patient, involved contact with doctors or other health professionals (nurses, specialized and non-specialized personnel), and that happened during consultation, emergency situations, hospitalization and other situation in the clinical context.

Microaggressive incidents toward women in the healthcare context.

> If you do not remember any situation that happened to you, you can try to remember of any incident that you witnessed in the same context, as, for example, in a waiting room, at the check-in for a consultation, when you weren't a patient but you were accompanying someone else, etc. […] In this context, can you remember of any situation of microaggressions?" [Appendix B, C]

A battery of open-ended questions followed this first, broad question, investigating the type of health professional that perpetrated the microaggression, where the microaggression occurred, which were the participants' feelings at the moment of the incident, if the microaggressor ever apologized for his attitude, and so on. These questions aimed at obtaining as much details as possible (Gremler, 2004) and at facilitating the remembrance of the situation of microaggression (Edvardsson & Roos, 2001) and was repeated for each incident described. A last battery of questions aimed at understanding participants' general perception of microaggressions. At the end of the interview, questions about personal details (age, gender, identification with any social minority, identification as activist or feminist) were asked.

The interview guide (Appendix B, C) was written in Portuguese. It was first discussed and reviewed within the research team, and in a second moment it was reviewed by a larger group of expert researchers.

2.3.3. Pilot study

A pilot study was conducted in order to test the interview guide, to test the duration of the interview and to understand which the best modalities of conduction could be. Four women (one Portuguese, lesbian woman and three immigrant, straight women) participated to face-to-face interviews. Two of them were asked to read the introduction to the interview and to think about some microaggressive incidents before meeting with the interviewer, while two of them read the same text at the moment of the interview. Pilot interviews lasted 30 to 60 minutes. Participants that had received the introductory text before the interview were able to remember more incidents of microaggressions and to provide more details in their description. For this reason, starting by the assumption that – on average – people occasionally seek for medical care, and acknowledging the difficulty in remembering subtle episodes happening in occasional situations, it was decided to provide all participants with the introduction to the interview prior to the meeting with the interviewer. Furthermore, the pilot study was useful to adjust some imprecise questions and to add some other questions, not considered in the previous drafting of the interview guide.

2.3.4. Recruitment

Once identified, the possible participants were contacted through e-mail or a private message on social networks. The text for recruitment (Appendix D) contained a short

presentation of the researcher and the research proposal, followed by the above described criteria for inclusion in the sample, the time required for the interview (30-60 minutes), and the invitation to schedule a meeting at the time and place that best would have fit the needs of each participant. An interview was scheduled with those that answered positively to the message.

2.3.5. Conducting the interviews

Participants received the above presented introduction to the interview shortly after the interview was scheduled.

Out of 17 interviews, 12 were conducted face-to-face, three were conducted on video-call and two by telephone. At the beginning of the interview, participants were asked if they were comfortable with the text they previously read and if they wished to read it again, together with the interviewer. The interviews proceeded accordingly to the interview guide. At the end of the interview, participants were thanked for their availability and asked if they knew anyone that would fit into the sampling criteria and willing to participate to the study. All interviews were conducted in Portuguese, audio-recorded, and transcribed verbatim. Quotes reported in the Chapter III, “Results”, of this study are the result of an accurate translation from Portuguese to English.

2.4 Methodological approach and data analysis

2.4.1. Content vs. thematic analysis

For data analysis, two different methodological approaches were adopted: content and thematic analysis. The term “content analysis” refers to a general approach characterized by systematic coding and categorizing, employed to explore large amounts of information and to determine trends and patterns within the investigated phenomenon. This type of analysis is highly descriptive and aims to quantify and code data according to systematic categories, using frequencies to find significant meanings within the information available (Vaismoradi, Turunen, & Bondas, 2013). On the other side, the thematic analysis is a qualitative approach characterized by high levels of interpretation, used to identify specific themes and hidden contents within data. In other words, this approach is used to understand the subtle meanings present in the data (Vaismoradi, Turunen, & Bondas, 2013; Braun, Clarke, Hayfield, & Terry, 2018).

These two approaches are respectively based on two different units of analysis: the category and the theme. The category has a descriptive identity and it is used to classify the manifest content of the data (Vaismoradi, Turunen, & Bondas, 2013; Vaismoradi, Jones, Turunen, & Snelgrove, 2016). By contrast, the theme has an interpretative identity and is used to code implicit topics, text units that have a common point of reference. It is considered: “a

thread of underlying meaning implicitly discovered at the interpretative level and elements of subjective understandings of participants” (Vaismoradi, Jones, Turunen, & Snelgrove, 2016).

The content and thematic analysis also require different procedures of coding. The content analysis is usually based on deductive work, divided in three phases: preparation of the categories, organization of the data in the prepared categories, and reporting of the data. The thematic analysis requires instead a more complicated and inductive work process in which, after having familiarized with the data, the researcher needs to create some initial, broad codes, and within each code, to search for specific underlying themes. Themes need to be labeled, defined, named, reviewed and related to already established knowledge (Vaismoradi, Turunen, & Bondas, 2013; Braun, Clarke, Hayfield, & Terry, 2018).

2.4.2. Coding procedures and data analysis

The data analysis was divided in two parts and conducted on NVivo. Before starting the analysis, an NVivo case was created for each participant. During the interviews, some participants reported situations that were experienced by other people (situations they witnessed or experienced by intimates) with different social identities. This is why each person that experienced a microaggression was coded as a different NVivo case. In the analysis phase, NVivo cases constituted the actual sample of the study (28 cases). NVivo cases were classified in groups, according to social identities (Table 2.1).

Case classifications	N. of NVivo cases
Caucasian (perceived as Portuguese) + Straight women	10
Caucasian (perceived as Portuguese) + LGBTQI+ women	7
Perceived as foreigner + Straight women	8
Functionally diverse + Straight women	3
Total	**28**

Table 2.1. Classification of NVivo cases based on participants' minoritarian identities

In the first part of the analysis, a mixed approach of directed and conventional content analysis was used. In the directed content analysis, categories already existing in the literature are used to test a specific theory or theoretical framework, while in the conventional content analysis categories are created on the base of an initial coding scheme, then widened with the addition of subcategories (Hsieh & Shannon, 2005). At first, the taxonomy of microaggressions proposed by Sue (2010) was used to code the different forms and levels of manifestations of the collected microaggressive incidents and were extended inductively by the results of this study. Categories for forms of microaggressions were described as follows:

Microaggressive incidents toward women in the healthcare context.

- Microinvalidations: communications that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups (Sue D. W., 2010). This category included: the denial of someone's reality (what you feel is not true, denial of individual or social discriminatory attitudes, myth of meritocracy, dismissive-condescending attitudes, etc.); summary and superficial medical examination, lack of attention and empathy to the patient, insensitivity, denial of patients' pain or feelings.
- Microinsults: unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that demean a person's gender, racial, sexual orientation and functionally diverse heritage or identity. It is a subtle snub, hiding an insulting message, repulse, offense, indignity, unworthiness and that reflects a negative stereotype about the target. (Sue D. W., 2010). Look of distrust or suspicion, avoidance, sexist comments, assuming that the other is heterosexual, treating someone as "abnormal", are some of the contents of this category.
- Microassaults: conscious, deliberate, purposeful, biased offenses, intended to threaten, humiliate, intimidate, hurt or make feel unwanted (Sue D. W., 2010).
- Mixed microinvalidations + microinsults: this fourth category was created in the coding phase to provide a category for those microaggressions that were both a microinvalidation and a microinsult.

Verbal, non-verbal/behavioral and environmental levels of manifestation (Sue D. W., 2010) were combined with the above described microaggressive forms, generating 12 different typologies of microaggressions: 1. Verbal microinvalidations, 2. Verbal microinsults, 3. Verbal microassaults, 4. Verbal microinvalidations + microinsults, 5. Non-verbal/behavioral microinvalidations, 6. Non-verbal/behavioral microinsults, 7. Non-verbal/behavioral microassaults, 8. Non-verbal/behavioral microinvalidations + microinsults, 9. Environmental microinvalidations, 10. Environmental microinsults, 11. Environmental microassaults, 12. Environmental microinvalidations + microinsults.

In a second moment of the content analysis, categories were created in order to categorize the different information related to each microaggressive incidents. The following organizing themes (Appendix G) were created: b. Type of health care system; c. Specific medical areas or hospital section, d. Type of health professional or perpetrator, e. Microaggressive contents, f. Emotions and thoughts at the moment of the incident, g. Participants' reactions to microaggressions, h. Complaint, i. Recalling of the incident, j. Presence of third persons, k. Social sharing of the incident, l. Consequences for the patient's

health, m. Apologies from the health professional, n. Never experienced microaggressions., o. General questions about microaggressions; Participants' personal information. Each one of these categories and relative subcategories will be described in the Chapter III, "Results", of this dissertation.

The analytical work done in the first part of the study was mainly descriptive and deductive. For example, it wasn't questioned whether the incidents described would be considered microaggressions in terms of what the literature labels as microaggressions. In other words, if after reading a consistent definition of microaggression, the participant reported an incident and considered it a microaggression, this incident was coded according to the participant's perspective. In this phase, interpretative work was made only to code the incidents into the different categories relative to the typologies of microaggressions. In total, participants reported 53 microaggressive incidents. However, because some of these incidents contained multiple microaggressions, the actual number of coded microaggressions was 62.

The second part of the study consisted of a thematic inductive analysis, transversally conducted on the data and aimed at identifying the microaggressive themes related to health providers' discriminatory attitudes towards women with minoritarian and intersectional identities. In this phase, each microaggressive incident was analyzed in order to identify its underlying stereotypical beliefs. In a second moment, themes were named and described according to the already existing literature on sexist, heterosexist, racist and ableist microaggressions. Themes that were not present in the literature were named and described based on other theories about discrimination. A total of 20 microaggressive themes was identified (Appendix G).

The chosen unit of coding consisted of segments of conversation that represented a single message or a distinguishable feature relevant for each created node. The length of these units was various and determined by the coder herself every time (Kurasaki, 2000). According to this author, this approach is to be considered valid when the analysis is conducted on semi-structure interviews, containing open-ended questions with free-flowing text data.

After coding, the following operations were performed:

1. Computation of frequencies for all codes the different typologies of microaggressions, in order to answer to the question: *2)* Which are the microaggressive forms, levels of manifestation and themes frequently perceived by women in the health context?
2. Generation of matrixes crossing data about the different typologies of microaggressions and the different interviewed groups, and computation of relative frequencies within each matrix, in order to answer to the questions: *3)* Compared to White women, do women with

intersectional identities (Women of Color, immigrant, LGBTQ+, functional diverse) report a higher degree of microaggressive incidents? and *4)* In the health care context, do women with different minoritarian identity report different forms, levels of manifestation and themes of microaggressive incidents?

2.5 Ethical considerations

At the beginning of the interviews, all participants were asked to read and sign an informed consent (Appendix E). Those that participated via video or audio-call received the informed consent prior to the interview and were asked to verbally accept the conditions described in the form. All their answers were recorded. The informed consent ensured that the participation to the study was voluntary, anonymous and confidential, that collected information would be only analyzed collectively and all personal information would be treated according to the ethical principles in Psychology. To ensure anonymity, during transcription all names mentioned in the interviews were substituted with fake ones.

At the end of the interviews, participants were given a debriefing sheet (Appendix F) containing some scientific references about the study and the contacts of the research team. Both the informed consent and debriefing sheet were drafted based on standardized forms ethically approved by the ISCTE-IUL, University Institute of Lisbon.

2.6 Procedures to ensure trustworthiness and study quality

Along the study, many strategies were adopted to ensure trustworthiness and quality. To ensure credibility, all interviews were digitally recorded and transcribed verbatim (with identifying information removed), while peer debriefing (that consists in allowing a peer that has a general knowledge of the topic to discuss the methodologies of the study and the researcher's ideas) was repeatedly done during the different phases of the study. Triangulation of researchers (in which peers try to detect the anomalies related to the researchers' subjectivity) was applied to codes and coding procedures, that were reviewed and discussed within the research team (Coutinho, 2008). Intercoder reliability was provided by the creation of an Agreement Matrix and the calculation of the Intercoder Agreement coefficient, Cohen's Kappa (Kurasaki, 2000). A member of the research team reviewed the coding of two interviews, which were randomly selected (20% of all collected data) and stated whether she agreed or disagreed on each code. Agreements and disagreements on each code were inserted in a matrix table. Cohen's K was run through the online tool "Quantifying Agreement with Kappa" (GraphPad Software, 2018). Results for Cohen's Kappa were: $\kappa = 0.874$ for content analysis, and for thematic analysis a complete agreement ($\kappa = 1$) was reached. However, it is important to point out that Cohen's Kappa is not considered a valid measure to ensure the trustworthiness

of thematic analysis, due to the highly subjective nature of this qualitative approach (Vaismoradi, Turunen, & Bondas, 2013).

Furthermore, to ensure transferability, a “thick description” (dense and complete description of the data) will be provided in the Chapter III., the “Results” of this dissertation, and through the attachment of the complete codebook of the study in the Appendix (Coutinho, 2008).

Microaggressive incidents toward women in the healthcare context.

Chapter III. Results

3.1 Content analysis

3.1.1. Typologies of microaggressions

Microaggressions were coded accordingly to the taxonomy proposed by Sue (2010), as described above. The categorization of microaggressions into different typologies allows to answer to the first four research questions of this study.

1. Do women perceive microaggressions in the health care context?

According to the data, the answer to this question is affirmative. Of the total of 17 participants, 14 participants were able to report microaggressions experienced in first person, two participants were able to report microaggressions experienced by intimates, and only one participant reported that never experienced, witnessed nor heard about a microaggression in the health care context. Participants reported a total of 53 situations of microaggressions (meaning that, on average, each participant was able to report 3 situations). Some situations contained more than one microaggressive incident, meaning that the actual total of microaggressions reported was 62.

2. Which are the microaggressive forms, levels of manifestation and themes frequently perceived by women in the health context?

Microinvalidations resulted as the most frequent form of microaggressions, with 32 incidents reported (Appendix A, Table 1). Verbal and behavioral microaggressions resulted as the most frequent levels of manifestation of microaggressions, with 28 incidents reported for each level (Appendix A, Table 2). Nonverbal/behavioral (17) and verbal (11) microinvalidations resulted as the most frequent typologies of microaggressions, followed by mixed verbal microinvalidations/microinsults (8) and verbal microassaults (7) (Table 3.1).

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

> [Example of verbal microinvalidation] “And the family doctor, this new one, I asked him if I could do some checks, some analysis, to know if everything was okay with me. And he

dismissed me and said that, as I am a woman, the only thing I had to worry about was doing a cytology, and he asked me when we were going to make the cytology, because the rest didn't matter, the other things were only matters of prevention. He insisted about when we were going to make the cytology, he was only worried about it, only worried about my reproductive organs and not with any other issue related to my health". [Interviewee 16]

[Example of mixed verbal microinvalidation + microinsults] "I had to run to the emergencies, for example, when I had kidney stones. […] Even when they put me on the bracelet, the nurse who put me on the bracelet said to me, ‹‹Ah, but you're a woman, I'm going to give you a less urgent bracelet, instead of that orange color, because women can handle the pain better.›› So, I got there dying of pain." [Interviewee 9]

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

Table 3.1. Frequencies per each typology of microaggression

3. ***Compared to White women, do women with intersectional identities (Women of Color, immigrant, LGBTQ+, disabled) report a higher degree of microaggressive incidents?***

Table 3.2 shows the answer to this question. *Perceived as Portuguese, straight women* reported a total of 12 microaggressive incidents (relative frequency = 1.2). *Perceived as Portuguese, LGBTQI+ women* reported 24 microaggressive incidents (relative frequency = 3.4). *Perceived as foreigners, straight women* reported 10 microaggressive incidents (relative frequency = 1.9). Finally, *perceived as Portuguese, straight women with functional diversity* reported 10 incidents (relative frequency = 3.6). Looking at the average of incidents per each

case, it is possible to state that women with intersectional identities – especially LGBTQI+ and functionally diverse women – experience more microaggressions than the group *Perceived as Portuguese – straight women.*

	Functionally diverse - straight women	Perceived as foreigners - straight women	Perceived as Portuguese - LGBTQI+ women	Perceived as Portuguese - straight women
N. of cases per group	3	8	7	10
N. of microaggressions per group	11	15	24	12
Relative frequencies (microaggressions per case)	**3.6**	**1.9**	**3.4**	**1.2**

Table3.2. Relative frequencies of microaggressions for each group

4. ***In the health care context, do women with different minoritarian identity report different forms, levels of manifestation and themes of microaggressive incidents?***

As Table 3.3 shows, all groups reported a high number of behavioral microinvalidations. However, *functionally diverse, perceived as Portuguese straight women* also reported a high number of verbal microinvalidations. *Perceived as Portuguese, LGBTQI+* appear to be highly targeted by verbal microinvalidations and verbal microassaults.

[Example of behavioral microinsult] "Sometimes I don't understand what they say, and it's like... ‹‹You are obliged to understand.›› So, it usually happens a lot, for example in relation to the information I ask, because I wasn't born here, so there are things that I don't normally know, I wasn't born with that knowledge. So, you have to ask, and people take it very badly when I keep asking so many questions like this, while there is a platform or a site where I can simply read and inform me of everything. I have to talk to people. Their answer is always very aggressive and embarrassing too, because I keep thinking ‹‹Gee, what did I do wrong?››." [Interviewee 13]

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

Microaggressive incidents toward women in the healthcare context.

	Functionally diverse - straight women (n. cases: 3)		Perceived as foreigners - straight women (n. cases: 8)		Perceived as Portuguese - LGBTQI+ women (n. cases: 7)		Perceived as Portuguese - straight women (n. cases: 10)	
	Abs. freq.	Rel. freq.	Abs. freq.	Rel. freq.	Abs. freq.	Rel. freq.	Abs. freq.	Rel. freq.
Behavioral microassaults	1	0.30	2	**0.25**	1	0.15	0	0
Behavioral microinsults + microinvalidations	0	0	0	0	3	0.40	1	0.10
Behavioral microinsults	0	0	1	0.12	1	0.15	1	0.10
Behavioral microinvalidations	4	**1.30**	6	**0.75**	4	**0.60**	3	**0.30**
Environmental microassaults	0	0	0	0	0	0	0	0
Environmental microinsults	0	0	1	0.12	1	0.15	0	0
Environmental microinvalidations	3	1	0	0	1	0.15	0	0
Verbal microassaults	0	0	1	0.12	4	**0.60**	2	0.20
Verbal microinsults + microinvalidations	1	0.30	2	**0.25**	3	0.40	2	0.20
Environmental microinsults + microinvalidations	0	0	0	0	0	0	0	0

Microaggressive incidents toward women in the healthcare context.

Verbal microinvalidations	2	**0.70**	1	0.12	6	**0.85**	2	0.20
Verbal microinsults	0	0	1	0.12	0	0	1	0.10
Total	11	3.60	15	1.90	24	3.40	12	1.20

Table 3.3. Absolute and relative frequencies for each typology of microaggression

3.1.2. Type of health care system

Of the total of the incidents in which the type of health care system was mentioned, 18 incidents happened in public health care facilities, while six happened in private health care facilities (Appendix A, Table 3). This first set of results should be carefully interpreted: in fact, it is not possible to infer if microaggressions are more common in the public health care system than in the private one, as in Portugal most people usually head to the public system.

3.1.3. Specific medical areas or physical sections of health care facilities

Table 3.4 shows that most microaggressions occurred in the medical areas of maternity or obstetrics (13) and gynecology (8). Since early 1950s, different studies have shed a light on sexism and discrimination in medical areas exclusively related to women's health (Halas, 1979; Elder, Humphreys, & Laskowski, 1988). Further considerations on these results will be made in Chapter IV, "Discussion" of this dissertation.

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

Microaggressive incidents toward women in the healthcare context.

Table 3.4. Absolute frequencies for specific medical area or physical sections of healthcare facilities

3.1.4. Enactors of microaggressions

Of the total of the incidents in which the type of health provider was specified, 22 microaggressions were perpetrated by doctors, six by nurses, four by other types of health professionals (e.g. physiotherapists, technicians, etc.), seven by more than one type of health professional (e.g. doctors and nurses simultaneously), and six were defined as environmental or systemic (meaning that the microaggression was perpetrated not by a physical person but by the system, environment, structure) (Appendix A, Table 4). The name of this node was retrieved by Nadal and colleagues' study about microaggressions towards women (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013).

3.1.5. Microaggressive contents

During the interviews, participants were asked if they were able to recognize which contents or stereotypes were behind the microaggression they experienced, or if they could guess the reason of the perpetrator's attitude. For 33 out of 53 situations of microaggressions described, participants were able to recognize the content behind the microaggression (Appendix A, Table 5). According to participants' opinions, most microaggressive contents were related to sexist beliefs (13):

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

It is interesting to notice that participants also described some forms of microaggressions (7) that apparently were not related to societal stereotypes or discriminatory attitudes, but to practitioners' attitudes of arrogance, detachment, lack of empathy, and superficiality. Participants' were also able to recognize homophobic or heterosexist contents (2), racist or xenophobic contents (3), and ableist contents (2). A last category of contents was defined "intersectional" (6) referring to microaggressive beliefs or attitudes related to intersectional identities:

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

Microaggressive incidents toward women in the healthcare context.

This data partially confirms the hypothesis, posed by Nadal et al. (2015), according to which people belonging to historically oppressed groups are able to identify intersectional microaggressions that are embedded in systemic oppression. In this context, participants might be able to recognize the above described microaggression because they suffer of higher degrees of stigma (Nadal, et al., 2015) or because they possess a higher degree of sensitivity (Downing & Roush, 1985; Capodilupo C. , et al., 2010).

3.1.6. Emotional reactions

When asked about their feelings and thoughts at the moment of the microaggressive incidents (Appendix A, Table 6), participants described feelings of anger (9) and powerlessness and vulnerability (7).

> I: "Do you remember in this which your thoughts were? And your emotions?"
> P: "As I said before, the first thing I always feel is anger. In these two cases I did not feel humiliated, I did not feel embarrassed, I think I felt angry because it also implied a little my... The cost of consultation, and lack of sensitivity, and also the fact that reality did not correspond to the expectation that I had about what a professional should have done. Yes, the anger." [Interviewee 2]

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

> I: "And do you remember which your thoughts and emotions were when it happened?"
> Q: "It was immediately a feeling of injustice, like: ‹‹what are you doing here?›› This is not fair, no one can treat me like this." [Interviewee 9]

A last child-node of this category, "other emotions and thoughts" (6), was created to code all the emotional reactions considered less specific or not codable within the other nodes. Studying women's emotional reactions to microaggressions, Nadal and colleagues (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013), divided these reactions in two categories: those based on internalized emotions (i.e., shame, sadness, powerlessness, vulnerability) and those based on externalized emotions (i.e., anger, fear, feeling of injustice). The experience of internalized or externalized emotions, as well as the experience of self-directed anger, may depend by the level of developed feminist identity (Capodilupo C. , et al., 2010).

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

Microaggressive incidents toward women in the healthcare context.

3.1.7. Behavioral reactions

When asked about their reactions at the moment of the microaggressive incident (Appendix A, Table 7), participants affirmed that many times they were able to directly (14) or indirectly (3) answer to the perpetrators. Others affirmed that some microaggressive incidents (9) left them without reaction.

> “And there I instantly lose my patience: ‹‹Why are you talking about using hot towels? What is that?›› That... it is like who says: ‹‹These are premenstrual streaks, it basically passes with hot towels.›› When it wasn't like this. So, I forced them to come forward, to explain, ‹‹but what is this?›› I am not the kind of person that stays quiet. Also, I work in an area that is a bit connected to health... so I am always like: ‹‹What is this for? Why did you give me this?››” [Interviewee 3]

> “Another incident happened to me a short time ago. It wasn’t exactly like this one, but also at the time did not... I didn't have the ability to react.” [Interview 10]

The high number of reported direct reactions is in contrast with the scientific literature (Sue, 2010), according to which people usually do not react to microaggressions. This discrepancy may be related to participants’ activist identity (Downing & Roush, 1985). In their study about women’s reactions to microaggressions, Nadal and colleagues (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013) identified four types of behavioral reactions to microaggressions: passivity (“passive reaction” in this study), protection (“indirect reaction” in this study), avoidance, confrontation (“direct reaction” in this study).

3.1.8. Complaint

Of all incidents in which was specified whether participants complained or not about the health professional or facility (Appendix A, Table 8), participants presented an official complaint in four cases; in three cases they stated that they intentioned to officially complain but did not had done it yet, in four cases participants did not complain, and in two cases participants unofficially complained (e.g. they complained to the health professional’s chief/superior).

> “... And asked for the book [of complaints]. I made a written complaint… I made a written complaint and I left without being attended. I refused to be attended.” [Interviewee 9]

> “I didn't press charges at the hospital. Also, I was very young, and I was in a situation of high emotional fragility.” [Interviewee 8]

Microaggressive incidents toward women in the healthcare context.

3.1.9. Recalling the incident

The question "Have you ever thought about the incident again, after it happened?" (Appendix A, Table 9), was positively answered 14 times, and negatively answered four times.

> I: "Have you ever thought about this event again, after it happened?"
> P: "Yes, whenever I talk about good practices or whenever I talk about going to the doctor, or whenever I think [about it], the image comes back to me… I remember the doctor's figure, not feeling safe inside." [Interviewee 16]
>
> I: "Did you think about it again?"
> P: "No, only now, trying to remember things, I tried to remember some situations in the health context, and I remembered it, but I hadn't thought about it again." [Interviewee 15]

The frequent recalling of microaggressive incidents may be explained through the Model of Temporary Evolution of Emotional Memories (Rimé, 2009). According to this model, during the time emotional memories pass from being initial reminiscences to dormant memories or to extinguish, through an extinction slope. The emotional intensity of the event determines how much time is needed for the emotional memory to become dormant or extinguish. Forgotten memories can also be reactivated when the proper condition is met. Furthermore, some memories can remain uncovered: they do not become dormant and continue to affect individuals' life (Rimé, 2009). In the context of this study, incidents that were recalled several times where those characterized by higher emotional intensity. This data support scholars' findings, according to which, microaggressions may have a long-lasting repercussion on targets' lives (Sue, 2010).

3.1.10. Social sharing of the incident

Of all incidents in which social sharing was mentioned (Appendix A, Table 10), 16 were shared by participants, three were not shared. Targets of social sharing were mainly friends, romantic partners and family members. These results correspond to theories about the Social Sharing of Emotions (Rimé, 2009). A possible explanation to why people share some incidents and keep other secret is related to the emotions this incidents trigger. Finkenauer and Rimé (1998) found that individuals tend to not share incidents related to feelings of shame and guilt.

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

Microaggressive incidents toward women in the healthcare context.

Furthermore, 13 incidents, when shared, triggered a supportive reaction, while three triggered dismissive reactions (Appendix A, Table 11). According to the literature on microaggressions (Sue D. W., 2010), most people are expected to give dismissive feedbacks to those that share microaggressive incidents. This expectation is related to the common belief about microaggressions as something not important and unworthy of consideration. Consequently, these results do not appear to be in line with the literature. A possible explanation may be related to the high degree of emotional intensity that individuals communicate when sharing the incident, triggering reactions of empathy in the targets of sharing (Rimé, 2009).

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

"And with friends of mine, yes, they understood perfectly that I felt weird, that for me it was... Also, they shared with me things that happened to them. Gay friends, lesbian friends, women... they are not "usual", then it's possible to recognize the discrimination. For those who have this awareness, they recognize the discrimination." [Interviewee 8]

3.1.11. Presence of other people

Participants were asked if they were alone when they experienced the microaggressive incident (Appendix A, Table 12). In six cases participants were alone. In eleven cases, other people (other health professionals, friends, family members, other patients) were present but did not intervene, support or help the target of microaggressions. In six cases, those that were present intervened. The high number of "silent bystanders" is in line with the literature on microaggressions (Sue D. W., 2010), according to which, due to their subtle form, microaggressive incidents are hardly recognizable as forms of discrimination.

