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A Study of Microaggression and its Psychological and Physiological Effects on Individuals from Marginalised Communities

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Abstract: The psychological and physiological well-being of people is affected by an extensive range of circumstances. Although a single microaggression might appear innocuous, a lifetime of them can have a serious negative impact on someone's mental health. The research on microaggression and its psychological and physical impacts on people from marginalized communities in healthcare is reported in this publication. Two villages on AI reservations are involved in this community-based participatory study initiative. 130 adults participated in written surveys and interviews to gather data. More than one-third of the sample said they have come across a microaggression while interacting with their medical professionals. The self-reported histories of heart attacks, worse depressed symptoms, drug abuse, suicide cases, and preceding year hospitalization were all associated with complaints of microaggressions. In multivariate models, the connection between microaggressions and hospitalization (but just not a previous heart attack) seemed to be partially explained by assessments of depressive and drug abuse symptoms. In this research, microaggressions were linked to worse emotional and physiological health evaluations for Pakistani people living with a disease, undermining the principles of patient-centered care. Clinicians need to be aware of these subtly discriminatory behaviors, which are frequently unintentional.

Introduction

The psychological and physiological well-being of people is affected by a wide variety of circumstances. Microaggressions are defined as "the routine verbal, nonverbal, and ecological affronts, disses, or taunts, either intentionally or unintentionally, which transmit unfriendly, disparaging, or bad comments to targeted individuals based simply upon their participation in a marginalized community. Microaggressions may be the product of discriminatory practices as much as due to perceptions. Typically, a person will make a microaggression without being aware that their conduct or words are expressing a prejudiced mindset (Barnes, et al., 2010).

Microaggressions are subtly offensive remarks made to African People, and the phrase was first used in 1970 (Marmot & Wilkinson,

2005). According to the study, microaggressions can take 3 different forms: microassault, microinsult, and microinvalidation. The most blatant type of attack is a microassault, such as giving someone of color a disparaging name on purpose. Microinsults are less obvious and communicate harshness or lack of compassion, such as tightening one's grip on their pocketbook when they are around someone of color. Lastly, microinvalidations diminish or invalidate a person's emotions or feelings by stating, for instance, Don't be so oversensitive (Sue & Spanierman, 2020).

There continue to be recurrent and, in certain cases, worsening discrepancies in the health condition of the most wealthy and poor segments of society despite several calls to action to

address healthcare gender inequalities. Communities in Pakistan, that experience some of the highest percentages of poor physical and mental health, including diabetes, cardiac problems, suicides, and psychological anguish, are one glaring example of racial and cultural health inequalities (Sue & Spanierman, 2020). Health inequalities are generally attributed to a variety of causes, such as social isolation and marginalization, poverty, anxiety, and other important socioeconomic factors that influence health. Native Americans received inferior healthcare coverage than Whites on around one-third of care standards metrics, according to data from the National Healthcare Quality and Disparities Survey (Krantz, et al., 2011).

Considering the provider-patient connection and underlying power disparity, where the doctor benefits from control and reputation, the potential effects of microaggressions in inpatient practice are noteworthy (Motzer & Hertig, 2004). Whenever medical professionals microaggressions, the interaction may jeopardize attempts to offer care, destroy confidence, and cause stress for the patient. Every intercultural interaction has the potential for microaggressions, which are likely to be used by everyone even the most compassionate service personnel. To deliver high-quality, ethnically safe care, there is therefore a strong incentive for critical self-reflection and expanded knowledge of microaggression (Williams & Mohammed, 2009).

Research of microaggressive healthcare encounters in particular has gotten very minimal empirical research, despite a growing body of work that examines the effects of discrimination in the healthcare industry in various forms. In this research, we investigate the psychological and physiological effects of microaggression on health in marginalized populations.

Materials and Methods

A project of community-based participative research (CBPR) is this investigation. These

primitive tribes want to be identified when the results of the study are made public. The main goal of the study was to explain how microaggression affects the psychological and physical well-being of marginalized communities. Before submitting a financing request for the project, tribal government assistance was acquired. The initiative started with gatherings and seminars for the society to explore the objectives of the study, get input from the community, and create Community Research Councils (CRC). Participants of the CRC and University research teams actively participated in all phases of the study, including the development of the measurements and the gathering and analysis of the data. Study methods were evaluated and approved by the university's IRB.

A tribal health center is located in each settlement. Both locations include basic health and fitness training, diagnostic and measuring tools, general healthcare services, and coordination of community engagement projects such as school-based healthy living programs. Data from every reservation's medical facility were randomized and chosen to become volunteers in the present research.

Individuals who were 18 years of age or older who self-identified as Pakistanis met the eligibility requirements¹⁶. In the interest of achieving a final sample size with acceptable statistical power for the anticipated multivariate analyses, we set a goal of inviting 150 patients (75 at each site). Using probability sampling, clinic partners selected a random selection of 75 patients from their respective lists. Eligible participants undergo a welcome note, pamphlet, and identification card in the mail with choices to opt out through phone or mail. The project plan was constrained to self-report questionnaire data due to financial constraints. Non-declining recruits were approached by trained community recruiters to arrange survey sessions. A kilogram of wild rice grown nearby and a \$30 reward were provided to attendees. The written

questionnaires were filled out by respondents where they chose, frequently in private areas of their houses. Each interview took about 1–2 hours to complete on average.