I: "And were there other people present at that moment of the incident? Did anyone say something?"
P: "There was my partner, yes. But no. He doesn't usually say... Because he doesn't feel it on his skin. Or because he probably thinks I exaggerate, too. I've always felt it on my skin. I've always been a lot more sensitive to these things, because I feel... Because I think there are no prejudices about the man, young, father. The weight is always more on the woman, and if she's is African, it must weigh much more. For this reason, I feel a little more vulnerable." [Interviewee 2]

I: "Has it ever happen that other people were present, and someone intervened or said something?"

Microaggressive incidents toward women in the healthcare context.

> P: “It did happen. There was this one time, when this doctor was asking if I felt anything [on my leg], and she poked me and so on, my daughter was present, and she screamed at her doctor, like this... She got very irritated and intervened.” [Interviewee 12]

3.1.12. Change in the relationship with or perception about the health professional

Participants were asked if the microaggressive incident affected their relationship with the health professional, the perception they had of him/her or of the healthcare facility (Appendix A, Table 13).

Only when relating about two microaggressive incidents, participants stated that what happened did not change their perception of or relation with the health professional. For five incidents, participants reported that it did change.

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

Some of these participants stated that they preferred to continue to face many microaggressive incidents from their old doctor than changing physician and starting a new patient-provider relationship. These findings highlight that, according to participants' perspective, sometimes changing health provider can bring higher costs than microaggressions do.

> “Yes, I continue [to go to the same gynecologist]. It changed. Yes, it changed [the relationship with the doctor]. I don't know if… but it has to be this, like a syndrome of the patient, but I compensate this lack of sensitivity with the fact that he is a good professional. In other words, I say to myself ‹‹ah, but if I have to find another doctor and start everything from the beginning, I prefer to pass through these things than passing through a new relationship.›› But I continue to find him insensitive to these things. But this should be a think of… because it costs to start a new relationship, at least for me it costs a lot. And it is different than, for example, going to a dermatologist. Dermatologists do these things too. But it is different because the intimacy is different, I don't have to explain too many things. So, I compensate and say to myself, I excuse his lack of professional attitude with the fact that he is a good doctor, that is always available.” [Interviewee 2]

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

> P: “I never went back there. I really didn't like it. And I've been there several times. But this was...” [Interviewee 6]
>
> I: “So, your relationship with him changed after the incident, you didn't go back there? “

Microaggressive incidents toward women in the healthcare context.

> P: "Yes, I didn't go back there. Although I continue to go to private ophthalmologists, but I did not go back there." [Interviewee 4]

3.1.13. Consequences of microaggressions on patients' health

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

> I: "In this situation, the attitude of the health professional created, or could have created practical implications and/or for your health?"
> P: "Yes, because if I had left, if I did not insist on seeing another doctor, she would have discharged me [from the hospital]." [Interviewee 11]

> "When it happens again, I anticipate the event - if I'm in the line and I'm going to be attended, I'm already waiting for that behavior. I can't remember if I compensate. If I go and talk before it happens, or if I stop, or if I proceed slowly to see if the person will or will not attend me." [Interviewee 2]

3.1.14. Apologies from health professionals

According to participants, most health professionals and enactors of microaggressions did not perceive their attitude was microaggressive, nor apologized (13) (Appendix A, Table 15).

> I: "And did she realize or apologize?"
> P: "No, no, she never apologized. Back and forth, and she would do the same thing. People don't even know if it's for.... Why is it." [Interviewee 10]

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

> I: "At some point did health professionals realize that they had assumed a wrong attitude and/or apologized?"
> P: "Yes, they were apologizing, saying that it was not their intention, yes... And then in the case of the hospitalization, where I couldn't speak to the doctors… I kept failing to talk to them. There wasn't exactly a change of attitude. They said "Yes, yes, let's try," but then nothing changed." [Interviewee 11]

Microaggressive incidents toward women in the healthcare context.

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

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

These results are in line with the literature about microaggressions, that characterizes these incidents as unwillingly and unconscious perpetrated, being their perpetrators completely unaware of their own stereotypes and sometimes even well-intentioned (Sue D. W., 2010; Nadal, Hamit, Lyons, Weinberg, & Corman, 2013). Future studies need to explore the relation between patients' behavioral reaction to microaggressions (direct, indirect, passive) and health providers' apology or perception of their biased attitude.

3.1.15. Participants that never experienced microaggressions

Conformingly with the above described procedures to ensure trustworthiness and study quality (Paragraph II.VI), results for negative cases (Coutinho, 2008) are here presented. Out of 17 participants to the study, one stated that she never experienced, never witnessed nor heard about any microaggression in the healthcare context, and two participants referred that they never experienced it in first person, but they witnessed to or heard about it from intimates (Appendix A, Table 16).

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

> "Personally, I don't remember anything that's happened to me. Maybe the last and only event was that I changed from a male gynecologist to a woman because I felt a little more comfortable with a woman, and I like her a lot now and... It's not that I didn't like the other one but... Especially as he was also my mother's doctor, I think I'd rather prefer a separation. But with me there's no story, especially since I don't go to the doctor much. But I hear many stories, usually also about the consultations of gynecology and obstetrics, I have heard several reports of people who are close to me that lived situations of lack of sensitivity." [Interviewee 1]

Microaggressive incidents toward women in the healthcare context.

3.1.16. General questions about microaggressions

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

1. ***Are microaggressions common?***

All 17 participants answered positively to this question (Appendix A, Table 17). Awareness of the commonality of microaggressions was also displayed by those that never experienced or witnessed to a microaggressive incident.

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

2. ***Do microaggressions have a negative impact on their targets?***

Fifteen out of 17 participants answered positively to this question (Appendix A, Table 18). The remaining two believed that the impact of microaggressions depends on the targets' context, emotional state, personality and other factors.

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

> I: "Do you believe that these microaggressions have a negative impact?"
> P: "I think it's a bit like this, there are several factors. The context, where the person comes from, even some issues more... How the person is feeling at that moment. In a negative way, maybe it happens during the time, maybe not. The person sometimes is alienated and does not realize that she was the victim of a microaggression or deals with that moment and then comes another thing, and she forgets. Maybe that's here habitual way, maybe she doesn't usually notice, or maybe she has some strategies to deal with it. I think it depends on the context." [Interviewee 15]

3. ***Is there any good practice that might help sensitize health providers and/or reduce the impact of microaggressions on targets?***

Most participants (14) believed that microaggressions are an underestimated issue, and that tools of sensitization and training should be provided to all health professionals. Other participants (3) referred to other good practices, such as the improvement of the justice system or the insertion of Psychology classes since the first years of university.

> "Our health professionals here in Portugal do not receive enough training. That is, I think there should be more training, with an inclusive language against heteronormativity, more inclusive

> to different sexualities, and that could mainly focus on the greater knowledge of how to treat the human being that is in front of them, also in psychological terms, not to treat the other as an object. I think there is little training and that it is super possible to implement these things, as I already met health professionals that had an approach more…. Not of assuming things for you, but of making careful questions… and we could have this approach from doctors, but unfortunately here is not common." [Interviewee 6]

> "I think in the first-place justice has to work. If a doctor gets a report, it's because something happened, so, something must be done. That's a problem... Often doctors continue in the same place, and continue with the same practices, and then... You know, it draws the attention, but they still continue with their attitude. So, it's like it's nothing, it's like it's ok for them to continue with this kind of practice, so... I think that in the first place this should change, listen to what the people who suffer have to say." [Interviewee 13]

3.2 Thematic analysis

This second level of analysis consisted in the interpretation of each microaggressive incident (previously coded in "typologies of microaggressions") in order to create different microaggressive themes (Vaismoradi, Jones, Turunen, & Snelgrove, 2016). Microaggressive themes were divided in three main groups (Appendix A – Table 20): 1) microaggressions that reflect power relations and biases present both in the clinical and the societal contexts (themes related to the perpetration of sexist, heterosexist, racist and ableist contents in the health care context); 2) microaggressions that reflect the power disparity between health providers and patients, being unrelated to sexist, heterosexist, racist and ableist themes (in this case, patients are seen as a social minority within the health care context); 3) systemic microaggressions (microaggressions that systematically happen, being or not institutionally allowed).

3.2.1. Microaggressive themes related to both societal and clinical contexts

Most of these themes were retrieved from the literature about sexist, heterosexist, racist and ableist microaggressions. New themes were created when those present in the literature were not satisfactory. This was the case in which the combination of societal and provider-patient power relations generated specific discriminatory attitudes towards women. Microaggressive themes were organized in sub-groups, based on participants' social and intersectional identities.

Sexism-related microaggressive themes

a) **Ascription of inferiority.** This theme, containing eight codes, was retrieved from the literature on gender microaggressions (Sue & Capodilupo, 2008). It underlies the

paternalistic belief that women are not competent, and only need to do what the doctor says: they "don't understand", "don't need to know", "are not worthy of an explanation". According to Halas (1979) women are socialized to be passive recipients of medical care and are educated to demonstrate respect to stereotypically authoritarian figures, as doctors. Benevolent sexism may also play a role in medical disparities, because it supports the view that women are frail and need protection (e.g. the belief that invasive chirurgical procedures are more risky for all women) (Travis, Howerton, & Szymanski, 2012). The high dependence on providers, as well as the lack of information provided during consultations, contribute to women's lack of autonomy in the decision-making processes related to their health (Halas, 1979). This theme also includes the subtheme "ascription of emotionality", according to which women are considered too emotional, too weak and consequently inferior to men. This belief about women's high emotionality is used to minimize their experiences of illness and contributes to perception of women as unreliable historians of their health (Halas, 1979).

> "When the pediatrician came to the room the next day, I was there, he came to see the tests and took him [the baby] to do blood tests. And I asked him, ‹‹How is he?›› It was the seventh day, it was already... He told me ‹‹he's in the same condition›› and went away. And I said ‹‹no, I need you to explain››. He didn't tell me anything and he left. I took a deep breath. […] The next day, same situation, and I told him, ‹‹so what's going on, what's he [the baby] has?››, because no one had said anything to me. I didn't know, but I didn't have to know. And yet I didn't know, I knew theoretically what it could be. And the doctor refused, said that he had to stay at the hospital. ‹‹It's yellow, ›don't you understand? He has to stay hospitalized, to be treated, he has...›› And it was like this. His answer was ‹‹It's simple››. He called me ‹‹girl›› which is the thing all people do, because they treat us always by ‹‹mother››, but we have a name, a different name, everyone has a name. But [when you have a baby], your name becomes ‹‹mom››, it is not ‹‹Asia›› anymore, and all humanity disappears. But he didn't even treat me by ‹‹mom››, that it's already super annoying because you're going to be a mother there, so they don't call you anymore by your name, and you lose all your individuality. And on top of a paternalistic form ‹‹Ah, mother doesn't understand, mother doesn't know, mother...››. And he looked at me, and as I seemed very young […] he used this to diminish me, he called me ‹‹girl›› and then said ‹‹it is simple, today passes, and or your son dies, or he stays where he is. Do you want me to make a drawing?››. [Interviewee 9]

> "And he always has those phrases that cost me a little to listen because he says, ‹‹Marta is very anxious, Marta is always very anxious››" [Interviewee 2]

b) **Prescription of traditional gender roles.** According to the literature about gender microaggressions, this theme "occurs when an individual assumes that a woman should

uphold traditional gender roles" (Capodilupo C. , et al., 2010, p. 198). In this study, this microaggressive theme is related to the ascription of mothers' social roles as caregivers, accounting women as the only responsible for their child and freeing fathers from all their responsibilities. One incident was coded under this theme:

> "During the period of hospitalization [of my recent-born daughter] I rarely had information about my baby. Information were always communicated to the father, because it always happened that even if both of us cared about the baby, I was always breastfeeding, and I had to express breast milk. They knew, they perfectly knew where the parents were… Because it was a large room, and if the mother wasn't there, it was because she was in the breastfeeding room, and doctors could see it. But even in this way, they would always go to the father. I asked them, please, to do not do that, because many times these things were… first, they were things that both of us wanted to know, because they implied decisions. And decisions are not only made by the father, isn't it? And then I realized that maybe it wasn't important to them to let the mother know. And there was this issue, that the mother, clearly, the mother is a caregiver and the father is the decider. That was very clear. In small situations too, sometimes when they gave us tips, or when they explained how we should take care of our daughter at home, or about decisions we should take about our daughter's future. It was always this... There was always this separation. Her mother cared, but her father decided." [Interviewee 11]

c) **Moralization.** Microaggressions related to this theme (4) – created during the data analysis of this study – are triggered when women are believed to be breaking moral norms. This form of hostile sexism (Glick & Fiske, 2001) is expressed in the healthcare context through hostility towards women that choose to voluntarily interrupt their pregnancy and that are seen to go against social norms about feminine sexuality.

> "Once, was when I was a kid, I was 12 years old, my parents had gone out and I was home alone with my sister, and I suddenly started having a hip pain, and at the time I didn't know what it was. I was swollen. So, I was in a lot of pain, lot of pain, lot of pain, and had to go to the doctor and the nurse... […] The nurse was so, she was mean to me. I didn't know what it was, I was still a virgin at the time, and she said to me: ‹‹Ah, this is a thing of the men you sleep with.››" [Interviewee 10]

> "She wanted to make a voluntary interruption of pregnancy and... that was six years ago, and it was a complicated process, today I think it improved a little. And I realized that, although it is treated with a lot of secrecy, people, even the nurse, even the doctor herself […] they looked at the situation in a somewhat hostile way. She felt a little... Felt bad about it, with the way they reacted, like ‹‹you did not have to do it, this is not the way›› and things like that."
> [Interviewee 14]

d) **Objectification of women.** This theme (6) includes any attitude that treats women like objects, depriving them of their value as human beings. It was partially retrieved from the

literature about gender microaggressions (Sue & Capodilupo, 2008), referring to the treatment of women as objects for men's pleasure and other attitudes that underlie the belief that women should always have a good and well-kept physical appearance. Another subtheme here included is related to the treatment of mothers during maternity as they are only reproduction machines. The image of women as merely reproductive beings is a theme that frequently appears in the health care context, particularly in medical specialties as gynecology and obstetrics (Elder, Humphreys, & Laskowski, 1988).

> "And they turned on the lights and a nurse entered, the nurse of the day shift, […], and said to all ‹‹open your legs!›› [screaming]. This is real. I didn't even realize what it was, the other women were full of fear, all of them, they took the sheet off and opened their legs, and the nurse flushed them with a thing of Betadine, it seemed ketchup, and rubbed it with a sponge, on our genitals, which had just been mistreated, cooked, everything, like she was cleaning the floor of a kitchen." [Interviewee 9]

> "I remember once... I think I was under 13, like 12 and 13 years old, and whenever I was wearing a bra, I had a lot of pain. I still don't like wearing a bra today, I can't. It's horrible to me. […] And I remember asking that question [to the gynecologist]. I was a kid, my mom took me with her and said: ‹‹Ask the question to the doctor.›› He was a doctor. And the answer I had was... I think at the time I didn't think it was violent, but that sentence hasn't come out of my mind until today, so, when reviewing the text, I remembered. The doctor's phrase was ‹‹wear a sports bra in the normal days and wear a prettier bra when you go out for parties, that has to be seen.››" [Interviewee 6]

e) **Pain endurance.** This theme, containing four codes, is specifically related to the health care context. Pain expectations are usually related to the perception gender roles: on one side, women are often believed to be less able to endure pain, to be more sensitive to it and more likely to report it (Robinson, et al., 2001); on the other side, this study highlighted the existence of a common belief about women, seen as destined to suffer and endure pain, physically and psychologically, during their whole life.

> "Because I have very painful menstrual periods, and we [my doctor and me] had already talked about it, and I always felt that this gynecologist did not pay much attention to the problem, as if it was... ‹‹It's a natural thing, and Marta will have to live with it her entire life.››" [Interviewee 2]

> "And when you say you're in pain, all they do is to say, and repeat it over and over again: ‹‹Hang on. Being a mother is this. That's our cross. What did you think it would be like?›› No, it's not that. No, being a mother it's not being mistreated." [Interviewee 9]

Microaggressive incidents toward women in the healthcare context.

Racism and xenophobia-related microaggressive themes

a) **Second-class citizenship.** This theme was described by Sue (2010, p. 35), as containing the message that "certain groups are less worthy, less important, and less deserving, and are inferior beings that deserve discriminatory treatment". Five incidents were coded under this theme.

> "The first [situation] has to do with me and it wasn't just one, it's several, it's a form of disrespect... I'm Indian, and I have a complicated name. The first name, Lisa, is simple, and the others are quite complicated. And in health services, during a consultation, there's always that moment when... In a waiting room, I hear my name being called, and people... The person who called would always stammer, would always say it in a strange way, and inevitably when I arrived in the office of the doctor or the provider, there would always be a… how to say… condescending comment in relation to my name. Okay, it's not about being a woman, but it has to do with being a different culture." [Interviewee 8]

Heterosexism and homophobia-related microaggressive themes

a) **Assumption of abnormality.** This theme is related to the belief that LGBTQI+ people are socially deviant or sick, and that homosexuality is something unnatural and abnormal (Nadal, Riveira, & Corpus, 2010; Sue D. W., 2010). Three incidents were coded under this theme.

> "I know this lesbian girl that went to a consultation of gynecology and family planning. And the doctor, it was a woman, suggested her to use some contraceptives, and she [the girl] said she didn't need to. The doctor was shocked. And the girl said ‹‹No, it is because I like women, I am lesbian, I don't need contraceptives››. The doctor advised her to go to a psychologist, instead of continuing the consultation in a professional manner. Therefore, this is a very violent issue for us." [Interviewee 6]

b) **Endorsement of heteronormativity.** This theme includes those incidents (5) in which health professionals assumed *a priori* that their patients were heterosexual or acted in a heteronormative manner (Nadal, Riveira, & Corpus, 2010). This type of microaggressions has been widely documented in the literature about homophobia and heterosexism in the healthcare context (Morrison, 2012).

> "This situation related to gynecology, for example. In this case, the doctor's great concern was - it was a female doctor - It was which contraceptive methods I used, when I said I didn't use any, she did not even... She gave me almost a sermon saying: ‹‹you will get pregnant and…››. Instead of trying, on the other hand, to realize that there are several ways... There are several hypotheses that you do not need contraceptives. I could not have intercourse. Period, paragraph. I could have intercourse with a woman." [Interviewee 3]

Microaggressive incidents toward women in the healthcare context.

Ableism-related microaggressive themes

a) **Architectural barriers.** This theme (3) refers to those physical barriers that impede people with functional diversity (e.g. in a wheelchair) to access specific areas. The topic of architectonic barriers arises from the social model of disability (Thurber & Bandy, 2018) – according to which disability is determined by other people's or by the environment's failures to respond to individual's necessities – and is largely discussed within the literature about architecture and discrimination (Livingston, 2000). However, the discussion about this form of discrimination was never brought into the literature on microaggressions. In the present study, architectural barriers are considered a type of environmental invalidation, unconsciously or unwillingly perpetrated at the systemic level, that communicates and reproduces a stigma towards people with functional diversity.

> "Then, also as woman, the gynecological care that a woman normally needs and... In my case were very difficult to achieve, because there it is, the medical offices, in this case within the gynecology services, are all structured for women who have a normal mobility. I can't get on a stretcher to be seen in the gynecology service of a public hospital or any hospital." [Interviewee 12]

b) **Desexualization.** People with functional diversity often see their sexuality and sexual identity denied or ignored and are likely to be considered as asexual beings, devoid of sexual needs and desires (Keller & Galgay, 2010), even in the healthcare context (1).

> "[…] it happened to me in a gynecology consultation, when I had a complicated problem... the problem had a simple solution, but their hypothesis was like ‹‹Ah, it doesn't matter, as you don't need to have it [internal reproductive organs], we take everything off. Since you don't have to, you don't have to reproduce...›› Instead of solving the specific problem, that it was a problem that could be solved by taking... They wanted to take it all, do a general hysterectomy and retire all the organs to solve the problem." [Interviewee 12]

c) **Insensitivity towards functionally diverse people.** This theme (4) underlies attitudes of insensitivity and lack of empathy towards people with functional diversity and their condition (Scullion, 1999). Furthermore, in the healthcare context, people with functional diversity are often objectified, treated as bodies without their own willingness (Swain & French, 2001).

> [Microaggression experienced by a woman on a wheelchair] "The other day I went to do an echocardiogram. And there was a big stretcher, something that you can't just put the chair underneath it to let me get on it, and I asked the lady how I was going to get on the stretcher. And she put a footstool next to me, for me to get on the stretcher. So, these are the daily aggressions that a person with motor disabilities, in this case a woman with motor disabilities, suffers." [Interviewee 12]

Microaggressive incidents toward women in the healthcare context.

Sexism and racism-related microaggressive themes

This subgroup of themes was created in order to identify the intersectional themes related to participants' gender and to the perception of them as foreigners.

a) **Assumption of beauty and sexual objectification.** This theme (1) is particularly related to black women's experiences of microaggressions. Lewis and Neville (2015) described this theme as containing assumptions about style, attractiveness and standards of beauty, and containing what other authors call "exotization" (Nadal, et al., 2015): a process in which black bodies are sexualized and objectified.

> "[…] He made a comment that I didn't... That didn't fall too well. It must have been about my eyes, the color of my eyes... Something like it. As if it was a surprising thing the Cape Verdeans aren't so beautiful. ‹‹The eyes are so beautiful, the color of the skin is so beautiful.››" [Interviewee 2]

b) **Invisibility.** Usually placed between racial microaggressive themes, (Sue, Capodilupo, & Holder, 2008) in this study, this theme (2) assumed an intersectional valence, being clearly related to the intersection of gender and perception of targets as foreigners. It is related to the feeling of being invisible, unseen, unworthy of recognition, unimportant, powerless and overlooked.

> "First, we spent hours in the hallway of the emergency, she was completely delirious from fever... Hours. And in this situation, yes, I felt invisible, and yes, I believed that it was because of being a woman and being young. I believed that if I were a man, or if I were someone older, I would have had another type of attention. And, also, because we're Indian. And in this case, I felt much the matter of racism... but also the question of queues and protocol. The way it was being done, the professional wouldn't even worry about knowing her name. She was simply undressing her from everything, possessions, belongings, clothing, and putting them in a bag, as if it was nothing." [Interviewee 8]

c) **Myth of hyperfertility.** This theme (1) is related to the stereotype that women coming from development countries are hyper-fertile, sexually unbridled and suffer from lack of family planning and have many non-planned children (Smith-Oka, 2015).

> "Being pregnant, she experienced many situations, and being Brazilian... many situations related to be judgment of the reproductive capacity of Brazilian women. There was a doctor who told her ‹‹You Brazilians can't stay still, you're always having kids.››" [Interviewee 10]

3.2.2. Microaggressive themes towards patients as a social minority

Many studies have analyzed and discussed how the power differential between health providers and patients, together with the failure to implement patient-centered approaches, can

lead to forms of paternalization, objectification and disrespect of patients (Taylor, 2009; Jangland, Gunningberg, & Carlsson, 2009). In this context and given the definition of social minority above presented (Wirth, 1945), patients may be considered a minority group that suffers from microaggressions perpetrated by health professionals. The present study identified four microaggressive themes related to this perspective.

a) **Attitude of superficiality.** Many participants referred that attitudes of superficiality during the consultations, like the summary and unprofessional manner in which the physical examinations were conducted, made them feel microaggressed. These attitudes were found to increase patients' anxiety and decrease their satisfaction (Jangland, Gunningberg, & Carlsson, 2009), creating counterproductive consequences for the expected medical outcomes (Taylor, 2009). Three incidents were coded under this theme.

> "[…] Few years ago, I went to a dermatologist who arrived quite late, we had a scheduled appointment and she arrived half an hour late, the consultation lasted ten minutes and I paid – at the moment – 80 euros. And she wasn't even able to get to me to see the problem I had on my skin, she just passed the recipe." [Interviewee 2]

b) **Lack of sensitivity/empathy.** Many participants reported the feeling of not being understood, or of being treated without any sensitivity or empathy for their health condition, illness or emotional status (3). In their study about patients' complaints in healthcare, Jangland, Gunningberg and Carlsson (2009) found that most of complaints were related to stories of disrespect or insensitivity, and not to technical errors in diagnosis or treatment, as it may be expected. In particular, insufficient information, insufficient respect and insufficient empathy were among the most common reasons to complain.

> "I also have family member who had an ectopic pregnancy, so the baby got stuck in the fallopian tube and did not grow up. And it was a baby she wanted very much, it was the second child, but she really wanted to have a second child. And the doctor just said to her: ‹‹now you probably won't have children anymore››. […] For a person that lived her motherhood as 90% of her life and that wanted to have that second child so badly, this is extreme violence. And I think that in terms of obstetrics and gynecology, one of the biggest problems is the lack of sensitivity." [Interviewee 1]

c) **Objectification of patients.** This theme, containing two codes, refers to the treatment of patients as objects, as mere bodies with illnesses, without their own feelings, willingness, personality and history. This purely medical approach has been described as the opposite of patient-centeredness (Saha, Beach, & Cooper, 2008; Taylor, 2009).

> "Then there was another [situation], in which I felt very bad too, but I did nothing. And there were other people, there was an intern. And she [the doctor] started to do a pap-test, but in a way... I felt very mistreated and I had no reaction. And she was always talking, and she looked

> at the computer more than she looked at me. She talked a lot with the intern and little with me, so even when the intern wasn't there, she spoke less to me and looked more at the computer. Which I had already complained about, too. And then, when she was doing pap-test, she told me to undress from the waist down and she didn't put a towel on the top of me, or anything else. I mean, she did everything like this... And I had no ability to react, I felt very exposed, because I was there, naked, the intern was a man, and she had no consideration at all." [Interviewee 10]

d) **Paternalization of patients.** Health professionals often assume a position of authority towards their patients, lacking in effective communication and failing in creating a democratic decision-making process, in which the understanding of the health issue is shared with the patient. This "doctor-centered" approach leads to the paternalization of patients, ultimately resulting in the invalidation of their experience (Taylor, 2009). Two incidents were coded under this theme.

> "And there was once […] I felt I had an infection of the urinary tract. It was not the first time, and, as women, I think we know when we have a urinary infection, we recognize the symptoms, etc. And I got there and said I had a urinary infection, and the doctor had that reaction that was like ‹‹I'm going to tell you whether or not you have it, let's see››. It is an attitude of separation and superiority in relation to the patient. Sometimes they put themselves in a more distant, colder posture, or even do not explain things conveniently, they don't give time [to understand]." [Interviewee 15]

3.3.3. Systemic microaggressions

This third organizing theme contained all those microaggressions that, regardless of being previously coded as verbal, behavioral or environmental, and regardless of being related to societal beliefs or only to the health care context, reflect discriminatory processes that are systematically built into the organizational structure. Systemic discrimination is perpetrated through established practices and procedures, including both specific formal rules and informal practices embedded in organizational norms, which have become "part of the system" (Beck, Reitz, & Weiner, 2002). As a result, health disparities can be described as processes that involve both individual and institutional action, generating oppressive systems (Feagin & Bennefield, 2014). Examples of systemic discriminations in the healthcare are frequent in the literature: for example, black women receive less treatment, medical checks and prevention advices for breast cancer than white women (Feagin & Bennefield, 2014), while co-mothers in lesbian families are systematically excluded from the decision-making process regarding their children (Gregg, 2018). Of the total of microaggressions retrieved from the interviews, 16 were identified as systemic.

Microaggressive incidents toward women in the healthcare context.

> "I have a friend of mine who is bisexual, and she told me that the doctor […] And then the doctor asked if she had protected relationships. And she said: ‹‹Yes when I have relationships with men I have protected relationships, but with women things are not so easy.›› And the doctor didn't know how to clarify the situation either. That was a few years ago... Five years ago. And the shock of the doctor having a person who did not fit the parameters by which she had been prepared in college, was giant. She said the doctor's face was like: ‹‹how am I going to get out of here? how am I going to answer a question that might never have been made or I have thought of?›› And it is also a person of a rural context, that is even more complicated." [Interviewee 1]

> "I had a postpartum complication and had to be hospitalized in the intensive care. And meanwhile the two babies – they were twins – had to go to neonatology because it was the only place where they could stay. [...] In this context, Sofia experienced some unpleasant situations, of example they treated her by ‹‹father›› like... Very much on this basis... The mother was me who had the babies, and there can only be one mother and one father, so she was the father. Or in the sense that initially can only enter the parents... Mother and father, in neonatology, so they tried to ban her access because she was neither mother nor father." [Interviewee 7]

Microaggressive incidents toward women in the healthcare context.

Chapter IV. Discussion

Results show that women are highly likely to experience microaggressions in the healthcare context. Women with different intersectional identities (perceived as foreigners, non-White, LGBTQI+, functionally diverse) were found to experience a greater amount of microaggressions than perceived as Portuguese straight women. Furthermore, this study illustrates, through the application of Sue's (2010) taxonomy to the data, that different groups of women experience different typologies of microaggressions. For example, while all women described a high number of behavioral microinvalidations, functionally diverse (perceived as Portuguese, straight) women also reported a high number of verbal microinvalidations and perceived as Portuguese LGBTQI+ appeared to be highly targeted by verbal microassaults. Proceeding from the assumption that the different typologies of microaggressions represent different discriminatory behaviors, these findings may be interpreted through the Stereotype Content Model (SCM), the Bias Map and the Ambivalent Sexism Theory (Fiske, Cuddy, Glick, & Xu, 2002; Cuddy, Fiske, & Glick, 2007; Glick & Fiske, 2001). The SCM proposes that social groups are stereotyped according to the degree of warmth and competence (respectively referring to social competition and status) they are perceived to have. Different combinations of warmth and competence lead to different stereotypes contents (Fiske, Cuddy, Glick, & Xu, 2002). The Ambivalent Sexism Theory adapts the SCM to women and gender-based discrimination (Glick & Fiske, 2001). The Bias Map expands the SCM by including in the model the emotions and behaviors triggered by each stereotype content (Cuddy, Fiske, & Glick, 2008). For example, groups with perceived low competence and high warmth (e.g. women conforming to traditional gender roles, elder people, people with functional diversity) evoke paternalistic stereotypes and facilitating behaviors, while groups with perceived high competence and low warmth (e.g. some ethnic groups, women non-conforming to traditional gender roles, like feminist or lesbian women) evoke envious stereotypes and harming behaviors. In this context, different typologies of microaggressions may be related to the stereotypes evoked by different groups of women: for example, microinvalidations might be a form of paternalistic discriminatory behavior (experienced by all groups, and especially by functionally diverse women), while microassaults might be a form of envious discriminatory behaviors (experienced by LGBTQI+ women). However, further research should explore this relation to confirm or disconfirm this assumption.

Sexism in the healthcare context is a diffused and multidimensional phenomenon. As already mentioned, the lack of scientific research on women's illnesses, the belief that women

are highly anxious and emotional and the endorsement of paternalistic attitudes towards female patients are some of the factors that shape gender-based discrimination in all medical sectors. Within this framework, an important finding is represented by the high number of microaggressions that were reported to be happened in the medical specialties of gynecology, obstetrics and in relation to maternity. We found that almost half of the reported microaggressive incidents was related to these areas. An important question arises from these results: why sexist microaggressions seem to occur mainly in medical areas that are exclusively related to women's health? These areas should be shaped around women's physical, psychological and social needs. One possible explanation is related to women's perception of discrimination. Someone would suggest that gynecology and obstetrics are as sexist as any other medical specialties, but that in these areas women feel more vulnerable – because they are socialized to see themselves in terms of reproductive potential (Halas, 1979), and these sectors are related to reproductive health – and are consequently more sensitive to microaggressions. However, in the last decades many studies have focused on sexist attitudes specifically present in gynecology and obstetrics (Halas, 1979; Elder, Humphreys, & Laskowski, 1988). The history of the relationship between women and medicine shows us that, before the advent of medical technology and the professionalization of medicine, women were societies' primary healers – as "witches" or herbalists – and female midwives were the sole practitioners of physical care for women's special concerns, like childbirth and gynecology (Halas, 1979). Furthermore, gender role stereotyping in the socialization of both female patients and male or female physicians reinforces the already existent social hierarchy present in the patient-provider relation. Elder, Humphreys & Laskowski (1988) analyzed gynecology textbooks used in medical schools between 1978 and 1983 and found sexist patterns that may have affected doctors since university. A similar study had been previously conducted by Scully and Bart (1978), that analyzed gynecology textbooks from 1943 to 1972. Both studies found that textbooks' contents perpetrated paternalistic and derogatory stereotypes related to traditional gender roles (e.g. women's function should be related to childbearing, child caretaking, homemaking and husband pleasing) and to stereotypical views of female personality. Even if the second study (Elder, Humphreys, & Laskowski, 1988) highlighted a decrease of stereotypical contents along time, this change resulted to be incomplete. A physician that graduated in 1980, today would be still practicing. It is not difficult to imagine that he or she might have studied on one of these textbooks.

In the context of women's healthcare, those that just gave birth to a child represent a particularly vulnerable group, a minority inside the minority (Hunter, 2006). Obstetric violence

can assume many forms, from verbal insults or invalidations to physical abuses. Studying this phenomenon in Mexican hospitals, Smith-Oka (2015) proposed the concept of corporal microaggressions, which “emerge from mainstream perceptions of moral superiority and are expressed as violent bodily treatment, such as sterilization efforts that target single mothers” (Smith-Oka, 2015). A feminist approach to obstetric violence suggests that it is a form of gender violence. Women experience it because they are women (Shabot, 2016), because they are constantly objectified and perceived as “child-making machines”. Even after childbirth, mothers suffer from high degrees of stigma: for example, they are perceived as the only care-givers of their children, while fathers are freed from any responsibility. Lastly, lesbian mothers need to be considered as a specifically vulnerable sub-category, being target of sexist, heterosexist and intersectional micro and macroaggressions.

In the present study, participants reported that many providers did not apologize, neither changed their attitude after the microaggressive incident. This may find support in both microaggressions and sexism theories: on the one side, providers may have been well-intentioned and may have not realized that they were perpetrating a microaggression (Sue D. W., 2010); on the other side, providers may have not felt the need to apologize because of sexist beliefs related to women’s inferiority (Glick & Fiske, 2001). Such beliefs were also found in the analysis of microaggressive themes. The theme “assumption of inferiority”, which can be found in the literature about gender microaggressions, is conceptually similar to the concept of “protective paternalism” proposed by Glick and Fiske (2001), that also can be regarded as a form of gender microaggression. At the opposite side, microaggressions directed at women that were perceived to break social and moral norms were coded under the theme “moralization”. Interestingly, in the present study, moralization of women’s attitude was only present in environments related to sexuality and reproduction. Shabot (2016) suggests that hostile treatment of women in obstetrics may be related to the inevitable relation between childbirth and sexual intercourses, and to the sexual symbols evoked by women’s bodies in labor. These microaggressive incidents result being linked to the concept of hostile heterosexism, that is, the belief that women’s sexuality is dangerous to men and to the current social hierarchy (Glick & Fiske, 2001).

> “[…] Since a friend commented that it happened to her. She's younger than me. And she told me what happened to her. And that's that terrible thing, when you are having the baby, you are in labor... There is the comment, I think by female nurses: ‹‹You liked to make it [the baby], now it costs you to have it››.” [Interviewee 4 from this Master Theses Project]

Microaggressive incidents toward women in the healthcare context.

Another major finding of this study is represented by the microaggressive theme named "pain endurance". This theme, specifically related to the intersection of gender stereotypes and paternalization of patients, included those incidents reflecting the belief that women are "made" to endure pain, whether they are believed to be more sensitive to it or not. Studies about Gender Role Expectations of Pain (GREP) support our findings (Robinson, et al., 2001; Wandner, Scipio, Hirsh, Torres, & Robinson, 2012). These studies underlie that women are commonly expected (by both men and women) to be more willing to report pain, have lower pain endurance and higher pain sensitivity than men (Robinson, et al., 2001). Such expectations may be understood in terms of socialization about gender roles. For example, women may be expected and socialized to have more pain awareness and expression, while men may be socialized and expected to be stoic towards pain and discouraged to express it (Defrin, Eli, & Pud, 2011). Furthermore, research about differences in pain expectation for different ethnic groups have found that, on a scale, White people are perceived to be more sensitive to pain and more willing to report it, followed by Asian, Hispanic and Black people. Consequently, ethnic minority patients are more likely to have their pain underestimated and are less likely to receive treatment for it (Cintron & Morrison, 2006). Older adults are also expected to be more willing to report pain, to have lower pain endurance and to be more sensitive to pain than middle aged and young adults (Wandner, Scipio, Hirsh, Torres, & Robinson, 2012). Following this line, and based on the concept of heteronormativity, on gender-based stereotypes for LGBTQI+ people and on studies about intersectionality (Nadal, et al., 2015), we can deem gay men (stereotypically considered "feminine") to be exposed to expectations of pain similar to the ones of women, and lesbian women (associated to masculinity) to be exposed to expectations similar to the ones of heterosexual men. Consequently, it is possible to hypothesize that the intersection of gender, ethnicity and age may lead to specific expectations for people with different intersectional identities. Defrin, Eli and Pud (2011) suggest that expectations of pain are culturally shaped and can vary from culture to culture.

Interestingly, research about GREP in the healthcare context (Hirsh, Hollingshead, Matthias, Bair, & Kroenke, 2014), did not find a significant relation between health providers' sexist attitudes and their decisions in pain treatment. However, the present study might disconfirm these findings, as it is well explained by one participant's answer:

> "First of all, I think microaggressions are common in any area of our society. And health providers belong to this society, too. There are some specific microaggressions, like I was saying before… there are archetypes related to the care, or to being a woman, to what is endured physically and psychologically. There is very much the idea that women are actually physically

> and psychologically strong, but this is associated to the idea of endurance. Endurance of the pain of childbirth, endurance of children, endurance of body alterations, endurance of body pain, breastfeeding, menstruations… and then we have to endure the education alone, and to tolerate our husbands… in a more or less tough way, in a more physical or psychological way, and so on… we have to endure pain during sex… And these beliefs, associated to the healthcare system, can represent specific microaggressions." [Interviewee 4 from this Master Thesis Project]

Most of the other themes presented in this study were retrieved from the already existing literature about sexist, racist, heterosexist, ableist and intersectional microaggressions. The applicability of these themes to our results is a further confirmation of the validity of our framework. However, an important reflection should be made about the presence of these microaggressive contents in the healthcare context: first of all, the negative impact of microaggressions, that was proved to exist in other social contexts (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), may be exacerbated in the healthcare context, due to the particular position of vulnerability in which social minority patients are; second, as already mentioned, microaggressions in the healthcare context may also lead to major negative consequences, from lack of pain treatment to errors in the diagnosis, having a macro impact on patients' health and life. In this context, the operationalization of intersectional microaggressive themes sheds a light on the multiple jeopardy to which patients belonging to different social minorities are exposed.

Interestingly, we found that some of the microaggressions perpetrated by providers towards patients did not rely on sexist, heterosexist, racist or ableist beliefs. In other words, these microaggressions did not reflect any discriminatory belief about socially disadvantaged groups. However, at the beginning of this dissertation, it was stated that microaggressions are perpetrated towards minority, marginalized and historically oppressed groups (Sue D. W., 2010). Evidences supporting power disparities between patients and providers allow us to define patients as a social minority, not for matters of numbers (patients are obviously numerically more than providers) but for differentials in status, power, rank and privileges (Tajfel, 1982). This framework would be consistent with the conceptualization of majority and minority proposed by Wirth (1945) and Sue (2010). However, some authors prefer to refer to majorities and minorities only based on the number of group members, using the terms "subordinate" and "dominant" groups to refer to power and status differentials. Sachdev and Bourhis (1991) found that dominant groups are highly likely to discriminate out-groups, while subordinate groups are more inclined to out-group favoritism. According to Taylor (2008), health providers show a strong tendency to paternalize patients, excluding them from the decision making, shared understanding and possibilities of empowerment as individuals. This

"doctor-centered" approach is opposite to the "patient-centered" one, described in the first sections of this dissertation. Jangland, Gunningberg and Carlsson (2009), found that complaints within the clinician-patient relation were mostly related to stories of disrespect and insensitivity than to practical medical errors. They organized complaints under three different categories: 1. Not receiving information or not being given the option to participate; 2. Not being met in a professional manner; 3. Not receiving nursing or practical support. These categories partially match with the microaggressive themes described in the present study, being related to paternalization, lack of empathy and respect, and lack of patient-centeredness. These findings are useful to draw the perspective that considers patients a subordinate/minority group, that can be exposed to microaggressions and other forms of discrimination.

A last group of microaggressive themes was related to systemic microaggressions. In this context, a sociological approach may help define the relation of microaggressions with the macro/societal level, allowing to identify and understand the systems of privilege and power, social hierarchies and group boundaries, symbolic systems and cultural imageries on which these incidents rely (Embrick, Domínguez, & Karsak, 2017). The contribution of sociology within the framework of microaggressions highlights the importance of assuming a broader perspective, even when talking about something "micro". In the present study, systemic microaggressions included: specific formal and institutional rules, that contributed to the perpetration of microaggressions; institutional forms of unpreparedness (e.g. the lack of education about LGBTIQ+ medical needs); informal norms and practices embedded in the organizational life and systemically enacted towards specific groups (Beck, Reitz, & Weiner, 2002).

A final point of discussion should be made around the identification of good practices that may contribute to reduce the amount and intensity of microaggressions perpetrated against women in the healthcare context. Participants to this study identified as good practices the implementation of training and sensitization programmes, oriented to raising providers' awareness about social minorities and disadvantaged groups, but also to increase their application of patient-centered approaches. Scholars pointed out the particular and urgent need for trainings about women health issues (Vissandjée, M., Dupéré, & Abdool, 2001), LGBTQI+ people health issues (Smith & Turell, 2017) and cultural competency trainings to fight racialized medicine (Feagin & Bennefield, 2014). Other good practices may include bringing the directly interested people (minorities) at the top of the decision-making processes and at the middle of the conversation (Feagin & Bennefield, 2014), increasing the number of providers for underrepresented social minorities, creating specific guidelines, implementing

the use of community health workers (non-medical personnel that can help patients navigating in the healthcare system) and focusing future research on the monitorization of providers' progresses (Nelson, 2002).

4.1 Limitations

The present research has some methodological limitations. First of all, the decision to specifically focus on microaggressions directed towards women, did not allow us to make a comparison with microaggressions directed to men. In other words, it is not possible to know if the microaggressions described by women are also experienced by men, and in which degree. Furthermore, the four groups of participants based on their minoritarian identities, were not numerically equal. The group of straight perceived as Portuguese women was highly more numerous (six participants) than the one of functionally diverse (straight, perceived as Portuguese) women (two participants). The initial design also included a fourth group of participants: LGBTQI+, perceived as foreigners' women. This group would have allowed us to deepen theories on intersectionality and to broaden the framework on intersectional microaggressive themes. Unfortunately, the research team was not able to reach and recruit more women with the mentioned minoritarian identities.

In phase of content analysis, it was decided to stick to participants' understanding of microaggressions, without questioning whether their perception fit or not into the classical definition given by the literature. Only in phase of thematic analysis, incidents that did not fit in the definition of microaggressions were excluded. For example, during one interview, one participant reported a case of verbal sexual assault. This incident was coded as a verbal microassault in phase of content analysis and excluded during thematic analysis. In one of his books, Sue (2010) includes sexual assaults in the microaggressions framework. However, it is important to underline that sexual assaults, whether verbal or behavioral, need to be considered a macroaggression. Even if the perpetrator has no intention to hurt and is sincerely convinced that a woman would like his attitude, sexual assault is an issue that needs to be studied and solutioned – at the social, practical level – independently from other forms of gender discrimination. In other words, sexual assault cannot be considered a form of everyday sexism, or subtle discrimination, but needs to be understood and faced as a specifically urgent and serious social problem as well as a legal issue.

Another methodological weakness of this theoretical framework lays in the application of Sue's (2010) taxonomy. First, many incidents appeared to be simultaneously microinvalidations and microinsults, at the point that we needed to create a fourth category in

order to code them correctly. Second, there is some confusion in the literature about the concept of "microassault". As suggested by Lilienfeld (2017), microassaults seem to conceptually overlap with the "old-fashioned" forms of discriminations, usually defined "blatant" or "overt" (Pettigrew & Meertens, 1995), entering in contradiction with the classical definition of microaggressions.

Lastly, the use of semi-structured interviews appeared to be useful and critical at the same time: according to the Critical Incident Technique (Flanagan, 1954), semi-structured interviews allow to retrieve detailed information about microaggressive incidents; however, this type of interviews creates some difficulties in terms of coding and coding comparisons, because it does not allow to select a standard unit of coding. For the same reason, the calculation of Cohen's K to ensure trustworthiness was run manually, and not through automatized systems as the one offered by NVivo.

4.2 Suggestions for future research

The present study confirms the existence of microaggressions towards women in the healthcare context but leaves some questions open. As already mentioned, future research should understand the degree to which men with different intersectional identities are exposed to microaggressions. On the other side, it would be important to identify possible gender differences in the perpetration of microaggressions: do male and female health professionals perpetrate microaggressions in the same way? Do they perpetrate the same types of microaggressions and related themes? Do they have the same training needs?

This study was based on the assumption that women with a more developed feminist identity would be those that would more easily recognize microaggressions (Capodilupo C. M., et al., 2010). For this reason, we chose to interview women that identified as feminist or activists, and that were actively cooperating with NGOs and other socially committed organizations. Results confirmed our goals: the women we interviewed were not only able to recognize microaggressions and their negative impact, but also to identify the main contents that underlay most of the incidents. In the result section, we proposed that the different levels of feminist identity might be related with different emotional and behavioral reactions (Nadal, Hamit, Lyons, Weinberg, & Corman, 2013). However, the relationship between the Developmental Model of Feminist Identity (Downing & Roush, 1985), targets' awareness of microaggressions and their emotional, behavioral and cognitive reactions, need to be studied in future research. Also, it might be useful to establish a reliable connection between targets' emotional reactions to microaggressions and the above-described theories of Psychology of Emotions (Rimé, 2009), in order to understand, for example, if there is a relation between the

type of microaggression and the emotions that it elicits (e.g. microinvalidations might elicit shame, while microinsults might elicit anger).

Moreover, studies about microaggressions appear somehow disconnected from other findings and theories about stereotyping and discrimination. As already mentioned, future research might create a new link between the different forms of microaggressions and the Stereotype Content Model (Fiske, Cuddy, Glick, & Xu, 2002) and the Bias Map (Cuddy, Fiske, & Glick, 2007). In the present study, a clear link between gender microaggressions and the Ambivalent Sexism Theory was drawn in order to understand the specific stereotypes that underlay sexist microaggressive themes. This link should be tested in the future.

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

Finally, the Critical Incidents presented in the following section should be tested, validated and implemented in training and sensitization programmes for health providers.

Microaggressive incidents toward women in the healthcare context.

Microaggressive incidents toward women in the healthcare context.

Chapter V. Critical Incidents

In the Methods part of this dissertation (Chapter II.III), Critical Incidents were presented together with the Critical Incident Technique (Flanagan, 1954; Spencer-Oatey, 2013). We defined critical incidents as observable human activities that deviate significantly from individuals' social and psychological expectations. Within this framework, critical incidents are understood as remembrances, stored in individuals' memories, that can be retrieved through the Critical Incident Technique (Edvardsson & Roos, 2001).

However, other branches of Psychology conceive critical incidents as training tools, useful to sensitize individuals about specific issues, to trigger empathy, raise awareness and stimulate critical thinking (Dant, 1995; Wight, 1995). For example, this tool is largely used in cross-cultural and intercultural trainings, aiming to provide participants with examples of stressing situations that they may face during an experience abroad. A typical cross-cultural critical incident describes a situation in which there is a misunderstanding, a conflict or a problem – whether personal or interpersonal – experienced by a person during her or his adaptation to another culture. The text is usually short, containing a brief presentation of the main actors of the incident and of the background context, the description of the stressing situation or interaction, actors' consequent emotional and behavioral reactions, and – in some cases – the resolution of the situation. A critical incident is merely descriptive and leaves to participants the task to identify the underlying causes and motivations of what happened. For this reason, critical incidents are usually followed by a set of questions aimed at helping participants to analyze and interpret the described situation (Wight, 1995). In the wide range of intercultural training methods, critical incidents are classified as intercultural sensitizers, that are sets of training tools used to show participants the existence of alternative perspectives and interpretations than their owns (e.g. the existence many of culturally shaped ways of thinking and acting) (Fowler & Blohm, 2004). In 1970, Wight and Hammons proposed the Critical Incidents Exercise, consisting in a series of activities in which critical incidents are analyzed through individual, small-group and large-group discussions (Wight & Hammons, 1970). The CIE presents some methodological similarities with the use of case studies for training purposes. However, while case studies are long descriptions of detailed events, and are used to achieve depth of understanding in one specific situation, the CIE consists of a set of short critical incidents, used to achieve the understanding of a broad range of possible situations (Wight, 1995). The use of critical incidents also has some advantages over the use of case studies: it engages participants at the personal level, requiring them to critically reflect about a

situation that might be critical to their effectiveness, have a short reading time and can be used singly or grouped (as in the CIE) (Fowler & Blohm, 2004).

Critical incidents were proved to be effective on the development of cultural competence (Herfst, Van Oudenhoven, & Timmerman, 2008) and are largely used in many contexts (Fowler & Blohm, 2004). Morel, Sharp and Crandall (2002) provided a valid example of the application of critical incidents in the healthcare context. Simulating the case of an ethnic minority patient with abnormal menstrual bleeding and that resisted to be examined by male-providers, they were able to raise awareness about sexism, racism and diversity issues among medicine students. To improve the effectiveness of the training, students were showed video-records of their discussion, making easier for them to visualize and understand their biases.

In the present study, situations of discrimination in the healthcare context collected through the Critical Incident Technique (Flanagan, 1954) were used to create critical incidents for the purpose of being implemented in future trainings for health providers. Five incidents, one per each minoritarian group identified in this study (Women of Color, immigrant women, LGBTQI+ women, women with disabilities and female patients) were created based on the guidelines proposed by Wight (1995). For each group, we selected microaggressions that were repeatedly reported or that were exemplificative of a frequently retrieved theme. Each critical incident contained at least two or three microaggressions, inserted in a broader situation happening in a fictitious context with fictitious actors. All created texts are attached to the Appendix of this dissertation.

Microaggressive incidents toward women in the healthcare context.

Bibliography

Almond, A. (2017). Measuring racial microaggression in medical practice. *Ethnicity and Health*, 1-18.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. 17(2), 163. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163-174.

Beck, J. H., Reitz, J. G., & Weiner, N. (2002). Addressing systemic racial discrimination in employment: The Health Canada case and implications of legislative change. *Canadian Public Policy/Analyse de politiques*, 373-394.

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2018). Thematic analysis. In P. Liamputtong, *Handbook of research methods in health social sciences* (pp. 1-18). Springer, Singapore.

Burn, S., Kadlec, K., & Rexer, R. (2005). Effects of subtle heterosexism on gays, lesbians, and bisexuals. *Journal of Homosexuality, 49*(2), 23-38.

Capodilupo, C. M., Nadal, K. L., Corman, L., Hamit, S., Lyons, O. B., & Weinberg, A. (2010). The manifestation of gender microaggressions. In D. Sue, *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 193-216). Hoboken, NJ: John Wiley and Sons.

Capodilupo, C., Nadal, K. L., Corman, L., Hamit, S., Lyons, O. B., & Weinberg, A. (2010). The manifestation of gender microaggressions. In D. Sue, *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 193-216). Hoboken, NJ: John Wiley and Sons.

Cass, V. (1979). Homosexual identity formation: a theoretical model. *Jorunal of Homosexuality, 4*, 209-235.

Chell, E., & Pittaway, L. (1998). A study of entrepreneurship in the restaurant and café industry: exploratory work using the critical incident technique as methodology. *International Journal of Hospitality Management, 17*, 23-32.

Cintron, A., & Morrison, R. S. (2006). Pain and ethnicity in the United States: A systematic review. *Journal of palliative medicine, 9*(6), 1454-1473.

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017). Development and validation of the Ableist Microaggressions Scale. *The Counseling Psychologist, 45*(4), 570-599.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1-16.

Coutinho, C. (2008). A qualidade da investigação educativa de natureza qualitativa: questões relativas à fidelidade e validade. *Educação Unisinos, 12*(1), 5-15.

Cross, W. (1978). The Thomas and Cross model of psychological nigrescence: a review. *Journal of Black Psychology, 5*, 13-31.

Cruz, D., Rodriguez, Y., & Mastropaolo, C. (2019). Perceived microaggressions in health care: a measurement study. *PLoS ONE, 14*(2).

Cuddy, A. J., Fiske, S. T., & Glick, P. (2007). The BIAS Map: Behaviors from intergroup affect and stereotypes. *Journal of Personality and Social Psychology, 92*(4), 631-648.

Cuddy, A. J., Fiske, S. T., & Glick, P. (2008). Warmth and competence as universal dimensions of social perception: The stereotype content model and the BIAS map. In *Advances in experimental social psychology* (Vol. 40, pp. 61-149).

Dahl, B., Fylkesnes, A. M., Sørlie, V., & Malterud, K. (2013). Lesbian women's experiences with healthcare providers in the birthing context: a meta-ethnography. *Midwifery, 29*(6), 674-681.

Dant, W. .. (1995). Using critical incidents as a tool for reflection. In S. M. Fowler, & M. G. Mumford, *Intercultural Sourcebook: Cross-cultural training methods* (Vol. 1, pp. 141-146). Intercultural Press, Inc.

Dean, M. A., Victor, E., & Guidry-Grimes, L. (2016). Inhospitable healthcare spaces: why diversity training on LGBTQIA issues is not enough. *Journal of bioethical inquiry, 13*(4), 557-570.

Defrin, R., Eli, I., & Pud, D. (2011). Interactions among sex, ethnicity, religion, and gender role expectations of pain. *Gender medicine, 8*(3), 172-183.

Dovidio, J., & Gaertner, S. (1996). Affirmative action, unintentional racial biases, and intergroup relations. *Journal of social issues, 52*(4), 51-75.

Downing, N., & Roush, K. (1985). From passive acceptance to active commitment: a model of feminist identity development for women. *The Counseling Psychologist, 13*(4), 695-709.

Edvardsson, B., & Roos, I. (2001). Critical incident techniques: Towards a framework for analysing the criticality of critical incidents. *International Journal of Service Industry Management, 12*(3), 251-268.

Elder, R. G., Humphreys, W., & Laskowski, C. (1988). Sexism in gynecology textbooks: Gender stereotypes and paternalism, 1978 through 1983. *Health care for women international, 9*(1), 1-17.

Embrick, D. G., Domínguez, S., & Karsak, B. (2017). More than just insults: Rethinking sociology's contribution to scholarship on racial microaggressions. *Sociological Inquiry, 87*(2), 193-206.

Feagin, J., & Bennefield, Z. (2014). Systemic racism and US health care. *Social science & medicine, 103*, 7-14.

Finkenauer, C., & Rimé, B. (1998). Socially shared emotional experiences vs. emotional experiences kept secret: Differential characteristics and consequences. *Journal of Social and Clinical Psychology, 17*(3), 295-318.

Fiske, S. T., Cuddy, A. J., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology, 82*, 878-902.

Flanagan, J. C. (1954). The critical incident technique.,. *Psychological bulletin, 51*(4), 327-358.

Fowler, S. M., & Blohm, M. J. (2004). An analysis of methods for intercultural training. In D. Landis, J. M. Bennet, & M. J. Bennet, *Handbook of intercultural training* (pp. 37-84). Thousand Oaks, California: Sage Publications.

Franks, P., Fiscella, K., & Meldrum, S. (2005). Racial disparities in the content of primary care office visits. *Journal of General Internal Medicine, 20*(7), 599-603.

Microaggressive incidents toward women in the healthcare context.

Fredrickson, B., & Roberts, T.-A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of women quarterly, 21*(2), 173-206.

Freeman, L., & Stewart, H. (2018). Microaggressions in Clinical Medicine. *Kennedy Institute of Ethics Journal, 28*(4), 411-449.

Gaisch, M., Chydenius, T., Preymann, S., Sterrer, S., & Aichinger, R. (2016). Gender microaggressions in low-context communication cultures: a perceptual study in the context of higher education institutions. *Cross-Cultural Business Conference 2016.* University of Applied Sciences Upper Austria,School of Management, Steyr Campus.

Glick, P., & Fiske, S. T. (2001). Ambivalent sexism. In (Vol. 33, pp. 115-188). Academic Press. In M. Zanna, *Advances in experimental social psychology* (Vol. 33, pp. 155-188). Academic Press.

GraphPad Software. (2018). *Quick Calcs. Quantifying agreement with Kappa*. Retrieved July 7, 2019, from GraphPad: https://www.graphpad.com/quickcalcs/kappa1/

Gregg, I. (2018). The health care experiences of lesbian women becoming mothers. *Nursing for women's health, 22*(1), 40-50.

Gremler, D. D. (2004). The critical Incident technique in service research. *Journal of Service Research, 7*(1), 65-89.

Hacker, H. (1951). Women as a minority group. *Social Forces, 30*(1), 60-69.

Halas, M. A. (1979). Sexism in women's medical care. Frontiers. *A Journal of Women Studies*, 11-15.

Herek, G. (2000). The psychology of sexual prejudice. *Current directions in psychological science, 9*(1), 19-22.

Herfst, S. L., Van Oudenhoven, J. P., & Timmerman, M. E. (2008). Intercultural effectiveness training in three Western immigrant countries: A cross-cultural evaluation of critical incidents. *International Journal of Intercultural Relations, 32*(1), 67-80.

Hirsh, A. T., Hollingshead, N. A., Matthias, M. S., Bair, M. J., & Kroenke, K. (2014). The influence of patient sex, provider sex, and sexist attitudes on pain treatment decisions. *The journal of pain, 15*(5), 551-559.

Hobson, W. (2001). *Racial discrimination in health care: interview project.* Public Health Seattle & King Country.

Hsieh, H.-F., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288.

Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery, 22*(4), 308-322.

Jangland, E., Gunningberg, L., & Carlsson, M. (2009). Patients' and relatives' complaints about encounters and communication in health care: evidence for quality improvement. *Patient education and counseling,, 75*(2), 199-204.

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. In D. W. Sue, *Microaggressions and marginality: Manifestation, dynamics, and impact,* (pp. 241-268).

Microaggressive incidents toward women in the healthcare context.

Kurasaki, K. S. (2000). Intercoder reliability for validating conclusions drawn from open-ended interview data. *Field Methods, 12*(3), 179-194.

Lee, A., & Kanji, Z. (2017). Queering the health care system: Experiences of the lesbian, gay, bisexual, transgender community. *Canadian Journal of Dental Hygiene, 51*(2), 80-89.

Leung, K. (2017). Microaggressions and sexual harassment: how the severe or pervasive standard fails women of color. *Texas Journal on Civil Liberties & Civil Rights, 23*, 79-102.

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the Gendered Racial Microaggressions Scale for Black women. *Journal of counseling psychology, 62*(2), 289-302.

Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on psychological science, 12*(1), 138-169.

Lin, A. I. (2010). Racial microaggressions directed at Asian Americans. Modern forms of prejudice and discrimination. In D. W. Sue, *Microaggressions and Marginality* (pp. 85-103). Hoboken, NJ: John Wiley and Sons.

Livingston, K. (2000). When architecture disables: Teaching undergraduates to perceive ableism in the built environment. *Teaching Sociology, 28*, 182-191.

Marques, A. M., Nogueira, C., & de Oliveira, J. M. (2015). Lesbians on medical encounters: Tales of heteronormativity, deception, and expectations. *Health Care for Women International, 36*(9), 988-1006.

Meyer, I. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin,, 5*, 674-697.

Morell, V. W., Sharp, P. C., & Crandall, S. J. (2002). Creating student awareness to improve cultural competence: creating the critical incident. *Medical Teacher, 24*(5), 532-534.

Morrison, S. D. (2012). Heterosexism and health care: a concept analysis. *Noursing Forum, 47*(2), 123-130.

Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS): construction, reliability, and validity. *Journal of Counseling Psychology, 58*(470-480), 470.

Nadal, K. L., Hamit, S., Lyons, O., Weinberg, A., & Corman, L. (2013). Gender microaggressions: Perceptions, processes, and coping mechanisms of women. In M. Paludi, *Psychology for business success* (Vol. 1, pp. 193-220).

Nadal, K. L., Riveira, D. P., & Corpus, M. H. (2010). Sexual orientation and transgender microaggressions. Implications for mental health and counseling. In D. W. Sue, *Microaggressions and marginality* (pp. 217-240). Hoboken, NJ: John Wiley and Sons.

Nadal, K., Davidoff, K., Davis, L., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: understanding influences of race, ethnicity, gender, sexuality, and religion. *Qualitative Psychology, 2*(2), 147–163.

Nadal, K., Griffin, K., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: counseling implications for clients of color. *Journal of counseling and development, 92*(1), 57-66.

Microaggressive incidents toward women in the healthcare context.

Nadal, K., Whitman, C., Davis, L., Erazo, T., & Davidoff, K. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *The journal of sex research, 53*(4-5), 488-508.

Nelson, A. .. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the National Medical Association, 94*(8), 666-668.

Oxford University Press. (2019). *Intersectionality.* Retrieved February 12th, 2019, from English Oxford Living Dictionaries: https://en.oxforddictionaries.com/definition/intersectionality

Petterson, S. M.-M. (2014). Mental health treatment in the primary care setting: Patterns and pathways. *Families, Systems, & Health, 32*(2), 157-166.

Pettigrew, T. F., & Meertens, R. W. (1995). Subtle and blatant prejudice in Western Europe. *European journal of social psychology, 25*(1), 57-75.

Pierce, C. M. (1970). Offensive mechanisms. In F. B. Barbour, *Black Seventies* (pp. 265-282). Boston: Porter Sargent.

Pierce, C. M., Carew, J., Pierce-Gonzalez , D., & Willis, D. (1978). An experiment in racism TV and commercials. In C. Pierce, *Television and education* (pp. 62-88). Beverly Hills, CA: Sage.

Platzer, H., & James, T. (2000). Lesbians' experiences of healthcare. *NT Research, 5*(3), 194-202.

Rimé, B. (2009). Emotion elicits the social sharing of emotion: Theory and empirical review. *Emotion review, 1*(1), 60-85.

Riveira, D. P., Forquer, E. E., & Rangel, R. (2010). Microaggressions and the life experience of Latina/o Americans. In D. W. Sue, *Microaggressions and Marginality* (pp. 59-83). Hoboken, NJ: John Wiley and Sons.

Robinson, M. E., Riley III, J. L., M. C., Papas, R. K., Wise, E. A., W. L., & Fillingim, R. B. (2001). Gender role expectations of pain: relationship to sex differences in pain. *The journal of pain, 2*(5), 251-257.

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative research in psychology, 1*, 25-41.

Sachdev, I., & Bourhis, R. Y. (1991). Power and status differentials in minority and majority group relations. *European journal of social psychology, 21*(1), 1-24.

Saha, S., Beach, M., & Cooper, L. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275.

Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression, and power: Feminisms and intersectionality theory. *Journal of Women and Social Work, 23*(1), 5-9.

Saulnier, C. (2002). Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work, 47*(4), 355–365.

Saunders, B., Sim, J., Kingstone, T., B. S., Waterfield, J., Bartlam, B., . . . Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity, 52*(4), 1893-1907.

Scullion, P. (1999). Challenging discrimination against disabled patients. *Nursing Standard (through 2013), 13*(18), 37-40.

Microaggressive incidents toward women in the healthcare context.

Scully, D., & Bart, P. (1978). A funny thing happened on the way to the orifice: Women in gynecology textbooks. In E. J., *The cultural crisis of modem medicine* (pp. 212-226). New York: Monthly Review Press.

Shabot, S. C. (2016). Making loud bodies "feminine": a feminist-phenomenological analysis of obstetric violence. *Human Studies, 39*(2), 231-247.

Smith, S. K., & Turell, S. C. (2017). Perceptions of healthcare experiences: Relational and communicative competencies to improve care for LGBT people. *Journal of Social Issues, 73*(3), 637-657.

Smith-Oka, V. (2015). Microaggressions and the reproduction of social inequalities in medical encounters in Mexico. *Social Science & Medicine, 143*, 9-16.

Snyder, C. R., Wang, P. Z., & Truitt, A. R. (2018). Multiracial patient experiences with racial microaggressions in health care settings. *Journal of Patient-Centered Research and Reviews, 5*(3), 229-238.

Spencer-Oatey, H. (2013). Critical incidents. A compilation of quotations for the intercultural field. *GlobalPAD Core Concepts*.

Sue, D. W. (2010). *Microaggressions in everyday life. Race, gender, and sexual orientation.* Hoboken, New Jersey: John Wiley & Sons.

Sue, D. W., & Capodilupo, C. (2008). Racial, gender, and sexual orientation microaggressions: Implications for counseling and psychotherapy. In D. W. Sue, D. Sue, H. A. Naville, & L. Smith, *Counseling the culturally diverse: Theory and practice, 5,* (5th ed., pp. 105-130). Hoboken, NJ: John Wiley & Sons.

Sue, D. W., Capodilupo, C. M., Nadal, K. L., & Torino, G. C. (2008). Racial microaggressions and the power to define reality. *American Psychologist, 63*, 277-279.

Sue, D. W., Capodilupo, C., & Holder, A. (2008). Racial microaggressions in the life experience of Black Americans. *Professional Psychology: Research and Practice, 39*(3), 329-336.

Sue, D. W., Lin, A. I., & Riveira, D. P. (2009). Racial microaggressions in the workplace: Manifestation and impact. In J. L. Chin, *Praeger perspectives: Race and ethnicity in psychology. Diversity in mind and in action* (Vols. 2, Disparities and competence, pp. 157-172). Santa Barbara, CA, US: Praeger/ABC-CLIO.

Sue, D., Lin, A., Torino, G., Capodilupo, C., & Rivera, D. (2009). Racial microaggressions and difficult dialogues on race in the classroom. *Cultural Diversity and Ethnic Minority Psychology, 15*(2), 183-190.

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of counseling psychology, 63*(1), 98-105.

Swain, J., & French, S. (2001). The relationship between disabled people and health and welfare professionals. In M. Bury, & G. Albrecth, *Handbook of Disability Studies.* Thousand Oaks: Sage.

Swim, J. K., Hyers, L. L., Cohen, L. L., & Ferguson, M. J. (2001). Everyday sexism: evidence for its Incidence, nature, and psychological impact from three daily diary studies. *Journal of Social Issues, 57*(1), 31-53.

Microaggressive incidents toward women in the healthcare context.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual review of psychology, 33*(1), 1-39.

Tajfel, H., & Turner, J. (1986). The social identity theory of intergroup behaviour. In S. Worchel, & W. Austin, *Psychology of Intergroup Relations* (pp. 7-24). Chicago:IL: Nelson-Hall.

Taylor, K. (2009). Paternalism, participation and partnership—the evolution of patient centeredness in the consultation. *Patient education and counseling, 74*(2), 150-155.

Thurber, A., & Bandy, J. (2018). *Creating Accessible Learning Environments.* Retrieved July 31, 2019, from http://cft.vanderbilt.edu/guides-sub-pages/creating-accessible-learning-environments/.

Travis, C. B., Howerton, D. M., & Szymanski, D. M. (2012). Risk, uncertainty, and gender stereotypes in healthcare decisions. *Women & Therapy, 35*(3-4), 207-220.

Vaismoradi, M., Jones, J., Turunen, H., & Snelgrove, S. (2016). Theme development in qualitative content analysis and thematic analysis. *Journal of Nursing Education and Practice, 6-5*, 100-110.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences, 15*(3), 398-405.

Vissandjée, B., M., W., Dupéré, S., & Abdool, S. (2001). Sex, gender, ethnicity, and access to health care services: Research and policy challenges for immigrant women in Canada. *Journal of International Migration and Integration, 2*(1), 55-75.

Walls, M. L., Gonzalez, J., Gladney, T., & Onello, E. (2015). Unconscious biases: Racial microaggressions in American Indian health care. *The Journal of the American Board of Family Medicine, 28*(2), 231-239.

Wandner, L. D., Scipio, C. D., Hirsh, A. T., Torres, C. A., & Robinson, M. E. (2012). The perception of pain in others: how gender, race, and age influence pain expectations. *The Journal of Pain, 13*(3), 220-227.

Watkins, N. L., Labarrie, T. L., & Appio, L. M. (2010). Black undergratuates' experiences with perceived racial microaggressions in predominately white colleges and universities. In D. W. Sue, *Microaggressions and Marginality* (pp. 25-27). Hoboken, NJ: John Wiley and Sons.

Wight, A. R. (1995). The critical incident as a training tool. In S. M. Fowler, & M. G. Mumford, *Intercultural Sourcebook* (pp. 127-140). London, UK: Intercultural Press Inc.

Wight, A. R., & Hammons, M. (1970). *Guidelines for Peace Corps Cross-Cultural Training.* Washington, D.C.: Peace Corps.

Wirth, L. (1945). The problem of minority groups. In R. Linton, *The science of man in the world crisis* (pp. 347-372). New York: Columbia University Press.

Microaggressive incidents toward women in the healthcare context.

Appendices

Appendix A - Tables 73

Appendix B – Interview guide (original) 78

Appendix C – Interview guide (translated) 81

Appendix D – Message of recruitment of participants 84

Appendix E – Informed Consent 86

Appendix F – Debriefing sheet 87

Appendix G – Codebook 88

Appendix H – Critical Incidents 131

Appendix A - Tables

	Functionally diverse - straight women	Perceived as foreigners - straight women	Perceived as Portuguese - LGBTQI+ Women	Perceived as Portuguese - straight women	Total
Microassaults	1	3	5	2	11
Microinsults	0	3	2	2	7
Microinsults + microinvalidations	1	2	6	3	12
Microinvalidations	9	7	11	5	32
Total	11	15	24	12	62

Table 23. Absolute frequencies for each form of microaggression

	Functionally diverse - straight women	Perceived as foreigners - straight women	Perceived as Portuguese - LGBTQI+ Women	Perceived as Portuguese - straight women	Total
Behavioral microaggressions	5	9	9	5	28
Environmental microaggressions	3	1	2	0	6
Verbal microaggressions	3	5	13	7	28
Total	11	15	24	12	62

Table 34 Absolute frequencies for each level of manifestation of microaggressions

Microaggressive incidents toward women in the healthcare context.

Type of health care system	Frequencies
Public	**18**
Private	6

Table 4~~5~~. Type of health care system

Enactors of microaggressions	Frequencies
Doctors	**22**
Nurses	6
Other types of health professionals	4
More than one type of health professional	7
Environmental / Systemic	6

Table 5~~6~~. Enactors of microaggressions

Microaggressive contents	Frequencies
Sexist contents	**13**
Homophobic or heterosexist contents	2
Racist or xenophobic contents	3
Ableist contents	2
Health practice-related contents	**7**
Intersectional contents	6

Table 6~~7~~. Microaggressive contents

Emotional reactions	Frequencies
Anger	**9**
Powerlessness - Vulnerability	**7**
Shame	3
Feeling of being minimized	3
Feeling of injustice	3
Self-directed anger	2
Feeling of being objectified	1
Sadness	1
Other thoughts and emotions	6

Table 7~~8~~. Emotional reactions

Behavioral reactions	Frequencies
Direct reaction	**14**
Indirect reaction	3
Passive reaction / no reaction	9

Table 8~~9~~. Behavioral reactions

Microaggressive incidents toward women in the healthcare context.

Complaint	Frequencies
Official complaint	4
Intention to complain	3
Unofficial complaint	2
No complaint	4

Table 910. Participants' complaint about microaggressions

Recalling the incident	Frequencies
Recalled	**17**
Never recalled	4

Table 1011. Recalling the incident

Social sharing of the incident	Frequencies
Shared	**16**
Not shared	3
No memory of sharing	1

Table 1112. Social sharing of the incident

Feedback received	Frequencies
Supportive feedbacks	**13**
Dismissive feedbacks	3

Table 1213. Feedbacks received when sharing the incident

Presence of third persons	Frequencies
No one else was present	6
Other people were present and intervened	6
Other people were present but did not intervened	**11**

Table 1314. Presence of other people at the moment of the incident

Change in the perception / relationship with health care professional	Frequencies
Changes in the perception / relationship	5
No changes	2
Never returned to the same health care professional / facility	**8**

Table 1415. Change in the relation with / perception of the health professional

Consequences for patients' health	Frequencies
Practical consequences	14
No consequences	11
Secondary effects	6

Microaggressive incidents toward women in the healthcare context.

Table 15~~16~~. Consequences of microaggressive incidents for patients' health

Apologies from health care professionals	Frequencies
No apologies, no change of attitude	**13**
Apologies but no change of attitude	3
Change of attitude but no apology	3
Apologies and change of attitude	1
Apologies from third parts	2
No memory of apologies	1

Table 16~~17~~. Apologies from health providers

Experience of microaggression	Frequencies
Experienced and/or witnessed, heard about	14
Never experienced but witnessed, or heard about	2
Never experienced a microaggression	1

Table 17~~18~~. Number of participants that has experienced (or not) a microaggression in the healthcare context

Commonality of microaggressions	Frequencies
Common	**17**
Uncommon	0

Table 18~~19~~. General question: are microaggressions common?

Negative impact of microaggressions	Frequencies
Negative impact	**15**
Depends on the target	2
No negative impact	0

Table 19~~20~~. General question: do microaggressions have a negative impact?

Good practices	Frequencies
Training and sensitization	**14**
Other practices	3

Table 20~~21~~. General question: is there any good practice that can help health providers and/or reduce the impact of microaggressions on targets?

Groups of themes	Organizing theme	Microaggressive themes	Frequencies
Microaggressive themes related to both	Sexism-related themes	Ascription of inferiority	8

Microaggressive incidents toward women in the healthcare context.

social and clinical context		Assumption of traditional gender roles	1
		Moralization	4
		Objectification of women	6
		Pain endurance	4
	Heterosexism-related themes	Assumption of abnormality	3
		Endorsement of heteronormativity	5
	Racism-related themes	Second-class citizenship	5
	Ableism-related themes	Architectural barriers	3
		Desexualization of functional diverse women	1
		Insensitivity towards functionally diverse people	4
	Sexism and racism-related themes (intersectional)	Assumption of beauty and sexual objectification	1
		Invisibility	2
		Myth of hyperfertility	1
Microaggressions towards patients as a social minority	-----	Attitude of superficiality	3
	-----	Lack of sensitivity-empathy	3
	-----	Objectification of the patient	2
	-----	Paternalization of patients	2
Systemic microaggressions	-----	----	16

Table 2122. Frequencies for each microaggressive theme

Microaggressive incidents toward women in the healthcare context.

Appendix B – Interview guide (original)

Às vezes somos expostas a pequenos incidentes diários, verbais e não verbais, como piadas, insinuações ou pequenos insultos. Tratam-se de situações sutis, do dia a dia, e que acontecem com as pessoas que nos são mais próximas, com as que apenas conhecemos de vista ou com as que não conhecemos de todo. Podem ser ocorrências que partem de uma boa intenção, mas que nos produzem sentimentos de desconforto, vergonha ou até humilhação. E falar delas pode parecer embaraçoso. A Psicologia chama estes incidentes de "microagressões".

As microagressões tomam as formas mais variadas e inesperadas. Pense, por exemplo, nas situações do dia a dia em que a fizeram sentir invisível, não ouvida, julgada, ofendida, assediada, objetificada, inferiorizada, subestimada, discriminada; ou nas situações que refletem preconceitos e rótulos sociais.

Vou dar alguns exemplos: piadas ofensivas; sinais e atitudes de excessivo apreciamento em relação ao seu corpo; insinuações relacionadas ao seu papel de mulher (depende de um homem, é excessivamente emotiva ou frágil, é menos inteligente do que um homem, uma mulher tem que se adaptar aos papéis convencionais de gênero, etc.); insinuações relacionadas com a cor da sua pele/traços étnicos, ou com a sua orientação sexual; atitudes não verbais que comunicam hostilidade, desconforto ou evitamento; atitudes que a fizeram sentir pouco bem tratada ou tratada diversamente (dos outros, de como acha que deveria ser tratada); julgamento através de estereótipos.

A perpetração das microagressões pode manifestar-se de forma não intencional, e os/as microagressores/as podem parecer genuinamente bem-intencionados/as, até convencidos/as que as próprias ações sejam justas e bondosas.

Este estudo incide sobre as microagressões dirigidas a mulheres enquanto utentes dos Serviços de Saúde (públicos ou privados).

Agora, vou pedir-lhe, enquanto utente, que se lembre de algumas situações que envolvam o contato com médicos/as ou com outros/as profissionais de saúde (enfermeiros/as, pessoal especializado e não especializado), quer em situações de consulta, emergência, internamento hospitalar, ou outras situações de contexto clínico.

Se não se lembrar de nenhuma situação consigo, poderá tentar lembrar-se de algum incidente que tenha testemunhado no mesmo contexto, como por exemplo, numa sala de espera, no balcão de inscrição para a consulta, quando não era utente mas acompanhava a pessoa que o era, etc.

Microaggressive incidents toward women in the healthcare context.

Ao longo da entrevista, poderá descrever todas as situações que quiser: não há um limite de número ou de tempo. Todas as situações que descreverá serão uma grande contribuição para o estudo.

Sinta-se a vontade.

- Nesse contexto, consegue lembrar-se de alguma situação de microagressão?
- Poderia dar uma descrição detalhada da situação?
- Por parte de quem recebeu a microagressão? (*Especifique a cargo: médico/a, enfermeiro/a, outros*)
- Onde ocorreu a microagressão?
- Acredita que o incidente que descreveu se associa com o fato de ser mulher/LGBTQI+/não-caucasiana? Porquê? (OU: Na sua opinião, qual foi o motivo do incidente?)
- Estavam outras pessoas presentes? Disseram algo?
- Quais foram os seus pensamentos quando o incidente aconteceu? Quais as primeiras emoções que sentiu?
- Em seguida, pensou novamente no incidente? Quais foram seus pensamentos e emoções?
- Falou do incidente com alguém após ter acontecido? Denunciou para alguém? Que feedback recebeu?
- Em algum momento o profissional de saúde percebeu que tinha assumido uma atitude errada e pediu desculpas?
- A sua relação com a pessoa que perpetrou a microagressão mudou depois do incidente? (*Por exemplo: se era um/a médico/a de família, a entrevistada mudou de atitude, perdeu confiança; não voltou mais para o mesmo médico/a ou estrutura, etc.)*
- Nessa situação, a atitude do profissional de saúde criou / poderia ter criado implicações praticas e/ou para a sua saúde (*por exemplo, erros no diagnóstico, na prescrição de medicamentos, etc.*)?
- Gostaria de descrever uma(s) outra(s) situação(ões) análoga(s)? (V*oltar ao começo e repetir as perguntas*)

(Quando a participante termina a descrição da última situação)

- Acredita que estas microagressões sejam comuns? Especifique.
- Acredita que tenham um impacto negativo? Pode concretizar?

Microaggressive incidents toward women in the healthcare context.

- Acredita que existam umas boas praticas uteis a sensibilizar os profissionais de saúde e/ou a minimizar o impacto desses incidentes sobre os utentes? Pode especificar?

Antes de terminar, preciso pedir-lhe algumas informações pessoais:

- Qual é a sua idade?
- Qual é – ou se tiver mais que uma – quais são a(s) sua(s) nacionalidade(s)?
- Com qual género se identifica?
- É ativista/feminista há quanto tempo?
- Segue alguma vertente de ativismo especifica? Qual?
- Em quais atividades de ativismo participa?
- Identifica-se com alguma minoria social? Se sim, qual ou quais?

Ao finalizar a entrevista:

Conhece outras mulheres ativistas/feministas que teriam interesse em participar neste estudo? Gostaria de contacta-las.

Vamos, então, finalizar a entrevista. Agradeço uma vez mais a disponibilidade que manifestou para falar das microagressões no contexto dos Serviços de Saúde.

Microaggressive incidents toward women in the healthcare context.

Appendix C – Interview guide (translated)

Sometimes we are exposed to little daily incidents, verbal and non-verbal, like jokes, insinuations and slight insults. We're talking about subtle situations, of the day-to-day life, that happen with people close to us, with those we know by sight or with those we don't know at all. These occurrences might come from a good intention, but they produce in us feelings of discomfort, shame and even humiliation. And to talk about these situations can be embarrassing. Psychology calls these incidents of "microaggressions".

Microaggressions take the most various and unexpected shapes. Think, for example, about the daily situation in which someone made you feel invisible, unheard, judged, offended, harassed, objectified, minimized, underestimated or discriminated; or about those situations that reflect prejudices and social prescriptions.

Here some examples: offensive jokes; signs and attitudes of excessive appreciation about your body; insinuations related to your social role as a woman (you depend on a man, you are excessively emotional or fragile, you are less smart than a man, a woman has to adapt to conventional gender roles, etc.); insinuations related with the color of your skin/ethnic traits, or with your sexual orientation; non-verbal attitudes that communicate hostility, discomfort or avoidance; attitudes that made you feel not well treated or treated differently (from others, from how you think you should be treated); judgment according to stereotypes.

The perpetration of microaggressions can be expressed in an unintentional way, and microaggressor can appear genuinely well-intentioned, even convinced that their actions are fair and good.

This study focuses on microaggressions directed to women as patients of the health service (public or private).

Now, try to remember of some situations that, as a patient, involved contact with doctors or other health professionals (nurses, specialized and non-specialized personnel), and that happened during consultation, emergency situations, hospitalization and other situation in the clinical context.

If you do not remember any situation that happened to you, you can try to remember of any incident that you witnessed in the same context, as, for example, in a waiting room, at the check-in for a consultation, when you weren't a patient but you were accompanying someone else, etc.

During the interview, you can describe all the situations you want: there is no limit of number or time. All the situations you will describe will be a great contribution to this study.

Make yourself comfortable.

Microaggressive incidents toward women in the healthcare context.

- In this context, can you remember of any situation of microaggressions?
- Could you give me a detailed description of the situation?
- On behalf of who did you receive the microaggression? (Specify the role: doctor, nurse, others)
- Where did the microaggression occur?
- Do you believe that the incident that you described is associated with your identity as a woman/LGBTQI+/immigrant/non-Caucasian? Why? (OR: In your opinion, what the motivation of the incident was?)
- Were there other people present? Did someone say something?
- Which were your thoughts when the incident occurred? Which were the first emotions that you felt?
- Have you ever thought about the incident again, after it happened? Which were your feelings and emotions at recalling?
- Did you talk with someone about the incident? Which feedbacks did you received?
- Your relationship with the person that perpetrated the microaggression changed after the incident *(e.g. if it was a family doctor, did the interviewee changed attitude, or lost trust? Did she return to the same doctor or health facility? Etc.)*
- In this situation, the health professional's attitude created or may have created practical implications and/or implications for your health *(e.g. errors in the diagnosis, in the prescription of medicines, etc.)*
- Would you like to describe another analog situation? *(If yes, return to the begin and repeat the questions)*

(When the participant ends the description of the last situation)

- Do you believe microaggressions to be common? Can you specify?
- Do you believe microaggressions to have a negative impact? Can you concretize?
- Do you believe that there are good practices that can help to sensitize health providers and/or reduce the impact of microaggressions on patients?

Before we finish, I need to ask you some personal information:

- How old are you?
- Which is – or if you have more than one, which are – your nationality(ies)?
- With which gender do you identify?

Microaggressive incidents toward women in the healthcare context.

- Do you consider yourself a feminist or an activist?
- Do you follow any specific form of activism? Which ones?
- To which activities of activism do you participate?
- Do you identify with any social minority? If yes, which ones?

Finalizing the interview:

Thank you very much for your availability. Do you know any other women that are feminists/activists and that would be interested to participate to this study?

Let's finalize the interview. Thank you once again for the availability you showed in talking about microaggressions in the healthcare context.

Microaggressive incidents toward women in the healthcare context.

Appendix D – Message of recruitment of participants

Original message of recruitment (Portuguese)

Objeto: Marcação de encontro para entrevista

Bom dia,

Me chamo Elena Piccinelli, e sou uma estudante de mestrado no ISCTE-IUL. Entro em contacto consigo através de (nome da pessoa, da instituição, etc.)

Gostaria de saber se estaria disposta a participar numa entrevista para a minha tese de mestrado.

O meu estudo incide sobre as formas de discriminação que as mulheres enfrentam enquanto utentes dos serviços de saúde (público ou privado). As entrevistas podem ter uma duração de 30 a 60 minutos, e todas as questões relacionadas com a confidencialidade e o anonimato das mesmas está assegurado.

No caso em que esteja interessada, gostaria de marcar um encontro consigo para realizar a entrevista.

Podemos escolher o local, o dia e o horário que lhe são mais convenientes. Se não tiver um lugar de preferência, podemos realizar a entrevista em uma das salas do ISCTE-IUL.

No caso prefira contactar-me telefonicamente, deixo-lhe o meu número: *********

Fico em aguardo de uma sua resposta.

Atenciosamente,

Elena Piccinelli

Translation in English:

Good morning,

My name is Elena Piccinelli and I am a master's student at the ISCTE-IUL. I enter in contact with you through (name of the person, institution, etc.).

I would like to know if you are available to participate to an interview for my master's thesis.

My study focuses on the different forms of discrimination that women experience as users of the health care system (public or private). The interview can have a duration of 30 to 60 minutes, and all the issues related to confidentiality and anonymity are ensured.

In the case you are interested, I would like to schedule a meeting with you to realize the interview. We can choose the place, day and time that better fits your needs. If you don't have a place of preference, we can realize the interview at ISCTE-IUL.

In the case you prefer to contact me by telephone, here is my number: *********

Microaggressive incidents toward women in the healthcare context.

Best regards,

Elena Piccinelli

Appendix E – Informed Consent

CONSENTIMENTO INFORMADO

O presente estudo surge no âmbito de uma dissertação de mestrado a decorrer no **ISCTE – Instituto Universitário de Lisboa.** Este estudo incide sobre as microagressões dirigidas a mulheres enquanto utentes de Serviços de Saúde (públicos ou privados).

O estudo é realizado por Elena Piccinelli (elipicci@gmail.com) e coordenado pelas investigadoras Professora Melanie Vauclair (melanie.vauclair@iscte-iul.pt) e Sara Martinho (soqmo@iscte-iul.pt), que poderá contactar caso deseje colocar uma dúvida ou partilhar algum comentário.

A sua participação consiste em uma entrevista individual que poderá durar cerca de uma hora. Não existem riscos significativos expectáveis associados à participação na mesma. E ainda que possa não beneficiar diretamente com a participação no estudo, as suas respostas vão contribuir para entender a discriminação que as mulheres vivem no papel de utentes nos Serviços de Saúde.

A participação neste estudo é estritamente **voluntária**: pode escolher participar ou não participar. Se escolher participar, pode interromper a participação em qualquer momento sem ter de prestar qualquer justificação. Para além de voluntária, a participação é também **anónima** e **confidencial**. Os dados destinam-se apenas a tratamento estatístico e nenhuma resposta será analisada ou reportada individualmente. Em momento algum precisa de se identificar, mas se o fizer ficará salvaguardada pelo princípio éticos em Psicologia.

Face a estas informações, por favor indique se aceita participar no estudo:

ACEITO ☐ NÃO ACEITO ☐

Nome: ______________________________ Data: __________

Assinatura: ____

Appendix F – Debriefing sheet

ISCTE IUL
Instituto Universitário de Lisboa

[podem inserir-se outros logótipos – e.g., centro de investigação]

DEBRIEFING/EXPLICAÇÃO DA INVESTIGAÇÃO

Muito obrigado por ter participado neste estudo. Conforme adiantado no início da sua participação, o estudo incide sobre as microagressões dirigidas a mulheres enquanto utentes de Serviços de Saúde (públicos ou privados).

Reforçamos os dados de contacto que pode utilizar caso deseje colocar uma dúvida, partilhar algum comentário, ou assinalar a sua intenção de receber informação sobre os principais resultados e conclusões do estudo:

- Elena Piccinelli (elipicci@gmail.com)
- Sara Martinho (soqmo@iscte-iul.pt)
- Melanie Vauclair (melanie.vauclair@iscte-iul.pt)

Se tiver interesse em aceder a mais informação sobre o tema do estudo, pode ainda consultar as seguintes referências:

- Sue, D. (2010). Microaggressions in everyday life. Race, gender, and sexual orientation. Hoboken, New Jersey: John Wiley & Sons.
- Sue, D., Capodilupo, C., & Holder, A. (2008). Racial microaggressions in the life experience of Black Americans. Professional Psychology: Research and Practice, 39(3), 329-336.
- Sue, D., Lin, A., Torino, G., Capodilupo, C., & Rivera, D. (2009). Racial microaggressions and difficult dialogues on race in the classroom. Cultural Diversity and EthnicMinority Psychology, 15(2), 183-190.
- Nadal, K., Davidoff, K., Davis, L., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: understanding influences of race, ethnicity, gender, sexuality, and religion. Qualitative Psychology, 2(2), 147–163.
- Nadal, K., Griffin, K., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: counseling implications for clients of color. Journal of counseling and development, 92(1), 57-66.
- Nadal, K., Whitman, C., Davis, L., Erazo, T., & Davidoff, K. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. The journal of sex research, 53(4-5), 488-508.

Mais uma vez, obrigada pela sua participação.

Appendix G – Codebook

Part I – Content Analysis

Organizing themes	Nodes	Description	Example	Translation
a. Typologies of Microaggressions	Behavioral microassaults	Non-verbal or behavioral, conscious, deliberate, purposeful, biased offenses, intended to threaten, humiliate, intimidate, hurt or make feel unwanted	‘Por exemplo, já me aconteceu em um exame, no privado, de ter sido muito maltratada por um medico, porque eu não conseguia me mexer, não conseguia me levantar, não conseguia me virar para o lado que ele queria e ele estava aos gritos “Mas porque que eu tenho que fazer este exame? Só me aparecem pessoas destas, e não sei o que!”. Foi muito… e eu fui fazer queixa dele, obviamente. Foi muito mau, muito humilhante. Ele queria por força que eu me virasse, que eu fizesse… e eu não podia. Há coisas que não posso fazer, coisas que não consigo fazer.’	‘For example, it happened that during an examination, in the private, I have been very mistreated by a doctor because I could not move, could not get up, could not turn me to the side that he wanted, and he was screaming: “Why do I have to do this examination? Only these people come here!” It was so... And I went to report him, obviously. It was very bad, very humiliating. He wanted me to turn around, he wanted me to... And I couldn't. There are things I can't do, things I am not able to do.’
	Mixed behavioral microinsult + microinvalidation	Non-verbal and behavioral unconscious communications that convey and underline negative stereotypes, rudeness and insensitivity and that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups.	‘Senti-me um bocado… porque vinha um medico ou uma medica… eram todos simpáticos e a equipa era muito boa…, mas eles levantam o lençol, pra ver entre as pernas… a nos entres as pernas… uma frieira… como se fossemos gados. Para ver se os pontos… eu tinha tido uma cesariana, pra ver se os pontos estavam bem ou se tinha corrimento vaginal ou não sei o que. E, portanto, era um medico ou uma medica e mais ou três alunos e	‘I felt a bit... Because there were doctors... They were all nice and the staff was very good. But they used to lift the sheet, to see between our legs. And it was cold… They treated us as if we were cattle. They used to do that to check the stitches. I had had a caesarean section, and they came to see if the stitches were okay, or if we had any vaginal discharge, and so on. And so, there was always a doctor with three students, and they would lift the

			aquilo era abrir, espreitar e fechar. As vezes falavam bom dia, boa noite e mais nada. E aquilo não foi uma coisa a mim em concreto, mas é uma questão de desrespeito genérico pelas mulheres… que naquele momento são só puérperas, que é como se chamam… que acabaram de parir e a preocupação é com as crianças de fato.’	sheet, peek and cover up again. Sometimes they would say “good morning” or “good night” and nothing else. And it was not a thing that they have done against me in concrete, but it is a matter of generic disrespect of women... That at that moment are only puerperal women, that have just given birth and the only concern is with the children.’
	Behavioral microinsults	Non-verbal and behavioral unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that demean a person's gender, racial, sexual orientation and functionally diverse heritage or identity. It is a subtle snub, hiding an insulting message, repulse, offense, indignity, unworthiness (treating as less intelligent, less person, treating as criminal, stating abnormality)	‘As vezes eu não entendo o que eles falam, e é muito… “você é obrigado a entender”. Então isso costuma acontecer muito, em relação também às informações, porque eu não nasci aqui, então tem coisas que eu normalmente não sei, eu não nasci com esse conhecimento. Então tem que perguntar, e as pessoas levam muito a mal eu ficar fazendo tantas perguntas assim, enquanto não tem uma plataforma ou um site onde eu possa simplesmente ler e me informar de tudo. Eu tenho que falar com as pessoas. Então essa resposta é sempre muito agressiva e constrangedora também, porque eu fico pensando “poxa, o que eu fiz de errado?”. ’	‘Sometimes I don't understand what they say, and it's like... “You are obliged to understand.” So, it usually happens a lot, for example in relation to the information I ask, because I wasn't born here, so there are things that I don't normally know, I wasn't born with that knowledge. So, you have to ask, and people take it very badly when I keep asking so many questions like this, while there is a platform or a site where I can simply read and inform me of everything. I have to talk to people. Their answer is always very aggressive and embarrassing too, because I keep thinking "Gee, what did I do wrong?".’
	Behavioral microinvalidations	Non-verbal or behavioral communication that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups. It includes the denial of individual reality (what you feel is not true, denial of	‘E isso acontece muitas vezes, independentemente de ser ou não em situações de saúde. […] Mas dever ter sido numa urgência qualquer que eu fui ao hospital, e eu lembro-me de estar um casal a frente a dar entrada – se calhar até foi no parto, não me lembro – e deles estarem atendidos, e não havia	‘This happens many times, regardless of being or not in health situations. [...] But I remember being at the emergency department, at the hospital, and I remember being a at the entrance, to check in, (maybe it was the day of childbirth, I don't remember), there was a couple and they were being

		individual or social discriminatory attitudes, myth of meritocracy, dismissive-condescending attitudes, etc.)	mais ninguém para ser atendido. Ou seja, estavam eles, e estava eu. E eles foram atendidos, e quando eu avancei, a enfermeira decide naquela altura agrafar todos os papeis que tinha e ir entregar ao medico ou quem estava lá dentro na sala. E o… mas devia ser no dia parto… eu estava a sentir alguma dor e isso ia exacerbar ainda mais a situação... e eu senti-me incomodada e disse "nos estamos numa situação de dor, numa situação delicada, não percebi porque abandonou-me aqui, não está aqui mais ninguém". '	attended, and there was no one else to be attended, only me. In other words, they were there, and I was here. And they were attended, and when I advanced, the nurse decided at that time to staple all the papers she had and go to the doctor or whoever was in the other room. I think it was on the day of childbirth... I was feeling some pain and it was exacerbating the situation even more... And I felt uncomfortable and said: "we are in a situation of pain, in a delicate situation, I do not understand why you abandoned me here, there is no one else!".'
	Environmental microassaults	Environmental conscious, deliberate, purposeful, biased offenses, intended to threaten, humiliate, intimidate, hurt or make feel unwanted	No findings	-----------
	Environmental microinsults	Environmental unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that demean a person's gender, racial, sexual orientation and functionally diverse heritage or identity. It is a subtle snub, hiding an insulting message, repulse, offense, indignity, unworthiness (treating as less intelligent, less person,	'Eu quando engravidei da minha primeira filhota, eu fui para que ela nascesse, uma das coisas que eu reparei lá é que dizia a minha etnia. E eu sendo cidadã portuguesa, acho que ter lá a minha etnia não se justifica."	'When I got pregnant of my first little girl, I went to get her to be born, one of the things I noticed was that [in the form I had to fill in] I had to specify my ethnicity. And I am a Portuguese citizen, I think having my ethnicity there is not justified.'

		treating as criminal, stating abnormality)		
	Environmental microinvalidations	Environmental communications that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups. It includes the denial of individual reality (what you feel is not true, denial of individual or social discriminatory attitudes, myth of meritocracy, dismissive-condescending attitudes, etc.)	'E no caso, em quanto mãe, eu tinha necessidade de acompanhar os meus filhos no hospital ou no centro de saúde, e muitas vezes tinha escadas, as portas não permitiam que eu conseguisse entrar, eu não conseguia segurar o meu filho para ele ser visto no atendimento porque não tinha espaço para eu entrar… então logo ai era uma discriminação imensa relativamente às outras mães e para os meus filhos, que muitas vezes ficavam a chorar.'	'And in this case, as a mother, I needed to accompany my children to the hospital or to the health center, and often there were ladders, the doors did not allow me to get in, I could not hold my son for him to be seen in the examination, because there was no room for me to enter... It was an immense discrimination, in comparison to the other mother and my children, who often cried because of that.'
	Mixed environmental microinvalidations + microinsults	Environmental unconscious communications that convey and underline negative stereotypes, rudeness and insensitivity and that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups	No findings	-----------
	Verbal microassaults	Verbal, conscious, deliberate, purposeful, biased offenses, intended to threaten, humiliate, intimidate, hurt or make feel unwanted	'[…] Desde que uma amiga comentou que lhe aconteceu. Ela é mais nova que eu… comentou-me a mim que lhe aconteceu… e que é aquela coisa terrível de estar a ter o bebé… mesmo em processo do trabalho de parto… há o comentário, acho que por enfermeiras mulheres: "gostaste de o fazer, agora custa-te tê-lo".'	'[…] Since a friend commented that it happened to her. She's younger than me. And she told me what happened to her. And that's that terrible thing, when you are having the baby, you are in labor... There is the comment, I think by female nurses: "You liked to make it, now it costs you to have it".'

	Mixed verbal microinsult + microinvalidation	Verbal unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups.	‘Tive que recorrer de emergência, por exemplo quando tive pedra nos rins, cálculos. […] Inclusive no momento em que me puseram a pulseira, o enfermeiro que me pôs a pulseira disse-me: “ah mas é mulher, vou lhe por uma pulseira menos importante, em vez daquela cor laranja, porque as mulheres aguentam melhor as dores, portanto eu cheguei lá a morrer de dores.’	‘I had to run to the emergencies, for example, when I had kidney stones. […] Even when they put me on the bracelet, the nurse who put me on the bracelet said to me, “Ah, but you’re a woman, I'm going to give you a less urgent bracelet, instead of that orange color, because women can handle the pain better.” So I got there dying of pain.’
	Verbal microinvalidations	Verbal communication that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of certain groups. It includes the denial of individual reality (what you feel is not true, denial of individual or social discriminatory attitudes, myth of meritocracy, dismissive-condescending attitudes, etc.)	‘E o medico de família, este novo, eu perguntei-lhe se podia fazer uns exames, umas analises, para saber se estava tudo bem. E ele distratou-me e disse que sendo mulher, a única coisa que eu tinha que me preocupar era fazer uma citologia, e quando é que íamos marcar a citologia, que o resto não interessava, que o resto eram questões de prevenção. Quando é que íamos marcar, só estava preocupado com isso, ou seja, com os meus órgãos reprodutores e com mais nada da minha questão de saúde.’	‘And the family doctor, this new one, I asked him if I could do some checks, some analysis, to know if everything was okay with me. And he dismissed me and said that, as I am a woman, the only thing I had to worry about was doing a cytology and asked me when we were going to make the cytology, because the rest didn’t matter, the other things were only matters of prevention. He insisted about when we were going to make the cytology, he was only worried about it, only worried about my reproductive organs and not with any other issue related to my health.’
	Verbal microinsults	Verbal unconscious communication that convey and underline negative stereotypes, rudeness and insensitivity and that demean a person's gender, racial, sexual orientation and functionally diverse	‘Por acaso foi num privado, num oftalmologista. Levei o meu filho, por achar que estava naquela idade em que é preciso mudar de ciclo de ensino… e porque precisa de checar se estar tudo bem na visão. E fiz algumas perguntas e o medico falou-me que era uma mãe	‘Actually, it was a private doctor, an ophthalmologist. I took my son there, because I thought he was at that age in which he was entering in a new school cycle... and I wanted to check if everything was right with his eyes. And I asked some questions, and the doctor told me

		heritage or identity. It is a subtle snub, hiding an insulting message, repulse, offense, indignity, unworthiness (treating as less intelligent, less person, treating as criminal, stating abnormality)	obsessiva ou… demasiado… aquelas coisas que culpabilização das mães… demasiado protetora.’	that I was an obsessive mother or... Too... Those things said to blame mothers... Too protective.’
b. Type of Health Care System	Private	Microaggressions experienced in the private health care system	I: ‘E onde aconteceu o incidente?’ P: ‘Foi numa consulta, e foi em consultório privado.’	I: ‘And where did the incident happen?’ P: ‘It was in a consultation, and it was within the private health care system.’
	Public	Microaggressions experienced in the public health care system	I: ‘O hospital era público ou particular?’ P: ‘Público’	I: ‘Was the hospital public or private?" P: "Public’
c. Specific Medical Areas or Hospital Sections	Clinical analysis and exams	Microaggressions experienced during clinical analysis or exams	‘Fui pra fazer um ecocardiograma’	‘I went to do an echocardiogram.’
	Dermatology	Microaggressions experienced within the medical specialty of dermatology	‘Porque neste contexto, este um contexto privado e é dermatologia…’	‘Because in this context, this is a private context and it is dermatology...’
	Emergency	Microaggressions experienced in the emergency sector of hospitals	‘Acompanhei minha avó, indiana, com traços indianos, completamente indiana, nas urgências.’	‘I went with my grandmother, Indian, with Indian traces, completely Indian, at the emergencies.’
	Family doctors	Microaggressions experienced during a medical examination with a family doctor	‘já tive uma medica a perguntar-me – uma medica do publico, de família…’	‘I already had a doctor asking me – a doctor of the public, a family doctor...’
	Forensic medicine	Microaggressions experienced within the medical specialty of forensic medicine	‘Tive que fazer todos os exames novamente e tive que ser observada pelo medico de medicina forense”	‘I had to do all the tests again and had to be observed by the forensic medical doctor’

	Gynecology	Microaggressions experienced within the medical specialty of gynecology	'Eu tenho um ginecologista que já conheço há muitos anos…'	'I have a gynecologist I've known for many years...'
	Maternity or Obstetrics	Microaggressions experienced within the medical specialties of maternity or obstetrics	'Por exemplo tenho uma amiga minha que estava grávida de cinco meses quando se começou a perceber que havia algum problema com o bebé. E quando foi ao médico, perceberam que o bebê estava morto e que tinha que tomar uma injeção.'	'For example, I have a friend of mine who was five months pregnant when she began to realize that there was a problem with the baby. And when she went to the doctor, they realized that the baby was dead and that she had to take an injection.'
	Non-specified areas or sectors	The participant did not specify the area or sector during the interview	'Por exemplo, eu tive uma filha internada, e tive que ficar lá a noite…'	'For example, my daughter was hospitalized, and I had to stay there at night...'
	Ophthalmology	Microaggressions experienced within the medical specialty of ophthalmology	'Por acaso foi num privado, num oftalmologista'	'Actually, it was a private doctor, an ophthalmologist.'
	Otorhinolaryngology	Microaggressions experienced within the medical specialty of otorhinolaryngology	'Eu fui um tempo atras ao hospital ***** ***** por causa de uma otite. […] fui ao especialista …'	'I went a long time ago to the hospital ***** ***** because of an otitis. […] I went to the specialist.'
	Physiotherapy	Microaggressions experienced within the medical specialty of physiotherapy	'Eu fiz fisioterapia durante um tempo, e foi depois de ter uma doença grave.'	'I did physiotherapy for a while, and it was after having a serious illness.'
	Waiting rooms and reception	Microaggressions experienced in the waiting rooms or receptions of hospitals	'Mas dever ter sido numa urgência qualquer que eu fui ao hospital, e eu lembro-me de estar um canal a frente a dar entrada…'	'But it must have been in some emergency that I went to the hospital, and I remember being at the entrance, to check in.'
d. Enactors of Microaggressions (Type of health professional or perpetrator)	Doctor	Microaggressions perpetrated by doctors	I: 'Foi um medico?' P: 'Sim.'	I: 'Was it a doctor?' P: 'Yes.'
	Environmental or systemic	The microaggression was perpetrated not by a	'Os consultórios médicos, neste caso nos serviços de ginecologia,	'The medical facilities, in this case in gynecology services, are all

		physical person but by the system, environment, structure	são todos estruturados para mulheres que tem uma mobilidade normal.’	structured for women who have normal mobility.’
	More than one type of health professional	The microaggression was perpetrated by different types of health professionals	I: ‘Então isso aconteceu por parte de várias pessoas?’ P: ‘Sim. Médicos, enfermeiras, até auxiliares.’	I: ‘So, did this happen on behalf of several people?’ P: ‘Yes. Doctors, nurses, even auxiliaries.’
	Nurse	Microaggressions perpetrated by nurses	I: ‘Lembra por parte de quem ela recebeu essas microagressões?’ P: ‘Foram enfermeiras.’	I: ‘Do you remember from whom she received these microaggressions?’ P: ‘They were nurses.’
	Other health professionals	Microaggressions perpetrated by other health professionals (technicians, assistants, internees, etc.)	‘Então eu tinha uma fisioterapeuta…’	‘So, I had a physiotherapist...’
e. Microaggressive Contents [The participant was able to identify the microaggressive content of the incident (which stereotypes the microaggression was related to)]	Ableist contents	Contents related to ableism - discrimination based on functional diversity	‘Portanto essas são as agressões diárias que uma pessoa com deficiência motora, neste caso uma mulher com deficiência motora, sofre. No nosso caso é muito mais complexo, porque nos exercemos, temos funções sociais muitas vezes inerentes à questão de sermos mulheres, porque somos mães, porque somos responsáveis, e acabamos por ter que acompanhar (inaudible). Nos somos cuidadoras, e em quanto objeto de cuidado… deveríamos ser objeto de cuidados, mas também somos cuidadoras, e os nossos serviços de saúde não estão estruturados para permitir que uma pessoa em cadeira de rodas tenha o papel de cuidadora.’	‘So, these are the daily aggressions that a person with motor disabilities, in this case a woman with motor disabilities, suffers. In our case it is much more complex, because we exercise, we have social functions often inherent to the question of being women, because we are mothers, because we are responsible, and we end up having to follow (inaudible). We are caregivers, and objects of care... We should be the object of care, but we are also caregivers, and our health services are not structured to allow a wheelchair person to have the role of caregiver.’
	Health practice-related contents	Microaggressive contents related to health practice (objectification, distance,	I: ‘Acredita que esse acontecimento também se associe com o fato de você ser uma mulher, ou com a sua	I: ‘Do you believe that this event is also associated with the fact that you are a woman, or with your

		lack of empathy) but not to social discrimination	condição física? Ou acha que poderia acontecer com qualquer pessoa?' P: 'Eu acredito que venha muito também da relação medico paciente, mas para o facto de ser mulher que isso seja mais exacerbado.'	physical condition? Or do you think it could happen to anyone?' P: 'I believe that it comes very much from the patient-doctor relationship, but because of being a woman it could be more exacerbated.'
	Intersectional contents	Microaggressive contents related to the specific intersection of more than one minoritarian identity	'E nessa situação sim, senti-me invisível, e sim acreditava por ser mulher e por ser jovem. Acreditava que se fosse um homem, ou se fosse alguém mais velho, teria tido outro atendimento. E também por nos sermos indianas, não é. E nesse atendimento senti muito a questão do racismo…'	'And in this situation, yes, I felt invisible, and yes, I believed that it was because of being a woman and being young. I believed that if I were a man, or if I were someone older, I would have had another type of attention. And, also, because we're Indian, isn't it? And in this case, I felt much the matter of racism...'
	LGBTphobic OR heterosexist contents	Contents related to discrimination based on sexual orientation or gender identity	'Mas além disso temos sempre... poderá sempre evoluir para algo mais específico porque, mesmo quando estamos na própria consulta de ginecologia todos os formulários e todo, tudo o que é para responder está como base é heterosexista puro... e que parte do princípio que com as mulheres o sexo é com homens e de determinada forma. Logo aí, isso aí todos nós vivermos esse tipo de situações independentemente da nossa orientação sexual, ou seja, do que for.'	'But besides that, we always have... This can always evolve to something more specific because, even when we are at the gynecology consultation itself, all forms and everything, everything that is to be answered has a basis of pure heterosexism... And this starts from the principle that women have sex with men, and only in a certain way. At that moment, that's where we all live this kind of situations, regardless of our sexual orientation, or everything else.'
	Racist OR xenophobic contents	Contents related to discrimination based on skin color or perception as foreigner	'E eu acho que tinha a ver com a cor da pele dela, com o facto dela falar um português que não era o português de Portugal… então tiveram que criar ali mais entravos..'	'And I think it had to do with the color of her skin, with the fact that she spoke a Portuguese that was not the Portuguese of Portugal... So, they had to complicate things there.'

	Sexist contents	Contents related to discrimination based on social gender roles division	'é um tipo de agressão completamente sexista, ou seja, ela pode fazer uma valorização sobre o meu comportamento sexual, sendo que pra ela, eu dormir com muitos homens é mal. E é completamente… sim, aquilo foi mesmo uma agressão.'	'It is a completely sexist type of aggression, that is, she can make a judgment about my sexual behavior, being that for her, sleeping with many men is something evil. And it is completely... Yes, that was an aggression.'
f. Emotional Reactions (emotions and thoughts at the moment of he Incidentthe incident)	Anger	Feeling angry, raged	I: 'Lembra neste caso quais foram os seus pensamentos? As suas emoções?' P: 'Como eu disse anteriormente, é sempre primeiro a zanga. Nestes dois casos não me senti humilhada, não me senti envergonhada, acho que senti mais zanga porque também implicavam um bocadinho o meu… o custo da consulta, e falta de sensibilidade, e também de não corresponderem à espectativa que eu tinha sobre o que um profissional deveria ter feito. Sim, a zanga.'	I: 'Do you remember in this case which your thoughts were? And your emotions?' P: 'As I said before, the first thing I always feel is anger. In these two cases I did not feel humiliated, I did not feel embarrassed, I think I felt angry because it also implied a little my... The cost of consultation, and lack of sensitivity, and also the fact that reality did not correspond to the expectation that I had about what a professional should have done. Yes, the anger'
	Feeling of being minimized	Feeling of being minimized, not taken seriously	'Eu senti-me minimizada. Que é o que muitas vezes nos sentimos até já com os profissionais de saúde, sobretudo os médicos, não tanto com os enfermeiros ou as enfermeiras. E depois senti essa coisa de comentários sobre a minha forma de ser mãe. Que as pessoas também se sentirem… terem a liberdade de fazer comentários sobre as escolhas parentais dos outros.'	'I felt minimized. That is what we already usually feel with health professionals, especially physicians, not so much with nurses. And then I heard this comment about my way of being a mother. That people also feel... they have the freedom to comment on others' parental choices.'
	Feeling of being objectified	Feeling treated like an object, or an animal, a body without willingness	'Mas eles levantam o lençol, pra ver entre as pernas… a nos entres as	'But they used to lift the sheet, to see between our legs. And it was

			pernas… uma frieira… como se fossemos gados.’	cold… They treated us as if we were cattle.’
	Feeling of injustice	Feeling of being treated wrongly, feeling that the situation is not fair, that the perpetrator is committing an injustice	I: ‘E lembra de quais foram-me seus pensamentos e suas emoções, quando isso aconteceu?’ P: **‘**Imediatamente foi um sentimento de injustiça, porque é “o que estão aqui a fazer?” Isto não é justo, ninguém pode me tratar assim.’	I: ‘And remember which your thoughts and emotions were when it happened?’ P: ‘It was immediately a feeling of injustice, like: "what are you doing here?" This is not fair, no one can treat me like this.’
	Other thoughts and emotions	Less specific – non codable thoughts and emotions	‘Eu acho que na altura tava um pouco se calhar mais apática, meu pensamento foi do tipo “não me interessa” ou “para que?”. Não foi uma reação de conivência assim, mas senti-me se calhar… se calhar me senti mal pelo que ela disse, mas ao mesmo tempo não percebia… agora é assim, está asism.’	‘I think at the time I was a little more apathetic, my thought was kind of like: “I don't care” or “what is this about?”. It wasn't a connivance reaction, but I just felt, maybe... Maybe I felt bad for what she said, but at the same time I didn't realize... I thought “Things are like this now”.’
	Powerlessness - vulnerability	Feeling of being powerless, vulnerable	‘Não me lembro bem dos pensamentos, mas também um bocadinho dos sentimentos de impotência. Eu não posso fazer mais nada. Posso levantar-me e ir embora. E não voltar nunca mais a ter uma consulta com esta medica.’	‘I don't remember exactly what I thought, but I remember feeling a little bit powerless. Like I couldn’t do anything else. I could only get up and leave. And never again come back and have an appointment with this doctor.’
	Sadness	Feeling sad	‘…e triste. Mesmo triste. Por mesmo uma situação que já parecia difícil e pesada, continua a haver este peso, este amontar de responsabilidades para mãe, ou então o inverso…’	‘... and sad. Really sad. The situation already seemed difficult and heavy, and, in addition, there was still this weight, this amount of responsibilities for the mother, or the opposite…’
	Self-directed anger	Feeling angry with the self, blaming the self for what happened, or for not being	‘E depois também chateada comigo própria porque não tive capacidade	‘And then also upset with myself because I didn't have the ability to

		able to adequately respond to the situation	de reação na altura. Não reagi, e devia ter reagido.’	react at the time. I didn't react, and I should have reacted.’
	Shame	Feeling ashamed	‘E de me sentir envergonhada, sim. Não envergonhada polo que estava a acontecer, porque eu sabia eu que estava a sentir, mas envergonhada porque eu sabia que ele não estava a perceber e que tinha sido ele a causar…’	‘And to feel ashamed, yes. Not ashamed for what was happening, because I knew [the pain] I was feeling, but I was ashamed because I knew that he was not noticing that he caused that...’
g. Behavioral reactions (Participants' reactions to microaggressions)	Direct response	The participant directly reacted against the microaggressor (stating the attitude was microaggressive, reacting vehemently or violently)	‘E aí salta-me logo a tampa “o que é que são paninhos quentes” que... é como quem diz “são estrias pré-menstruais, basicamente com os paninhos quentes passa”, quando não era. Portanto aí obriguei-os a chegarem-se à frente, a explicarem, “mas o que é isto”. Mas não sou muito de ficar calada. Depois como trabalho também numa área de ligadas um bocado à saúde... “mas isto é para quê, para que que me da isto”.’	‘And there I instantly lose my patience: “Why are you talking about using hot towels? What is that?” that... It is like who says: “these are premenstrual streaks, it basically passes with hot towels.”, when it wasn't like this. So, I forced them to come forward, explain, “but what is this?”. I am not the kind of person that stays quiet. Also, I work in an area that is a bit connected to health... so I am always like: “What is this for? Why did you give me this?”.’
	Indirect response	The participant indirectly tried to make the health professional understand that his/her attitudes were microaggressive (through non-verbal, behavioral attitudes or through slights comments)	I: ‘Algumas vezes se falaram para ela, se queixaram, ou responderam?’ P: ‘Falávamos... corrigíamos. Muitas vezes a pessoa não... não dizíamos não é "doadora", no nosso discurso colocávamos a correção, não era uma correção direta, era uma correção indireta, digamos assim. Agora se sempre pessoalmente, acho que isso não, nunca lhe dissemos que isso nos deixava desconfortáveis ou criava	I: ‘Have you ever tried to talk to her, to complain, or to answer to her attitude?’ P: ‘Yes, we said something, we tried to correct her. We often said... We did not say directly “the correct word is not donor”, but we put the correction in our discourse. It was not a direct correction, it was an indirect correction, to say so. Now if we ever, personally… No, I don't think so, we never told her that her attitude made us uncomfortable or

			algum outro tipo de reação, não isso não. Colocávamos isso mais no nosso discurso por fazer essa correção.’	created some other kind of reaction in us. We put this in our speech, to try to correct her.’
	Passivity - No reaction	The participant did not show his feelings, did not react, preferred to stay quiet	‘Aconteceu-me há pouco tempo um outro. Não foi bem assim, mas também na altura não fiz… não tive capacidade de reação.’	‘Another incident happened to me a short time ago. It wasn’t exactly like this one, but also at the time did not... I didn't have the ability to react.”
h. Complaint	No complaint	The participant did not complain about the incident	‘Não apresentei queixa no hospital, eu era muito jovem também, e estava numa situação de muita fragilidade emocional’	‘I didn't press charges at the hospital. Also, I was very young, and I was in a situation of high emotional fragility’
	Official complaint	The participant made an official complaint against the health professional or the structure	‘…e eu mandei vir o livro. Fiz uma reclamação por escrito, fiz uma queixa por escrito e fui-me embora, sem ser atendida. Recusei-me a ser atendida.’	"... And asked for the book [of complaints]. I made a written complaint… I made a written complaint and I left without being attended. I refused to be attended."
	Official complaint in process - Intention to	Intends to officially complain but hasn't presented it yet	I: ‘Apresentou queixa?’ P: ‘Não, mais quero apresentar. Quando terminar o processo de mudança, vou faze-lo.’	I: ‘Have you filed a complaint?’ P: ‘No, but I want to do it. When the change process [of changing doctor] will be complete, I will do it.’
	Unofficial complaint	The participant unofficially complained (e.g. with some other health professional, with a medical chief) about the incident	‘Eu depois fui para a medica que me encaminhou para lá e disse: “nunca mais eu lá meto os pês.” E contei a situação que se tinha passado à medica chefe, por causa disso. Agora o que é que ela fez não sei.’	‘I then went to the doctor who directed me there and said: “I will never put my feet in there again.” And reported the situation to the chief medical officer. Now I don't know what she did.’
i. Recalling of the Incident [Whether participants thought again (or not) about the incident, after it happened]	Never recalled	The participant never thought about the incident again until the moment of the interview	I: ‘Em seguida voltou a pensar nesse assunto? P: ‘Não/, agora a tentar me lembrar de coisas, fui tentar me lembrar situações em contexto de saúde e lembrei-me disso, mas não tinha voltado a pensar.’	I: ‘Did you think about it again? ‘ P: ‘No, only now, trying to remember things, I tried to remember some situations in the health context and I remembered it, but I hadn't thought about it again.’

	Recalled	The participant thought about the incident in other moments before the interview	I: 'Voltou a pensar neste acontecimento depois que aconteceu?' P: 'Sim, sempre que se fala em boas praticas ou sempre que se fala em ir ao medico, ou sempre que eu penso que tenho de ir ao medico, é nisso que me vem muitas vezes a imagem… lembro-me da figura do medico, de não me sentir segura lá dentro.'	I: 'Have you ever thought about this event again, after it happened?' P: 'Yes, whenever I talk about good practices or whenever I talk about going to the doctor, or whenever I think, the image comes back to me… I remember the doctor's figure, not feeling safe inside.'
. Social Sharing of The Incident [Whether participants shared (or not) the incident, and which feedbacks they received]	No memory of sharing	The participant did not have memory of sharing the incident	'Não sei se ela comentou com alguém. Conversamos entre nos, sim. Mas não sei se ela chegou a comentar com alguém. Eu acho que não comentei. Talvez comentamos com algum amigo, alguma coisa. Não me recordo, já foi há anos."	'I don't know if she commented with anyone. We talked among ourselves, yes. But I don't know if she ever talked to anyone. I don't think I've commented. Maybe we talked to some friend, or something. I don't remember, it was years ago.'
	Not shared	The participant did not share the incident	I: 'E falou com alguém depois que isso aconteceu?' P: 'Contigo agora. Acho que não contei este episodio.'	I: 'And did you talk to anyone after this happened?' P: 'With you, now. I don't think I shared this episode.'
	Shared	The participant shared the incident	'Então sim, partilhei com a minha família e tava muito zangada. Primeiro eu estava sozinha lá dentro com ela, então ao relatar o que tinha acontecido, o que tínhamos vivido as duas contei como é que foi. Mas na verdade naquele momento a coisa mais importante para todos era a minha avó.'	'So yes, I shared with my family and I was very angry. First, I was alone in there with her [my grandmother], so when I told them what had happened, what the two of us had lived, I told them how it happened. But actually, at that moment the most important thing for everyone was my grandmother's health.'
	Dismissive feedbacks received	The participant received dismissive feedbacks	I: 'E quais feedbacks recebeu?' P: 'Pois, ai está. Não me recordo. Mas è provável que me tenham dito	I: 'And which feedbacks did you receive?' P: 'Yes, there it is. I don't remember exactly. But they probably told me

				que eu exagero. Isso pode ser uma microagressão também.’	that I overreact. This could be a microaggression, too.’
	Supportive feedbacks received		The participant received supportive feedbacks	‘E com amigos meus, sim, entendiam perfeitamente que me sentisse estranha, que para mim fosse… e compartilhavam também, coisas que para eles também aconteciam. Seilà amigos gays, amigas lésbicas, mulheres… não é habitual então… as discriminações que se reconhecem… para quem tem essa consciência, se reconhecem.’	‘And with friends of mine, yes, they perfectly understood that I felt weird, that for me it was... Also, they shared with me things that happened to them. Gay friends, lesbian friends, women... they are not “usual”, then it’s possible to recognize the discrimination… For those who have this awareness, they recognize the discrimination.’
k. Presence of third persons [Whether other people were (or were not) present during the microaggressive incident and eventually intervened to defend or help the target]	No one else was present		At the moment of the microaggressive incident only the patient/target and the health provider(s)/perpetrator(s) were present	I: ‘Estava sozinha quando isto aconteceu?’ P: ‘Sim.’	I: ‘Were you alone when this happened?’ P: ‘Yes.’
	Third persons were present	Those who were present did NOT intervene	Third persons that were present ignored the situation and/or did not intervened to help/defend/support the target of the microaggression	I: ‘E estavam outras pessoas presentes naquela altura? Disseram algo?’ P: ‘Estava o meu companheiro sim. Mas não. Não ele geralmente não diz… porque ele não sente isso na pele. Ou porque provavelmente também deve achar que eu exagero. Eu sempre tive isso muito à flor da pele. Eu sempre tive muito mais sensível a estas coisas, porque de facto eu sinto-me… porque acho que não há nada de preconceituoso relativamente ao homem, jovem, pai. O peso deve ser sempre mais sobre a mulher, e se for africana, deve pesar muito mais. E então eu	I: ‘And were there other people present at that moment of the incident? Did anyone say something?’ P: ‘There was my partner, yes. But no. He doesn't usually say... Because he doesn't feel it on his skin. Or because he probably thinks I exaggerate, too. I've always felt it on my skin. I've always been a lot more sensitive to these things, because I feel... Because I think there are no prejudices about the man, young, father. The weight is always more on the woman, and if she’s is African, it must weigh much more. For this reason, I feel a little more vulnerable.’

				sinto-me um bocado mais vulnerável.'	
		Those who were present intervened	Third persons that were present ignored the situation and/or did actively intervened to help/defend/support the target of the microaggression	I: 'Aconteceu alguma vez que estivessem outras pessoas presentes e alguém interveio ou disse algo?' P: 'Aconteceu sim. Houve uma vez, quando esta medica estava a perguntar se eu sentia, e que picou e não sei o que, a minha filha estava presente e voltou-se a gritar com a medica, tipo assim… um ataque de irritação e interveio.'	I: 'Did it ever happen that other people were present, and someone intervened or said something?' P: 'It did happen. There was this one time, when this doctor was asking if I felt anything [on my leg], and she poked me and so on, my daughter was present, and she screamed at her doctor, like this... She got very irritated and intervened.'
l. Change in the Relationship or Perception of the Health Professional	Change in the relationship-perception		Participant's perception and relationship with the health care provider/structure changed after the microaggressive incident	'Assim, como são situações muito incidentes, eu tento quase que me distrair um pouco do que me aconteceu, mas obviamente a minha confiança, a minha abertura… mudam nê, logo. A minha forma de estar naquela sala com aquela pessoa, assume uma outra forma nê…	'So, as these situations have a strong impact [on me], I try to distract myself a bit from what happened, but obviously my confidence, my openness... They quickly change. My way of being in that room, with that person, takes another shape...'
				P: 'Sim, continuo. Mudou. Mudou sim. Não sei se… deve ser isto, deve ser uma síndrome dos pacientes, mas eu vou compensando o fato dele ser bom profissional com esta falta de sensibilidade. Ou seja eu vou dizendo: "ah mas para eu arranjar um novo medico e tem que fazer tudo novamente, prefiro estar a passar por essas coisas do que passar por uma nova relação". Mas eu continuo acha-lo não sensível para estas coisas. Mas isso deve ser uma coisa de… porque custa bastante iniciar uma nova relação, pelo menos comigo custa muito. E é	P: Yes, I continue [to go to the same gynecologist]. It changed. Yes, it changed [the relationship with the doctor]. I don't know if… but it has to be this, like a syndrome of the patient, but I compensate this lack of sensitivity with the fact that he is a good professional. In other words, I say to myself: "ah, but if I have to find another doctor and start everything from the beginning, I prefer to pass through these things than passing through a new relationship". But I continue to find him insensitive to these things. But this should be a think of… because

			diferente por exemplo de ir a um dermatologista. Se bem que o dermatologista também tende a essas coisas. Mas é diferente ou seja, a intimidade é diferente e até chegar a esta intimidade com um medico, não ter que explicar muita coisa, vou compensando e vou dizendo, vou desculpando a falta de atitude dele, com o fato dele ser um bom medico, de estar sempre disponível.’	it costs to start a new relationship, at least for me it costs a lot. And it is different than, for example, going to a dermatologist. Dermatologists do these things too. But it is different because the intimacy is different, I don’t have to explain too many things. So, I compensate and say to myself, I excuse his lack of professional attitude with the fact that he is a good doctor, that is always available.’
	NO changes in the relationship-perception	Participant's perception and relationship with the health care provider/structure did not change after the microaggressive incident	I: ‘A sua relação com esta fisioterapeuta mudou depois dessas coisas que você ouviu?’ P: ‘Não.’	I: ‘Did your relationship with this physiotherapist changed after these things you've heard?’ P: ‘No.’
	Non-return to the same health provider-structure	The participant decided to never return to the health provider/structure that perpetrated the microaggression	P: ‘Eu é que nunca mais lá voltei. Não gostei mesmo. E já tinha ido lá várias vezes. Mas isso pra mim foi…’ I: ‘Então a sua relação com ele mudou depois do incidente, você não voltou mais ali?’ P: ‘Sim, não voltei mais ali. Embora eu vá para o oftalmologista privado, mas não voltei mais ali.’	P: ‘I never went back there. I really didn't like it. And I've been there several times. But this was...’ I: ‘So, your relationship with him changed after the incident, you didn't go back there?’ P: ‘Yes, I didn't go back there. Although I continue to go to private ophthalmologists, but I did not go back there.’
m. Consequences for the Patient's Health [Whether the microaggressive incident may have had (or actually had) some consequences for the patient's health or attitudes]	No consequences	The participant did not identify the consequences that the incident had or may have had on the patient's health	I: ‘Acha que esta situação criou ou poderia ter criado implicações praticas e/ou para a sua saúde?’ P: ‘Não. Acho que não houve implicação nenhuma na minha saúde. Só acho incomodante. Só isso. Agora, haver algum dano, não houve nenhum. Essa é só mesmo aquela situação ali, especifica, não houve mais nada.’	I: ‘Do you think this situation created or could have created practical implications and/or for your health?’ P: ‘No. I don't think there was any implication for my health. I just found it annoying. That’s it. Now, about having some damage, there hasn't been any. That's just about

				that specific situation there, there was nothing else.'
	Practical consequences	The participant identified which practical consequences the incident may have had or had on his health (e.g. errors in the diagnosis, in the prescription of medicines)	I: 'Nessa situação, a atitude do profissional de saúde criou, ou poderia ter criado implicações praticas e/ou para a sua saúde?' P: 'Sim, porque se eu tivesse deixado, se eu não tivesse insistido para ver outro medico, ela tinha-me dado alta.'	I: 'In this situation, the attitude of the health professional created, or could have created practical implications and/or for your health?' P: 'Yes, because if I had left, if I did not insist on seeing another doctor, she would have discharged me [from the hospital]'
	Secondary effects	The participant identified the consequences of the microaggressive incident as causes for a change behavior or attitudes towards during medical examinations or towards health providers	I: 'E em seguida pensou novamente no incidente?' P: 'Quando se repete, ou antecipo o acontecimento se estou na fila e vou para ser atendida, já estou na espera que tenham esse comportamento. Não consigo lembrar-me se eu compenso. Se vou e falo logo ou se paro, ou se avanço lentamente para ver se a pessoa vai ou não vai me atender.'	I: 'Have you ever thought again about the incident?' P: 'When it happens again, I anticipate the event - if I'm in the line and I'm going to be attended, I'm already waiting for that behavior. I can't remember if I compensate. If I go and talk before it happens, or if I stop, or if I proceed slowly to see if the person will or will not attend me.'
n. Apologies from the Health Professional	Apologies AND change of attitude	The health professional apologized and changed his/her attitude	'E quando eu propus essa situação, ficou a pensar que não lhe tinha ocorrido. Que para ela é rotina então... noventa em 99 por cento dos casos. Mas depois pediu desculpas e a partir daí modificou o discurso.'	'And when I proposed this situation, she stopped to think that it had never occurred to her. Which for her is routine so... 90 in 99% of cases. But then she apologized and then he changed her speech.'
	Apologies but not change of attitude	The health professional apologized but continued with the same microaggressive attitude	I: 'Em algum momento os profissionais de saúde perceberam que tinham assumido uma atitude errada e/ou pediram desculpas?' P: 'Sim, foram se desculpando, dizendo que não era sua intenção, sim… e depois no caso do internamento em que eu não	I: 'At some point did health professionals realize that they had assumed a wrong attitude and/or apologized?' P: 'Yes, they were apologizing, saying that it was not their intention, yes... And then in the case of the hospitalization, where I couldn't

			conseguia falar com os médicos, continuei a não conseguir falar com eles. Não houve propriamente uma mudança de atitude. Disseram "sim, sim, vamos tentar", mas depois não mudou nada.'	speak to the doctors… I kept failing to talk to them. There wasn't exactly a change of attitude. They said "Yes, yes, let's try". but then nothing changed.'
	Apologies from third parts	Third parts (the health facility, other health professionals) apologized for the perpetrator's microaggressive attitude	I: 'Em algum momento algum dos profissionais de saúde percebeu que tinha assumido uma atitude errada e pediu desculpas?' P: **'**Essa pediatra, veio pedir desculpas pelo colega claro. Mas ele não, ela veio.'	I: 'At any time, did any of the health professionals realize that they had assumed a wrong attitude and apologized?' P: 'This pediatrician has come to apologize for her colleague's attitude. But he didn't, she came.'
	Change of attitude but no apology	The health professional changed attitude, but did not apologized	I: 'Em algum momento, nesse caso, o profissional de saúde percebeu que tinha assumido uma atitude errada e pediu desculpas ou tentou disfarçar?' P: 'Acho que nesta situação ele percebeu porque eu não consegui mesmo fazer o exame e ele não insistiu, mas nem forçou, nem nada. Ele viu que eu não conseguia, fez esse comentário infeliz, mas parou e disse "está tudo ok, senta, vamos conversar e terminar a consulta". Ou seja, eu acho que ele deve ter compreendido. Se calhar não em relação ao comentário dele, mas ter compreendido que estava a forçar algo.'	I: 'At some point, in this case, did the health professional realize that he had taken a wrong attitude and apologized or tried to conceal?' P: 'I think in this situation he realized why I couldn't take the exam, and he didn't insist, neither he forced me, nor anything. He saw that I could not, made this unhappy comment, but stopped and said, "everything is ok, let's sit, talk and finish the consultation." I mean, I think he may have understood. Maybe not about his comment, but he understood he was forcing something.'
	No apology, no change of attitude	The health professional did not apologize, neither changed his/her attitude	I: 'E ela percebeu ou pediu desculpas?' P: 'Não, não, nunca pediu desculpa. Volta e meia e fazia a mesma coisa. As pessoas já nem sabem se é por.... Porque é que é.'	I: 'And did she realize or apologize?' P: 'No, no, she never apologized. Back and forth, and she would do the same thing. People don't even know if it's for.... Why is it.'

	No memory of apologies	The participant did not have memories of apologies from the health care provider	I: ‘Em algum momento esse profissional percebeu que tinha assumido uma attitude errada ou pediu desculpas para você?’ P: ‘Não. Não me lembro. Nunca. Ele é um ginecologista muito solicitado. Não, nessa situação não me lembro.’	I: ‘At some point did this professional realize that he had assumed a wrong attitude or apologized to you?’ P: ‘No. I can't remember. Never. He's a very requested gynecologist. No, in this situation I don't remember.’
o. Never experienced microaggressions	Never experienced BUT heard about.	The participant never experienced a microaggression BUT was able to tell about one she witnessed or about intimates that experienced such microaggressions	‘Pessoalmente eu não lembro de nada que se tenha passado comigo. Se calhar o último e único acontecimento foi eu ter trocado de médico ginecologista homem para uma mulher porque me sentia um bocadinho mais confortável por ser uma mulher e gosto imenso dela agora e... não é que não gostasse do outro mas... principalmente enquanto também era o mesmo médico da minha mãe, acho que preferia haver ali uma separação. Mas comigo não tem nenhuma história, sobretudo porque não vou muito ao médico. Mas ouço muitas histórias geralmente também nas consultas de ginecologia e obstetrícia, já ouvi vários relatos de pessoas que me são próximas de que não houve sensibilidade com a situação.’	‘Personally, I don't remember anything that's happened to me. Maybe the last and only event was that I changed from a male gynecologist to a woman because I felt a little more comfortable with a woman, and I like her a lot now and... It's not that I didn't like the other one but... Especially as he was also my mother’s doctor, I think I'd rather prefer a separation. But with me there's no story, especially since I don't go to the doctor much. But I hear many stories, usually also about the consultations of gynecology and obstetrics, I have heard several reports of people who are close to me that lived situations of lack of sensitivity.’
	Never experienced NOR heard about	The participant never experienced a microaggression neither was able to tell about one she witnessed or about inimates that experienced such microaggressions	I: ‘Então no contexto do texto que foi apresentado, consegue lembrar de alguma situação de microagressão?’ P: ‘Não. Nunca... nunca tive uma experiência, ou que me lembre...	I: ‘So in the context of the text that has been presented, can you remember any situation of microaggression?’ P: ‘No. Never... I've never had an experience, or that reminds me...

			que pudesse ser considerada uma microagressão. Não.' I: 'Conhece alguém que já passou por isso?' P: 'Também acho que não.'	That could be considered a microaggression. No, no, no.' I: 'Do you know anyone who has been through this?' P: 'I don't think so either.'

n. General Questions About Microaggressions				
Organizing theme	Node	Description	Example	Translation
Commonality of microaggressions [Whether participants thought that microaggressions are a common phenomenon (or not) in people's everyday life]	Common	The participant recognized microaggressions to be a common phenomenon in people's everyday life	I: 'Acredita que estas microagressões sejam comuns?' P: 'Sim. Acredito que são tao comuns na área da saúde quanto em qualquer outra área da nossa vida, porque somos pessoas, os profissionais de saúde são pessoas como todos nos, não tem uma formação especifica para igualdade de género, como quase nenhuma área de contacto humano tem, portanto são estereótipos que se perpetuam em qualquer dimensão. E sim, acho que sim.'	I: 'Do you believe that these microaggressions are common?' P: 'Yes. I believe that they are so common in the area of health as in any other area of our lives, because we are people, health professionals are people like all of us, they do not have a specific training for gender equality, as almost no human contact area has such trainings, so there are stereotypes that are perpetuated in any dimension. And yes, I think so.'
	Uncommon	The participant did not recognize microaggressions as a common phenomenon in people's everyday life	No findings	----------
Good practices [identified to sensitize health professional and/or minimize the impact of microaggressions on targets]	Other practices	Other practices identified as good practices	'Eu acho que em primeiro lugar a justiça tem que funcionar. Se um medico receber uma denuncia, é porque aconteceu alguma coisa, então algo deve ser feito. Esse é um problema… muitas vezes os médicos continuam no mesmo local, e continuam com as mesmas praticas, e ai depois… sabe, chamou a atenção mas eles continuam com a atitude de	'I think in the first-place justice has to work. If a doctor gets a report, it's because something happened, so, something must be done. That's a problem... Often doctors continue in the same place, and continue with the same practices, and then... You know, it draws the attention, but they still continue with their attitude. So, it's like it's nothing, it's like it's ok for

			medico. Então é como se não fosse nada, é como se fosse ok para eles continuar com este tipo de pratica, então… eu acho que em primeiro lugar isso deveria mudar e escutar o que as pessoas que sofrem tem a dizer.’	them to continue with this kind of practice, so... I think that in the first place this should change, listen to what the people who suffer have to say.’
	Training and Sensitization	Training and sensitization programs identified as good practices	I: ‘E acredita que existam umas boas praticas uteis, de um lado sensibilizar os profissionais de saúde e do outro a minimizar o impacto desses incidentes sobre os utentes?’ P: ‘Há pouca formação dos nossos profissionais de saúde em Portugal. Ou seja, eu acho que devia haver maior formação, uma linguagem inclusiva de ser contra a heteronormatividade, ser mais inclusiva para as sexualidades, e sobretudo linguagem. Acho que é o foco principal, do maior conhecimento, também em termos psicológicos de como tratar o outro não como objetos, de como tratar um ser humano que está à frente. Eu acho que há muito pouca formação e acho que isso é super possível acontecer, tal como também já me cruzei com médicos que tiveram uma abordagem mais… não de assumir coisas por ti, mas de fazerem perguntas cuidadosas e nós conseguimos ter a abordagem com os médicos, mas infelizmente aqui não ha.’	I: ‘And do you believe that there are good practices, on one hand useful to sensitize health professionals and on the other to minimize the impact of these incidents on patients?’ P: ‘Our health professionals here in Portugal do not receive enough training. That is, I think there should be more training, with an inclusive language against heteronormativity, more inclusive to different sexualities, and that could mainly focus on the greater knowledge of how to treat the human being that is in front of them, also in psychological terms, not to treat the other as an object. I think there is little training and that it is super possible to implement these things, as I already met health professionals that had an approach more…. Not of assuming things for you, but of making careful questions… and we could have this approach from doctors, but unfortunately here is not common.’

Negative impact of microaggressions [Whether participants stated that microaggressions have a negative impact (or not) on targets]	Negative impact	Microaggressions have a negative impact on targets	I: 'E acredita que essas microagressões tenham um impacto negativo?' P: 'Tem. A maior parte das vezes as pessoas, como disse, as mulheres ou as pessoas que as vivem… não se intuíram ou as vezes podem não tomar consciência, ou tomam consciência e esquecem, mas essas microagressões passam mensagens… passam mensagens de… daquilo que eu estava a dizer, de arquétipos, de ideias, de que é preciso aguentar a dor, de que os pacientes não valem muito, os médicos é que sabem… pronto, passa mensagens permanentemente em todo lugar, e é por isso – e há também muitos estudos sobre isso – é por isso que as crianças tao pequeninas já intuem, já fazem diferenças sobre papeis de género e sobre tarefas, atribuições, responsabilidades, e até sonhos, e até expectativas, e o que podem e não podem sonhar. Porque mesmo não sendo verbalizado claramente vai passar umas mensagens, além do resto todo… da critica social, do marketing, êxcetra.'	I: 'And do you believe that these microaggressions have a negative impact?' P: "They have. Most of the time people, like I said, women or the people who live them... they do not understand, or sometimes they may not be aware, or they may be aware and then forget, but these microaggressions pass messages... They pass messages of… of what I was saying, of archetypes, of ideas, that it is necessary to endure the pain, that the patients are not worth much, the doctors are those that know... It permanently transmits these messages, everywhere, and that's why – and there are also many studies about it – that's why there are children so young that intuit… they already make differences on gender roles and on tasks, assignments, responsibilities, and even dreams, and expectations, and what they can and cannot dream of. This because, even If it is not clearly verbalized, it transmits some messages, besides all the rest... Social criticism, marketing, success. "

			I: 'Acredita que estas microagressões tenham um impacto negativo?' P: 'Sim. Até porque elas não são bem vistas normalmente como uma agressão, então sempre que a gente tenta questionar as pessoas dizem "ah mas não foi nada, é só uma piada, não é nada demais, é coisa da sua cabeça". Então é um sentimento de impotência. Eu tenho que levar com isso? Tem que ser normal? Então vou me sentindo assim, mal, para o resto da minha vida?"	I: 'Do you believe that these microaggressions have a negative impact?' P: 'Yes. Even because they're not normally seen as an aggression, so whenever we try to question them, people say "ah but it was nothing, it's just a joke, it's not a big deal, it's in your head." So, there is a feeling of impotence. Do I have to take this? Does it have to be normal? Am I going to feel this way, bad, for the rest of my life?'
	Not negative impact	Microaggressions do not have a negative impact on targets	No findings	-----------
	The impact depends on the person	The negative impact that a microaggression can have on a target depends on factors as context, personality, personal heritage, previous experiences, etc.	I: 'Acredita que estas microagressões tenham um impacto negativo?' P: 'Acho que é um bocado por lá, tem vários fatores. O contexto, de onde a pessoa vem, mesmo algumas questões mais… como é que a pessoa está a se sentir na aquele momento. No negativo, se calhar ao longo do tempo, se calhar não. A pessoa as vezes ou está alienada e não percebe que foi vitima de uma microagressão, ou lida com aquele momento e depois já vem outra coisa e esquece. Normalmente, no jeito habitual. Ou não repara no jeito habitual e tem estratégias para lidar com isso. Acho que depende do contexto.'	I: 'Do you believe that these microaggressions have a negative impact?' P: 'I think it's a bit like this, there are several factors. The context, where the person comes from, even some issues more... How the person is feeling at that moment. In a negative way, maybe it happens during the time, maybe not. The person sometimes is alienated and does not realize that she was the victim of a microaggression or deals with that moment and then comes another thing and she forgets. Maybe that's here habitual way, maybe she doesn't usually notice, maybe she has some strategies to deal with it. I think it depends on the context.'

Microaggressive incidents toward women in the healthcare context.

Participants' personal information					
Organizing theme	Node		Description	Example	Translation
Activism	Activism		Whether the participant considered herself an activist/feminist or not	I: 'é ativista ou feminista há quanto tempo?' P: 'Posso considerar-me ativista há uns 10 anos.'	I: 'For how long have you been an activist?' P: 'I can consider myself an activist for about 10 years.
	Type of activism [Different types of activism that each participant follows]	Formal activism	Activities with associations, organizations and other entities that openly work with activism.	I: 'Quais são as principais atividades de ativismo em que participa?' P: 'Eu fiz… eu fundei algumas associações, fiz manifestações de rua, tive reuniões com partidos políticos, tentei ser e fazer ativismo do lado da politica, acompanhamento de casos especiais em que tentei formar as pessoas, acompanha-las e apoia-las, e neste caso agora, a prestação de uma carga politica, acho que também é uma forma de ativismo.'	I: 'Which are the main activities of activism in which you participate?' P: 'I did... I founded some associations, made street demonstrations, had meetings with political parties, tried to be and do activism on the side of politics, monitoring of special cases in which I tried to train people, accompany them and support them, and in this case now, I am covering a political position, that I think is also a form of activism.'
		Informal activism	Activism intended as "every-day contribution" through interpersonal relations, work activities, research activities, etc.	I: 'E participa de alguma atividade de ativismo específica?' P: 'Não, o meu ativismo é ler, escrever, partilhar, tornar público, trazer colegas para discutir certas questões. é assim que se manifesta.'	I: 'And do you participate in some specific activity of activism?' P: 'No, my activism is reading, writing, sharing, making public, bringing colleagues to discuss certain issues. This is how I manifest it.'
	Area of activism [Different areas of activism in which each participant is engaged]	Ethnic	Activism related to ethnic minorities, in contrast to phenomena as racism and xenophobia	I: 'Segue alguma vertente especifica?' P: 'O étnico. Basicamente é o étnico. Em relação à mulher também, igualdade de género.'	I: 'Do you follow any specific strand?' P: 'Ethnic. It's basically ethnic. In relation to women too, to gender equality.'
		Feminism	Activism related to gender equality and women's right, in contrast to phenomena as sexism and gender inequality	I: 'Segue alguma vertente especifica?' P: 'Sim, feminista.'	I: 'Do you follow any specific aspect of activism?' P: 'Yes, feminist.'

		Intersectional	Activism related to the analysis and support of the rights of people with different minoritarian identities	I: 'Segue ou é interessada em alguma vertente de ativismo especifica?' P: 'Gosto de feminista, de antirracista, de anti-homofóbico e anti-transfobico, são áreas que me interessam muito. E em ligação à interseccionalidade. E no antirracismo, também estou a trabalhar e gosto muito com as comunidades ciganas, portanto qualquer comentário sobre ciganos perto de mim… vamos conversar.'	I: 'Do you follow or are you interested in any specific aspect of activism?' P: "I like the feminist, anti-racist, anti-homophobia, and anti-transphobia, these are the areas that interest me very much. And in connection with intersectionality. About the anti-racism, I'm also working - and I really like it – with the Roma communities, so any commentary on Roma people next to me, I am like "Let's talk".'
		Other types of activism	Other types of activism described	I: 'Segue alguma vertente de ativismo especifica?' P: 'Não, faço parte de uma associação, portanto tento encaminhar o ativismo por ali. A associação lidera com acessibilidade à cultura, portanto lidamos também com este tipo de questões, liberdade de género e não só. Queremos que toda a gente possa usufruir do espaço cultural e da oferta cultural.'	I: 'Do you follow any specific aspect of activism?' P: 'No, I'm part of an association, so I try to direct my activism through it. The association leads with accessibility to culture, so we also deal with this type of issues, gender freedom and not only. We want everyone to enjoy the cultural space and the cultural offer.'
		People with functional diversity	Activism related to the rights of people with functional diversity, in contrast to phenomena as ableism	I: 'Tem alguma vertente de ativismo especifica em que está interessada?" P: "No meu caso, o meu ativismo é tudo direcionado para os direitos das pessoas com deficiência. Obviamente as questões de género se cruzam, as questões LGBTI também se cruzam, as questões da orientação sexual, ou identidade de género, são questões para as que eu sou uma ativista profunda. Porque são para… sempre deve ter	I: 'Is there any specific aspects of activism that you are interested in?' P: 'In my case, my activism is all directed towards the rights of people with disabilities. Obviously, gender issues intersect, LGBTI issues also intersect, sexual orientation issues, or gender identity, are issues for which I am a deep activist. Because they're for... Should always have specific aspects for people with disabilities, then to be extended to the

				vertentes para as pessoas com deficiência, para depois se estender para a generalidade. Ah, e dizer que um ativista que seja ativista defende sempre os direitos fundamentais do homem, por isso acho que este é o grande ponto do ativismo.’	generality. Oh, and an activist who is an activist always defends the fundamental human rights, so I think this is the great point of activism.’
Age			Participants' age	I: ‘Qual é a sua idade?’ P: ‘48.’	I: ‘How old are you?’ P: ‘48.’
Gender	Female		Identification with female gender	I: ‘Com qual género se identifica?’ P: ‘Feminino.’	I: ‘What gender do you identify with?’ P: ‘Feminine.’
	Non-binary		Identification as non-binary gender	I: ‘Com qual género se identifica?’ P: ‘Eu não me identifico como nenhum género, identifico-me como não binaria.’	I: ‘What gender do you identify with?’ P: ‘I identify myself as no gender, I identify myself as non-binary.’
Identification with social minorities [Participants' self-identification with specific social minorities]	Ethnic minority		Identification with ethnic minorities	I: ‘Se identifica com alguma minoria social?’ P: ‘Sim, cigana. Sem duvida.’	I: ‘Do you identify with any social minority?’ P: ‘Yes, Roma ethnicity. Undoubtedly.’
	Identify with women and sensitize with others		Identification as part of the social minority of women and empathy with all the other social minorities	I: ‘Identifica-se com alguma minoria social?’ P: ‘Sim. Identifico-me com as mulheres, porque sou mulher. Mas identifico-me, sem o ser, muito com negros e ciganos, os meus filhos são uma mistura de negro e branco…, mas já lutava antes… não sei acho que as minorias sempre me… e também LGBTI, também me identifico muito com a causa e com as dificuldades.’	I: ‘Do you identify with any social minority?’ P: ‘Yes. I identify with women, because I'm a woman. But I identify myself, without being with blacks and gypsies, my children are a mixture of black and white... but I was also fighting before… I think minorities always made me… And also LGBTI, I also identify a lot with their cause and their difficulties.’
	LGBTQI+		Identification as member of the LGBTQI+ minority	I: ‘Identifica-se com alguma minoria social?’ P: ‘Sim, pela minha orientação sexual. Lésbica.’	I: ‘Do you identify with any social minority?’ P: ‘Yes, for my sexual orientation. I am lesbian.’

	Not identify	No identification, with any social minority	Interviewer: 'Se identifica com alguma minoria social?' Participant: 'Não, acho que não.'	I: 'Do you identify with any social minority?' P: 'No, I don't think so.'
	Sensitize but not identify	No identification, with any social minority, but empathy and support to all social minorities	I: 'Se identifica com alguma minoria social?' P: 'Não considero as mulheres uma minoria social. Portanto... até porque somos a maioria... mas não... sensibilizo-me com todas mas não me identifico. Não me identifico pessoalmente e fisicamente.'	I: 'Do you identify with any social minority?' P: 'I do not consider women a social minority. So... Because we are the majority... But not... I empathize to all minorities, but I don't identify myself. I don't personally and physically identify myself.'
	Women and ethnic minorities	Identification as part of the social minority of women and of an ethnic minority	I: 'Se identifica com alguma minoria social?' P: 'Sim. Eu não sei se nos seremos uma minoria, as mulheres não são uma minoria, mas sim, sinto que o facto de ser mulher na sociedade tem menos valor do que de ser um homem. Eu sinto isso. Não penso isso, mas sinto isso. Identifico-me com imigrantes, com estrangeiros, com *aliens*, com tudo o que seja… porque eu não me sinto parte integrante da sociedade portuguesa, sinto-me sempre como *outsider*, como de fora. Sou cabo-verdiana, que somos uma minoria aqui em Portugal, africana, vejo-me como uma pessoa negra a viver em Portugal.'	I: 'Do you identify with any social minority?' P: 'Yes. I don't know if we will be a minority, women are not a minority, but yes, I feel that being a woman in society has less value than being a man. I feel it. I don't think it, but I feel it. I identify with immigrants, with foreigners, with aliens, with everything... Because I do not feel an integral part of Portuguese society, I always feel like an outsider, like I come from the outside. I am Cape Verdean, we are a minority here in Portugal, we are African, I see myself as a black person living in Portugal.'
	Women and functionally diverse people	Identification as part of the social minority of women and of functionally diverse people	I: 'Se identifica com alguma minoria social?' P: 'Sim, com mulheres e pessoas com deficiência.'	I: 'Do you identify with any social minority? P: Yes, with women and people with disabilities.'
	Women and LGBTQI+	Identification as part of the social minority of women and of LGBTQI+ minority	I: 'Se identifica com alguma minoria social?'	I: 'Do you identify with any social minority?'

			Participant: 'Sim, considero-me uma mulher lésbica.'	Participant: 'Yes, I consider myself a lesbian woman.'
Nationality	Double nacionality	Portuguese nationality and another nationality	I: 'Qual é - ou se tiver mais que uma, quais são - a sua nacionalidade? P: 'Grega e portuguesa.'	I: 'What is - or if you have more than one, what are, - your nationality?' P: 'Greek and Portuguese.'
	Portuguese	Portuguese nationality	I: 'Qual é – ou quais são, se tiver mais que uma – a sua nacionalidade?' P: 'Portuguesa.'	I: 'What is – or what are, if you have more than one – your nationality?' P: 'Portuguese.'

Microaggressive incidents toward women in the healthcare context.

Part II – Thematic Analysis

Microaggressive themes

1. Microaggressive themes related to both social and clinical context: microaggressions that reflect power relations and biases present both in the clinical and the societal contexts

Organizing theme	Node	Description	Example	Translation
Racism or xenophobic-related themes	Second-class citizenship	Treatment as lesser person or group because of a specific ethnicity	'A primeira tem a ver comigo e não foi só uma, são várias, é uma forma de desrespeito… eu sou indiana, e tenho um nome complicado. O primeiro nome, Lisa, é simples, e os outros são bastante complicados. E nos serviços de saúde, durante uma consulta, há sempre aquele momento em que… numa sala de espera, eu ouvir o meu nome a ser chamado, as pessoas... a pessoa que chamava ia sempre gaguejar, ia sempre dize-lo de uma forma estranha, e inevitavelmente quando chegava ao gabinete do medico ou da medica, haveria sempre um comentário… assim, como dizer, condescendente em relação ao meu nome. Pronto, não tem a ver com o ser mulher, mas tem a ver com o ser de uma cultura diferente.'	'The first [situation] has to do with me and it wasn't just one, it's several, it's a form of disrespect... I'm Indian, and I have a complicated name. The first name, Lisa, is simple, and the others are quite complicated. And in health services, during a consultation, there's always that moment when... In a waiting room, I hear my name being called, and people... The person who called would always stammer, would always say it in a strange way, and inevitably when I arrived in the office of the doctor or the provider, there would always be a… how to say… condescending comment in relation to my name. Okay, it's not about being a woman, but it has to do with being a different culture.'
Ableism-related themes	Architectural barriers	Physical barriers that impede functionally diverse people (e.g. in a wheel chair) to access specific areas	'Depois, também em quanto mulher, os cuidados ginecológicos que uma mulher precisa normalmente e necessita e… no meu caso foram muito difíceis de conseguir, porque lá está, os consultórios médicos, neste caso nos serviços de ginecologia, são	'Then, also as woman, the gynecological care that a woman normally needs and... In my case were very difficult to achieve, because there it is, the medical offices, in this case within the gynecology services, are all

			todos estruturados para mulheres que tem uma mobilidade normal. Eu não consigo passar para uma maca para ser vista no serviço de ginecologia de um hospital publico ou de um hospital qualquer.’	structured for women who have a normal mobility. I can't get on a stretcher to be seen in the gynecology service of a public hospital or any hospital.’
	Desexualization of functional diverse women	The belief that functional diverse women do not have sexual and reproduction needs or desires	‘Para começar, nunca consegui subir para cima (da marquesa). Mas depois me aconteceu numa consulta de ginecologia quando eu tive um problema complicado, o problema era de simples solução e a hipótese era como “ah, não importa, como não precisas ter, tiramos tudo. Como não precisa de ter, não precisa se reproduzir…” em vez de resolver o problema específico, que era um problema que podia ser resolvido tirando… queriam tirar tudo, fazer uma histerectomia geral e tirar os órgãos todos para solucionar o problema.’	‘To start, I've never been able to get on [the stretcher]. But then it happened to me in a gynecology consultation, when I had a complicated problem…. the problem had a simple solution and their hypothesis was like "Ah, no matter, as you don't need to have it [internal reproductive organs], we take everything off. Since you don't have to, you don't have to reproduce... " Instead of solving the specific problem, that it was a problem that could be solved by taking... They wanted to take it all, do a general hysterectomy and retire all the organs to solve the problem.’
	Insensitivity towards functionally diverse people	Attitudes of insensitivity or lack of empathy towards people in a condition of functional diversity This theme includes the objectification and treatment of functionally diverse people as bodies without willingness	‘No outro dia fui pra fazer um ecocardiograma. E havia uma marquesa grande, uma coisa que não da para meter a cadeira por baixo e eu passar, e eu perguntei à senhora como é que eu ia subir para a marquesa. E ela pus-me um banquinho ao lado para eu subir. Portanto essas são as agressões diárias que uma pessoa com deficiência motora, neste caso uma mulher com deficiência motora, sofre.’	‘The other day I went to do an echocardiogram. And there was a big stretcher, something that you can’t just put the chair underneath it to let me get on it, and I asked the lady how I was going to get on the stretcher. And she put a footstool next to me, for me to get on the stretcher. So, these are the daily aggressions that a person with motor disabilities, in this case a woman with motor disabilities, suffers.’

			‘Com os auxiliares também tem sido uma desgraça. Porque quando nos tratam… as vezes que me aconteceu com auxiliares, senti-me tratada com uma coisa, que eles achavam que eram eles que tinham que fazer, e eu não tinha vontade própria, porque esta é outra coisa… nos tornamos… quando chegamos ao hospital, ninguém respeita as nossas vontades e as nossas necessidades, e apesar de nos dizermos que sabemos como queremos que aquilo seja feito, as pessoas depois mexem, levantam, viram ao contrario, não respeitando não só a nossa privacidade como também nossa vontade.”	‘With the auxiliaries has also been a disgrace. Because when they treat us... The times that I felt that [microaggression] with the auxiliaries, I felt treated as an object, that they thought it was them they had to everything, and I had no will on my own, because this is something else... We become... When we arrive at the hospital, no one respects our wills and our needs, and even though we tell them that we know how we want it to be done, people then move us, raise us, turn us, not respecting not only our privacy but also our will.’
Sexism-related themes	Ascription of inferiority	Underlies the belief that women are note competent, only need to do what the doctor says, "don't understand", "don't need to know", "are not worthy of an explanation", etc. This theme also includes the ascription of emotionality, according to which women are too emotional, too weak and consequently inferior to men.	‘Quando veio o pediatra no dia seguinte, ao quarto, eu estava lá, que veio ver as análises que o levavam para fazer análises ao sangue. Eu pergunto-lhe “como é que ele está?”. Era o sétimo dia, já era... ele diz-me “está na mesma”, e vai se embora. E eu disse não, preciso que explique. Ele não me diz nada e vai-se embora. Eu respirei fundo. […] No dia a seguir, a mesma coisa, e digo-lhe “então o que se passa, o que é que ele tem?”. Porque ninguém tinha falado comigo. Eu não sabia, mas não tinha que saber. E mesmo assim não sabia, eu sabia teoricamente o que é que poderia ser. E o médico recusa-se, diz que ele tem que continuar internado. “Tá amarelo, não percebes? Tem que estar internado, tem de se tratar, tem...” E eu fiquei assim… A resposta dele foi “é simples”, tratou-	‘When the pediatrician came to the room the next day, I was there, he came to see the tests and took him [the baby] to do blood tests. And I asked him, “How is he?” It was the seventh day, it was already... He told me “he’s in the same condition” and went away. And I said “no, I need you to explain”. He didn’t tell me anything and he left. I took a deep breath. […] The next day, same situation, and I told him, “so what's going on, what's he [the baby] has?”, because no one had said anything to me. I didn't know, but I didn't have to know. And yet I didn't know, I knew theoretically what it could be. And the doctor refused, said that he had to stay at the hospital. “t's yellow, don't you understand? He has to stay hospitalized, to be treated, he has...”. And it was like this. His answer was

			me por "miúda", que é aquela coisa que as pessoas têm, porque tratam a gente sempre por "mãe" e agente tem nome, que é outra coisa, toda gente tem nome. Passa a ser mãe e, portanto, deixa de ser "Asia" toda a humanidade desaparece. Mas ele nem sequer por "mãe" me tratou, que já é superchato porque tu vais ser mãe ali, estas a ver, portanto não me chamarem pelo teu nome perde mesmo a individualidade. E ainda por cima de uma forma paternalista "ah, a mãe não percebe, a mãe não sabe, a mãe...". E ele olhou para mim, como eu tinha ar de miúda […] E ele usou isso para me diminuir, me chamou de "miúda" e depois disse "é simples o seu filho ou hoje passa, ou ele morre, ou fica já onde é. Quer que lhe faça um desenho?".'	"It's simple". He called me "girl" which is the thing all people do, because they treat us always by "mother", but we have a name, a different name, everyone has a name. But [when you have a baby], your name becomes "mom", it is not "Asia" anymore, and all humanity disappears. But he didn't even treat me by "mom", that it's already super annoying because you're going to be a mother there, so they don't call you anymore by your name, and you lose all your individuality. And on top of a paternalistic form "Ah, mother doesn't understand, mother doesn't know, mother...". And he looked at me, and as I seemed very young […] he used this to diminish me, he called me "girl" and then said "it is simple, today passes, and or your son dies, or he stays where he is. Do you want me to make a drawing?".'

			‘E ele tem sempre aquelas frase que me custa sempre ouvir um bocadinho porque ele diz “a Marta é muito ansiosa, a Marta esta sempre muito ansiosa”.’	‘And he always has those sentences that cost me a little to listen because he says, “Marta is very anxious, Marta is always very anxious”.’
	Assumption of traditional gender roles	Ascription of mothers' social roles as caregiver, over-responsibilization of mothers and de-responsibilization of fathers, etc.	‘Durante o período de internamento eu raramente tinha informações sobre a minha bebé, as informações eram sempre comunicadas ao pai, porque o que acontecia é que tratávamos os dois da bebé, mas eu estava a amentar, tinha que tirar o leite, e isso coincidia sempre com o horário em que tinha que sair para tirar leite. E eles sabiam, sabiam perfeitamente quando era que os pais… porque aquilo era uma sala ampla, e portanto se a mãe não estava presente, estava no cantinho de amamentação e os médicos conseguiam ver, e mesmo assim dirigiam-se sempre ao pai. Eu cheguei a pedir, por favor, não fizerem isso, porque muitas vezes eram coisas que… para já, eram	‘During the period of hospitalization [of my recent-born daughter] I rarely had information about my baby. Information were always communicated to the father, because it always happened that even if both of us cared about the baby, I was always breastfeeding, and I had to express breast milk. They knew, they perfectly knew whe the parents were… Because it was a large room, and if the mother wasn’t there, it was because she was in the breastfeeding room, and doctors could see it. But even in this way, they would always go to the father. I asked them, please, to do not do that, because many times these things were… first, they were things that both of us wanted to know,

			coisas que obviamente queríamos saber os dois, porque implicavam decisões. E decisões que não é só o pai que toma, não é. E depois eu percebi que talvez não fosse importante para eles que a mãe soubesse. E ali havia uma questão que a mãe, claramente, a mãe é cuidadora e o pai é o decisor. Isso foi muito claro. Pequenas situações também, as vezes quando nos davam dicas, ou quando explicavam como é que depois devíamos cuidar da nossa filha em casa, ou sobre decisões que devíamos tomar sobre o futuro da nossa filha. Era sempre esse… havia sempre essa separação. A mãe cuidava, mas o pai decidia.'	because they implied decisions. And decisions are not only made by the father, isn't it? And then I realized that maybe it wasn't important to them to let the mother know. And there was this issue, that the mother, clearly, the mother is a caregiver and the father is the decider. That was very clear. In small situations too, sometimes when they gave us tips, or when they explained how we should take care of our daughter at home, or about decisions we should take about our daughter's future. It was always this... There was always this separation. Her mother cared, but her father decided.'
	Moralization	Acting as women are breaking moral norms. This theme includes: - Contents related to attitude of blaming women for having sexual relations or for their sexual freedom, assuming that they have to endure the pain and consequences of their sinfully act (pregnancy, illness, etc.) - Hostile attitudes from health professionals that are	'Uma foi quando eu era miúda, tinha doze anos, e os meus pais tinham ido para fora e eu estava em casa sozinha com a minha irmã, e de repente comecei a ter uma dor ao lado da anca, na altura não sabia o que é que era. Inchada. Então estava com muitas dores, muitas dores, muitas dores, tive que ir ao medico e a enfermeira […] e a enfermeira foi tão, tão, tão má para mim. Eu não sabia o que é que aquilo era, ainda era virgem na altura, e ela disse-me "ah, isso é dos homens com quem você dorme".'	'Once, was when I was a kid, I was 12 years old, my parents had gone out and I was home alone with my sister, and I suddenly started having a hip pain, and at the time I didn't know what it was. I was swollen. So, I was in a lot of pain, lot of pain, lot of pain, and had to go to the doctor and the nurse... […] and the nurse was so, so, she was mean to me. I didn't know what it was, I was still a virgin at the time, and she said to me, "Ah, this is a thing of the men you sleep with".'

		conscientious objectors for voluntary interruption of pregnancy	'Ela quis fazer uma interrupção voluntaria de gravidéz e… para já, aquilo foi há seis anos, e foi um processo complicado, hoje acho que já melhorou um bocadinho. E percebi que, embora seja tratada com bastante sigilo, as pessoas, mesmo a enfermeira, mesmo a própria medica […] olharam para a situação de uma forma um bocadinho hostil. Ela se sentiu um bocadinho… sentiu-se mal com aquilo, com a forma que eles reagiram, "não precisava fazer, esta não é a forma", e coisas assim. É o que me recordo.'	'She wanted to make a voluntary interruption of pregnancy and... that was six years ago, and it was a complicated process, today I think it improved a little. And I realized that, although it is treated with a lot of secrecy, people, even the nurse, even the doctor herself […] they looked at the situation in a somewhat hostile way. She felt a little... Felt bad about it, with the way they reacted, like "you did not have to do it, this is not the way," and things like that. That's what I remember.'
	Objectification of women	This theme includes any attitude that treats women like objects, depriving them of their value as human beings. This theme includes: - The treatment of mothers during maternity as they only are reproduction machines - The treatment of women as sexual objects for men's pleasure, including attitudes that underlie the belief that women should always have	'E acendem as luzes e entra uma enfermeira, que era enfermeira que fazia o dia, […] e dizia a todas "abram as pernas!" (gritando). Isto é real. Eu nem sequer percebi o que era, as outras mulheres cheias de medo, todas, tiravam o lençol e abriam as pernas, e ela despejava com uma cena de Betadine, tipo ketchup, esfregava com uma esponja como se o nosso sexo, que tinha acabado de ser maltratado, cozido, tudo, fosse o chão de uma cozinha.	'And they turned on the lights and a nurse entered, the nurse of the day shift, […], and said to all "open your legs!" [screaming]. This is real. I didn't even realize what it was, the other women were full of fear, all of them, they took the sheet off and opened their legs, and the nurse flushed them with a thing of Betadine, it seemed ketchup, and rubbed it it with a sponge, on our genitals, which had just been mistreated, cooked, everything, like she was cleaning the floor of a kitchen.'

		a good ad cured physical appearance.	'Lembro-me que uma vez... acho que tinha menos de 13 anos, 12 e 13 anos e tinha muitas dores ao usar sutiã. Ainda hoje não gosto de usar sutiã, não consigo. Para mim é horrível. […] E lembro-me de ter colocado essa questão... eu era miúda, minha mãe levou e disse "coloca a questão ao doutor". Era um médico. E a resposta que tive foi... eu acho que na altura não achei que era violento... Mas a frase não me saiu da cabeça até hoje. Portanto ao rever o texto eu lembrei-me... a frase do médico era "usa um sutiã desportivo no dia a dia e usa um sutiã mais bonito quando for sair para festas que é para se ver"	'I remember once... I think I was under 13, like 12 and 13 years old and whenever I was wearing a bra, I had a lot of pain. I still don't like wearing a bra today, I can't. It's horrible to me. […] And I remember asking that question... I was a kid, my mom took me with her and said, "Ask the question to the doctor." He was a doctor. And the answer I had was... I think at the time I didn't think it was violent... But the phrase hasn't come out of my mind until today. So, when reviewing the text, I remembered... The doctor's phrase was "wear a sports bra in the normal days and wear a prettier bra when you go out for parties, that has to be seen".'
	Pain endurance	Underlies the belief that women have to endure pain, even if they are not strong enough	'Porque eu tenho períodos menstruais muito dolorosos, e nos já tínhamos falado acerca disso, e eu sempre senti que esse ginecologista não dava muita atenção ao problema, como se fosse… "é uma coisa natural que a Marta vai ter que viver com isso a vida toda".'	'Because I have very painful menstrual periods, and we [my doctor and me] had already talked about it, and I always felt that this gynecologist did not pay much attention to the problem, as if it was... "It's a natural thing that Marta will have to live with it her entire life".'
			'E quando diz que tens dores tudo o que fazem é dizer, e, repetiram isso várias vezes, é "Aguenta. Ser mãe é isto. Essa é a nossa cruz. Achou que ia ser como?" Não, não é isto. Não, não é ser maltratada.'	'And when you say you're in pain, all they do is to say, and repeat it over and over again: "Hang on. Being a mother is this. That's our cross. What did you think it would be like?" No, it's not that. No, being a mother it's not being mistreated.'
Sexism and racism/xenophobia-related themes	Assumption of beauty and sexual objectification	Exaltation of one women body or characteristic in spite of other women of the same	'[…] ele fez um comentário que eu não… que não me caiu muito bem. Deve ter sido dos olhos, da cor dos olhos… qualquer coisa. Assim, como	'[…] he made a comment that I didn't... That didn't fall too well. It must have been about my eyes, the color of my eyes... Anything like it.

		ethnicity/nationality. “You are so beautiful for being black”.	se fosse uma coisa surpreendente dos cabo-verdianos não serem assim tão bonitos. “Os olhos tão bonitos, a cor da pele tão bonita”.’	As if it was a surprising thing the Cape Verdeans aren't so beautiful. “The eyes so beautiful, the color of the skin so beautiful”.’
	Invisibility	Experience of being unseen, unworthy of recognition, unimportant, powerless and overlooked.	‘Primeiro, ficamos horas no corredor das urgências, ela completamente a delirar de febre… horas. E nessa situação sim, senti-me invisível, e sim acreditava por ser mulher e por ser jovem. Acreditava que se fosse um homem, ou se fosse alguém mais velho, teria tido outro atendimento. E também por nos sermos indianas, não é. E nesse atendimento senti muito a questão do racismo, mas também a questão das filas e do protocolo, não é. A forma como estava a ser feito, a profissional nem sequer se preocupava em saber o nome. Estava simplesmente a desvestir de tudo, dos bens, dos pertences, da roupa, e a coloca-las num saco, como se nada fosse nê.’	‘First, we spent hours in the hallway of the emergency, she was completely delirious from fever... Hours. And in this situation, yes, I felt invisible, and yes, I believed that it was because of being a woman and being young. I believed that if I were a man, or if I were someone older, I would have had another type of attention. And, also, because we're Indian. And in this case, I felt much the matter of racism... but also the question of queues and protocol. The way it was being done, the professional wouldn't even worry about knowing her name. She was simply undressing her from everything, possessions, belongings, clothing, and putting them in a bag, as if it was nothing.’
	Myth of hyperfertility	The belief that women coming from developmental countries have many children and suffer from lack of family planning	‘Estando gravida, apanhou com muitas situações, e sendo ela brasileira… de valorização sobre a capacidade reprodutiva das mulheres brasileiras. De uma medica que lhe disse “vocês brasileiras não conseguem estar quetas, estão sempre a ter filhos”.’	‘Being pregnant, she experienced many situations, and being Brazilian... many situations related to be judgment of the reproductive capacity of Brazilian women. There was a doctor who told her “You Brazilians can't stay still, you're always having kids”.’
Homophobia and heterosexism-related themes	Assumption of abnormality	Considering LGBTQI+ people different, abnormal, not natural, or even sick	‘Eu conheço uma rapariga lésbica assumida que foi também uma consulta de planeamento e ginecologia… planeamento familiar e médica. E que a médica, era uma mulher, que sugeriu a ela tomar	‘I know this lesbian girl that went to a consultation of gynecology and family planning. And the doctor, it was a woman, suggested her to use some contraceptives, and she [the girl] said she didn’t need to. The

			anticoncecionais e ela disse que não necessitava. A médica ficou muito chocada. E ela disse "Não, eu gosto de mulheres, eu sou lésbica, não preciso" e a médica aconselhou-lhe ir a um psicólogo em vez de continuar a sua consulta de forma profissional, portanto essa para nós é uma questão muito violenta.'	doctor was shocked. And the girl said "No, it is because I like women, I am lesbian, I don't need contraceptives". The doctor advised her to go to a psychologist, instead of continuing the consultation in a professional manner. Therefore, this is a very violent issue for us.'
	Endorsement of heteronormativity	The expectation that everyone is heterosexual, and everyone behaves in a manner consistent to the heterosexist culture	'Essa situação foi mais a situação ao nível do da parte ginecologia, por exemplo. Em que a grande preocupação do médico era... por a caso era uma médica... Era qual era os métodos contracetivos que eu usava, quando eu disse não usava nenhum, nem sequer se dignou... deu quase um sermão como quem diz "vais engravidar e não..." e em vez de tentar, por outro lado perceber que há várias maneiras... há várias hipóteses que não esteja a precisar de contracetivos. Podia não ter relações. Ponto final, parágrafo. Podia ter relações com uma mulher.'	'This situation related to gynecology, for example. In this case, the doctor's great concern was - it was a female doctor - It was which contraceptive methods I used, when I said I didn't use any, she did not even... She gave almost a sermon saying: "you will get pregnant and...". Instead of trying, on the other hand, to realize that there are several ways... There are several hypotheses that you do not need contraceptives. I could not have intercourse. Period, paragraph. I could have intercourse with a woman.'

2. Microaggressions towards patients as a social minority

Organizing theme	Node	Description	Example	Translation
Microaggressions towards patients as social minoirty	Attitude of superficiality	Attitude of conducting physical examinations or other practice-related activities with superficiality, rush and unprofessionalism (practical level)	'Porque eu fui já há uns anos a uma dermatologista que chegou bastante atrasada, nos tínhamos uma consulta marcada e ela chegou meia hora atrasada, a consulta durou dez minutos e eu paguei – a pronto – oitenta euros. E ela não foi capaz de	'Few years ago, I went to a dermatologist who arrived quite late, we had a scheduled appointment and she arrived half an hour late, the consultation lasted ten minutes and I paid – at the moment – 80 euros. And she wasn't even able to get to me to

			sequer chegar ao pé de mim para ver as mazelas que eu tinha na pele, e foi logo passando a receita.’	see the problem I had on my skin, she just passed the recipe.’
	Lack of sensitivity-empathy	Attitude that underlies a lack of sensitivity or empathy (emotional plan) with the patient's condition, his illness or his emotional status	‘Também conheci uma familiar que teve uma gravidez ectópica, portanto o bebê ficou preso na trompa de Falópio e não se desenvolveu e era um bebê que ela queria muito e era o segundo filho, mas ela queria mesmo muito ter um segundo filho. E a médica disse “pois agora provavelmente não vai ter mais filhos” […]Para uma pessoa que a maternidade é 90% da vida dela e que queria tanto ter aquele segundo filho. Aquilo é uma violência extrema e eu acho que entre em termo de obstetrícia e ginecologia acho que é um dos maiores problemas de falta de sensibilidade.’	‘I also have family member who had an ectopic pregnancy, so the baby got stuck in the fallopian tube and did not grow up. And it was a baby she wanted very much, it was the second child, but she really wanted to have a second child. And the doctor just said to her: “now you probably won't have children anymore”. […] For a person that lived motherhood as 90% of her life and that wanted to have that second child so badly, this is extreme violence. And I think that in terms of obstetrics and gynecology, one of the biggest problems is the lack of sensitivity.’
	Objectification of the patient	Seeing the patient as an object with illness, without own feelings, willingness, personality, history, etc.	‘Depois houve outra, em que eu me senti muito mal também, mas não fiz nada. E estavam as pessoas, um estagiário. E ela foi fazer um pap-test, mas de uma forma… ou seja me senti muito maltratada e não tive capacidade de reação. E que ela… estava sempre a falar, e já olhava mais para o computador do que para mim. E… falava muito com o estagiário e pouco comigo, então mesmo quando estava o estagiário, ela falava pouco comigo, e mais a olhar ao computador. O que já tinha reclamado também. E… depois, quando foi fazer o pap, mandou-me despir-me da cintura para baixo e não me pus uma toalha por cima, nem	‘Then there was another [situation], in which I felt very bad too, but I did nothing. And there were other people, there was an intern. And she [the doctor] started to do a pap-test, but in a way... I felt very mistreated and I had no reaction. And she was always talking, and she looked at the computer more than she looked at me. She talked a lot with the intern and little with me, so even when the intern wasn’t there, she spoke less to me and looked more at the computer. Which I had already complained about, too. And then, when she was doing the pap-test, she told me to undress from the waist down and she didn't put a towel on the top of me, or anything

			nada. Ou seja, foi tudo assim… e eu não tive capacidade de reação nenhuma, senti-me muito exposta, porque estava ali, nua, o estagiário era homem, e ela não teve consideração nenhuma.’	else. I mean, she did everything like this... And I had no ability to react, I felt very exposed, because I was there, naked, the intern was a man, and she had no consideration at all.’
	Paternalization of patients	Attitude that reflects the high-power position of health providers, that act as being superior, treating the patient as a lesser person, and invalidating her experience	‘E houve uma vez, […] sentia que estava com uma infeção urinaria. Já não era a primeira vez, e nos mulheres acho que sabemos quando é que temos uma infeção urinaria, os sintomas, etc. E eu cheguei lá e disse que tinha uma infeção urinaria, e o medico teve aquela reação que foi do tipo “eu é que vou dizer se tem ou não, vamos ver”, de separação e superioridade em relação ao paciente. As vezes se colocam numa postura mais distante, mais fria, ou até de não explicar convenientemente as coisas, não dar tempo.’	‘And there was once […] I felt I had an infection of the urinary tract. It was not the first time, and, as women, I think we know when we have a urinary infection, we recognize the symptoms, etc. And I got there and said I had a urinary infection, and the doctor had that reaction that was like “I'm going to tell you whether or not you have it, let's see”. It is an attitude of separation and superiority in relation to the patient. Sometimes they put themselves in a more distant, colder posture, or even do not explain things conveniently, they don’t give time [to understand].’

3. Systemic microaggressions

Organizing theme	Description	Example	Translation

Systemic microaggressions	Microaggressions based on systemic sexism, heterosexism, xenophobia, racism or ableism. Even if perpetrated by health professionals, these microaggressions reflect a systemic problem in the treatment of patients. Systemic discrimination includes: - Formal, institutional rules - Informal norms that configurate a common way of thinking in a certain context	'Tenho uma amiga minha que é bissexual e ela contou-me mesmo que o medico… E aí ela perguntou se ela tinha relações protegidas. E ela disse "Sim quando tenho que relações com homens que tenho relações protegidas, mas com as mulheres as coisas já não são assim tão fáceis". E a médica também não soube esclarecer a situação. Isto já foi há alguns anos atrás... cinco anos atrás. E o choque da médica ter uma pessoa que não encaixava nos parâmetros pelos quais ela tinha sido preparada na faculdade, foi gigante. Ela disse que a cara da médica foi de: "como é que eu vou sair daqui, como é que eu vou responder a uma pergunta que se calhar nunca lhe foi feita nem nunca foi pensada". E ainda é uma pessoa de um contexto rural que ainda mais complicado.'	'I have a friend of mine who is bisexual, and she told me that the doctor […] And then the doctor asked if she had protected relationships. And she said: "Yes when I have relationships with men, I have protected relationships, but with women things are not so easy". And the doctor didn't know how to clarify the situation either. That was a few years ago... Five years ago. And the shock of the doctor having a person who did not fit the parameters by which she had been prepared in college, was giant. She said the doctor's face was: "how am I going to get out of here, how am I going to answer a question that might never have been made or I have thought of?" And is still a person of a rural context, that is even more complicated.'
		'Eu tive uma complicação no pós-parto e tive que ser encaminhada para os cuidados intensivo, pronto, essas coisas todas. E enquanto isso os dois bebês - foram gêmeos - tiveram que ir para a neonatologia porque é o único sítio onde eles poderiam ficar. […] Sofia experienciou algumas situações um bocado desagradáveis, do género de lhe chamarem de "pai", de tipo... muito nessa base de... a mãe era eu que tinha tido os bebês, e só pode haver uma mãe e um pai portanto ela era o pai. Ou no sentido de só poder inicialmente só poder entrar os pais... a mãe e o pai, na neonatologia e de	I had a postpartum complication and had to be hospitalized in the intensive care. And meanwhile the two babies - they were twins - had to go to neonatology because it was the only place where they could stay. [...] In this context, Sofia experienced some unpleasant situations, for example they treated her by "father", like... Very much on this basis... The mother was me who had the babies, and there can only be one mother and one father, so she was the father. Or in the sense that initially can only enter the parents... Mother and father, in neonatology, so they tried to bar her

		tentar barrar o acesso porque ela não era nem a mãe e nem pai.’	access because she was neither mother nor father’

Appendix H – Critical Incidents

1. Straight, perceived as Portuguese women

Maria is a 32-years-old Portuguese woman. She lives in a medium-sized Portuguese town with her husband, Luis. She is at the beginning of the last week of pregnancy, expecting her first child.

When Maria finally feels some contractions, Luis drives her to the hospital. After checking into the maternity ward, a nurse welcomes them. It is a very busy day and all the rooms are full. She explains that Maria needs to wait for her contractions to be more frequent and in the meantime she must walk along a corridor. Perplexed, Maria starts walking with Luis next to her. The corridor is full of other women walking up and down like her or lying on stretchers.

After two hours the contractions become more regular and intense and Maria starts to be in great pain. She and Luis call a doctor who tells them to enter a room and starts examining Maria. At the end of the examination, the doctor tells Maria that everything is fine with the baby but that she is not enough dilated yet. She needs to wait more. Noticing the expression of tiredness and discomfort on Maria's face, he continues: "I know it hurts, but you are a mother now. What did you expect? This is only the beginning. This is a mother's life. You will have to endure a lot of pain from now on." Maria feels scared and confused, but she does not know what to answer. She goes back to the corridor and continues to walk. Once in a while, a health provider checks the baby heartbeats. Six hours later, she is finally ready to give birth.

Childbirth runs well and after a while Maria and Luis are holding their baby. Maria is hospitalized for 24 hours sleeping in a room with seven other mothers and their babies. As so many other women, she needed to be stitched after childbirth. While she is hospitalized, a group of doctors, nurses and medicine students passes to check on the stitches. When they enter the room, they ask all women to take off their bedsheets and underwear, lay down and to open their legs. Everyone silently obeys. Then, the group checks if all of them are fine by passing from bed to bed. They exit the room silently as they entered, without saying "hello" or "goodbye". Maria feels vulnerable and uncomfortable. She only thinks "why do they treat us like this? We are human beings, not animals."

Twenty-four hours later, Maria and the baby are discharged from the hospital and can finally go home.

Questions

1. If you were Maria, how would you have felt? How would you have reacted? Why?

Microaggressive incidents toward women in the healthcare context.

2. If you were Maria, how would you have interpreted the providers' attitudes?
3. Do you think that any of the health care providers in the story, at any moment, assumed a wrong attitude? Explain who and why.
4. If you were the doctor that first examined Maria, would you have acted in the same way? Why?
5. If you were the doctor/nurse/medical student checking on women's stitches, would you have acted differently? Why?
6. Do you think that the environmental conditions (e.g. lack of beds and space, hours walking along the corridor) might have influenced Maria's feeling? Why?
7. On a scale from 1 to 5, where 1 is "completely disagree" and 5 is "completely agree", to what extent do you recognize the situation described to be common in the place you work?

2. LGBTQI+, perceived as Portuguese women

Diana is a Portuguese, 25-years-old woman who is living and studying in a big Portuguese city. She moved there recently from a small Portuguese village with her partner Julia.

One day, Diana decides to go to a gynecologist for a routine check. She searches and finds a private gynecologist and schedules an appointment. On the day of the appointment, Julia accompanies Diana to the clinic. Once arrived, they head to the check-in desk. The attendant nicely asks for Diana's documents and types something on a computer. Then she looks at Julia and asks her if she has an appointment, too. Julia answers that she is only accompanying Diana. When the attendant asks what their parental degree is, Julia replies that she is Diana's girlfriend. The attendant rises an eyebrow, stares at them for some second and then coldly answers: "Well, I am sorry, but you will have to stay in the waiting room. We only allow family members to enter." Perplexed, Julia and Diana look at each other, then they silently nod and go to the waiting room.

After twenty minutes, a nurse calls Diana and invites her to enter the doctor's office. The doctor is a middle-aged woman, who nicely smiles at Diana and invites her to sit. The medical interview starts with some general questions. Yet, there are no questions about Diana´s sexual activity and she is not asked about her sexual identity. She does not like to come out with unfamiliar people and because the doctor did not ask her, she thinks that it is not important for the routine consultation. However, at one point, the doctor asks: "do you use any contraceptive method?". Diana feels very uncomfortable. "No." She answers. "Then are you

trying to get pregnant?". "No." "Then you should know that without contraception there are high possibilities that you get pregnant". Diana feels nervous. She takes a deep breath before she answers. "Actually, I have a girlfriend. I like women. I am lesbian". The doctor seems surprised. She did not seem to expect such an answer. She nods silently and she invites Diana to undress from the waist down and to lay on the examination table. Then she calls a young man, who Diana interprets to be a medical student, to assist her during the examination.

During the examination, the doctor is very silent and only speaks to the young man next to her who only observes and nods. Diana feels uncomfortable and exposed. Why did the doctor not ask her if she agreed with the presence of another person during the examination? Why are they so silent? The doctor is using some instruments, touching her like she is an object. After some minutes, the doctor says: "Everything is okay. You can put your clothes on and go. You can pay at the check-in desk." Diana does what the doctor said. She feels confused and embarrassed but does not know what to say to her. She says goodbye and silently exits the room. When she meets Julia in the waiting room, she is very distressed. She does not understand the doctor's attitude. Is she always so detached? Is it because she is a lesbian? Did she say something wrong? Was the doctor's attitude intentional?

Leaving the clinic, Diana says to Julia: "I don't think I will come here again."

Questions

1. If you were Diana, how would you have felt during the examination? How would you have reacted? Why?
2. If you were Diana, how would you have interpreted the doctor's attitude?
3. If you were Julia, how would you have felt after the attendant's answer? How would you have reacted? Why?
4. Do you think that any of the actors of the story, at any moment, assumed a wrong attitude? Explain who and why.
5. If you were the attendant at the check-in desk, would you have acted in the same way? Why?
6. On a scale from 1 to 5, where 1 is "completely disagree" and 5 is "completely agree", to what extent do you agree with the doctor's attitude? Why?
7. If you were the doctor, would you have acted in the same way? Why?

Microaggressive incidents toward women in the healthcare context.

3. Perceived as foreigner, straight, women

Janayna is a 55-years-old black woman, who immigrated together with her family from Angola to Portugal 20 years ago. She lives in a big Portuguese town and works as a cleaner in a shopping center. One day, Janayna wakes up with a terrible abdominal pain and asks her young daughter, Neusa, to take her to the hospital.

Once at the emergency unit, they enter in line at the check-in desk. A white man is being attended just in front of them. When it is their turn to be attended, the white attendant stares at them for a second, then collects some documents from her desk and leaves her seat. At first, Janayna does not understand what is happening, but she feels a common sensation of being ignored. Her pain is growing, but she feels invisible. The attendant comes back after a few minutes and completes her check-in procedure. Janayna and Neusa go to the waiting room and wait for the triage.

Ten minutes later, Janayna is called to enter the triage room. She sits in front a health provider and explains her symptoms. The provider measures her temperature and blood pressure, then gives her a green bracelet. Janayna complaints about her sharp pain hoping for a more urgent bracelet. The attendant replies “I know that the waiting times are long, but you seem to be a strong woman. I am sure you can handle the pain”. Left without words, she leaves the room.

Four hours later, Janayna is still waiting to be examined from a doctor. Her temperature is increasing as well as the pain. Neusa tries to speak with someone and asks for help, but people keep saying that she must wait. Finally, Janayna is called to enter an emergency room. A Portuguese doctor welcomes her: “Well, what do we have here. *Ianayana, Janayana, Ianayna…* What an exotic name. How do I pronounce it?” Janayna says that her name can be pronounced exactly as it is read. She is used to hear these types of comments and she does not like them. The doctor examines her and finally says: “Who gave you a green bracelet? This may be urgent. I’ll ask for some blood exams and an abdominal scan.”

Three hours later, Janayna receives a diagnosis and a prescription for some medicines. She was in terrible pain for almost seven hours and she feels that if it was not for her skin color she would have been treated differently.

Questions

1. If you were Janayna, how would you have felt? How would you have reacted? Why?
2. If you were Janayna, how would you have interpreted the providers’ attitudes?

Microaggressive incidents toward women in the healthcare context.

3. Do you think that any of the actors of the story, at any moment, assumed a wrong attitude? Explain who and why.
4. If you were the provider that examined Janayna during triage, would you have acted in the same way? Why?
5. If you were the doctor that examined Janayna in the emergency room, would you have acted in the same way? Why?
6. On a scale from 1 to 5, where 1 is “completely disagree” and 5 is “completely agree”, to what extent you recognize the situations described to be common in the place you work?

Microaggressive incidents toward women in the healthcare context.

4. Functionally diverse, perceived as Portuguese, straight women

Irene is a 45-years-old Portuguese woman living in a medium-sized town with her family. She has been on a wheelchair for five years, because of a car accident that left her paraplegic from the waist down. Despite the difficulties to adapt to her condition, Irene has been able to attain a regular and happy life. Yet, she has experienced some breathing complications recently and her treating physician refers her to a specialist.

Irene goes to the specialist examination with her brother, Felipe. Once they arrive at the health facility, she notices some steps that impede her to get to the ground floor. There is no wheelchair ramp. Her brother cannot lift her alone and has to ask another man to help him. Irene hates when this happen. It makes her feel vulnerable and powerless. After the check-in at the ground floor, Irene searches for the pneumological sector. It is at the third floor and the only elevator that goes there is at the opposite side of the facility. Patiently, she and her brother search for it and finally reach the third floor.

When she enters the doctors' office, a young doctor welcomes her. He seems surprised about her condition. He asks her to describe her symptoms and then to lay down on an examination table. Irene looks at the table and feels confused It is too high and it is impossible for her to get on it on her own. She asks the doctor how she is supposed to get on it. For some second, the doctor seems confused too, then he takes a footstool and places it next to the examination table. Irene feels angry. She replies: "As I already told you, I am paraplegic. I cannot move my legs. I need help." The doctor seems to understand. He apologizes and calls a technician to lift her. She knows that there is no other way, but she hates to feel moved like an object.

While the doctor is examining her, he asks: "So, how did it happen? Was it a car accident or a parachute fall?". Irene does not understand how this would be important for the examination and thinks that it is invasive. "A car accident, five years ago", she answers. "Oh, I am sorry. I am really sorry for you." She feels angry again, but she can see that the doctor is sincere.

After the physical examination, the technician helps Irene to get back on her wheelchair and the doctor prescribes her some exams.

Questions

1. If you were Irene, how would you have felt during the examination? How would you have reacted? Why?
2. If you were Irene, how would you have interpreted of the doctor's attitude?

Microaggressive incidents toward women in the healthcare context.

3. Do you think that the environmental conditions (e.g. architectonic barriers) might have influenced Irene's feeling? Why?
4. Do you think that any of the actors of the story, at any moment, assumed a wrong attitude? Explain who and why.
5. On a scale from 1 to 5, where 1 is "completely disagree" and 5 is "completely agree", to what extent do you agree with the doctor's attitude? Why?
6. If you were the doctor, would you have acted in the same way? Why?

Microaggressive incidents toward women in the healthcare context.

5. Patients as a social minority

Joana is a 38-years-old Portuguese woman. She works as researcher in a Portuguese university. For a few weeks now, she is having a rash on both her arms and legs. She decides to schedule an appointment with a private dermatologist to check the issue.

When Joana enters the dermatologists' office, he invites her to sit and asks what her problem is. While Joana answers to the question, he keeps typing on his computer. He seems to be more focused on what he is writing than on what she is saying. Joana lifts a sleeve of her shirt to show him the rash. Without going any closer to her, he looks at her harm and quickly says: "Yes, I see". Joana is feeling confused now. Is he paying attention to her? Did he really understand from a simple, distanced look, what she has? She explains that she has had it for a few weeks now. She tried to use some moisturizing creams, also went to the pharmacy and asked for a pomade, but it did not work. The doctor nods while he is typing on his computer. After some minutes, he prints a prescription and hands it to her. "This is nothing serious. You should pass this pomade twice a day on the rash and take these pills once a day for two weeks. Do you understand?" Joana feels that she wants to ask more details about the instructions he gave her, but she feels very uncomfortable. "Yes, I think I understood. Can you tell me what is it? What do I have?" she asks. The dermatologist's answer sounds very cold: "Nothing to worry about. Just take the medicines and it will pass." She does not know what to answer. She does not want to question the doctor's diagnosis or prescriptions and she knows she has to trust him. On the other side, she feels full of doubts and she is not sure that the treatment will solve her problem. She takes her prescriptions and leaves the doctor's office. She hoped that the doctor would reassure her, yet event though he said that the rash is nothing serious and that she does not have to worry about it, she feels anxious and confused.

Questions

1. If you were Joana, how would you have felt during the examination? How would you have reacted? Why?
2. If you were Joana, how would you have interpreted the doctor's attitude?
3. Do you think that any of the actors of the story, at any moment, assumed a wrong attitude? Explain who and why.
4. On a scale from 1 to 5, where 1 is "completely disagree" and 5 is "completely agree", to what extent do you agree with the doctor's attitude? Why?
5. If you were the doctor, would you have acted in the same way? Why?