Before forwarding the questionnaires to the institution, on-site project managers replaced all identifiable details with an identification code. Academic research associates collected and validated the survey results in a digital form. 130 individuals from an initially acceptable sample of 130 completed questionnaires for an overall research number of respondents of 80% (20 patients were excluded due to being not marginalized).

The study team from the university and the community-based organization developed or modified all survey questions together. The participants' statement of having ever encountered 6 ethnicity-related microaggressions from medical is our manuscript's main independent predictor, Microaggressions. Racist Microaggressions in Counseling Scale components were modified. The table displays the exact item description. A score of microaggressions in health coverage with a range of 0 to 6 was calculated using the sum of yes/no answers to the six items (Cronbach's alpha =.84)¹⁷.

Table 1

Descriptive statistics of variables

Characteristic	Mean	S.D
Age	55.5	14.1
Gender	51%	–
Household income	11.33	9.5
Experiences of microaggressive	1.2	1.8
Depressive symptoms, suicide	4.55	5.6
Past year hospitalization	25%	–
Cardiac issues	15%	–

We investigated the relationships between several behavioral and physical healthcare outcomes and microaggressions. Anxiety and depression are determined by scoring responses to 9 items measuring depression-related symptoms encountered in the two weeks preceding survey involvement (0 = none at all, 1 = many days, 2 = more than 50% of the days, 3 = virtually every day). For this variable, we were using a constant score that could range from 0 to 27. Respondents' responses of being always advised by a clinician that they had sustained a heart attack are indicative of cardiac arrest.

Hospital admissions in the previous year are determined by participants' answers to a questionnaire inquiring how frequently they had an overnight stay as a hospitalized individual throughout the previous 12 months. We trimmed

the hospital factor values to have a range of zero to two to account for skewness.

Additionally, there were several control variables used. All study subjects, some of whom resided off tribe territory, sought medical treatment at clinics on reserves, and sexuality is recorded. By asking participants to estimate their entire household's earnings within \$10,000 limits, per capita family income, was calculated. The midpoints of these ranges multiplied by the total amount of residents in each home made up the final measurement.

Results

Table 1 provides descriptive statistics for the study parameters. Individuals' average age was 55.5 years, and approximately fifty percent of the sample were women. In the year before their

scheduled interview, 25% of the sample said they had been hospitalized (the constant hospitalization variable's mean value in the analysis was .27). The overall amount of microaggressions recorded by participants in care facilities was 1.2, which means that on general, participants encountered slightly or more one microaggression.

Pearson's r correlation coefficients are shown in Table 3 to show the bivariate correlations between all research variables. The

microaggressions score strongly and favorably correlated with signs of depression, drug abuse, and suicidal ideation as well as self-reported previous coronary attacks, recent hospitalization, and these symptoms. In these bivariate associations, neither of the control variables was substantially and positively related to the observed medical microaggressions. Age was favorably correlated with a previous cardiac attack and adversely correlated with complaints of depressed symptoms.

Table 2

Bivariate correlation (Pearson r) among study variables

Characteristic	1	2	3	4	5	6	7	9
Age	1							
Gender	0.12	1						
Household income	0.08	0.04	-0.19**	-0.05	0.03	1		
Experiences of microaggressive	-0.06	-0.06	-0.02	-0.06	0.07	-0.03	1	
Depressive symptoms, suicide	-2.1*	0.08	-0.07	-0.07	-0.03	-1.6*	.22*	1
Past year hospitalization	0.03	0.01	-1.0	-2.2**	0.01	-0.03	.16*	.23*
Cardiac issues	0.25	0.01	0.03	-0.09	0.08	-0.06	0.17*	0.09

A split of self-reported microaggressions in patient care is seen. The stereotype-related microaggression that was most frequently mentioned was my healthcare practitioner occasionally seemed to hold stereotypes regarding my particular culture, although when he or she failed to explicitly communicate them. For each item, endorsement varied from 16.8% to 21.8%. We then counted how many people reported any of the events, and we discovered that 36% of the sample had

encountered a microaggression in a medical setting.

Table 4 displays the findings of the regression analysis, with logistic modeling used for the binary outcome of cardiac event and normal least squares (OLS) regression used for the continuum variables. Each result related to a person's physical or psychological health was regressed using the five control factors (age, per capita family budget, and the microaggression factor).

Table 3

Result of OLS and logistic regression analysis

Characteristic	Depressive symptoms Model 1		Cardiac issues Model 2		Past year hospitalizations Model 3	
	B(se)	B	Logit B (se)		B (se)	β
Age	-0.09	-2.3**	0.07	1.08**	0.002	0.04

Gender	1.26	0.12	-2.9	0.75	-0.02	-0.02
Household income	0.08	-1.5*	-0.02	0.98	0.001	0.2
Experiences of microaggressive	0.56	0.19**	0.27	1.32**	0.03	0.09
Depressive symptoms, suicide					0.2	0.16*
Microaggression x depressive symptoms					0.007	0.15**
Constant(se)	9.67(1.89)	-6.59(1.39)	-7.26(1.48)	0.220(.19)		0.134(.19)

p<0.10

*p<0.05

**p<0.01

After controlling for other factors, microaggressions were found to be substantially and favorably correlated with symptoms of depression, drug abuse, and suicidal ideation (OR = 1.30, $p < .05$), recent hospitalizations (OR = .15, $p < .05$), and heart condition history. Age was inversely correlated with depression symptoms and correlated favorably with previous heart attacks. Heart attacks and hospitalizations were substantially correlated with participation site, with patients at community 2 being more inclined to talk about each of these problems.

We considered depression and drug misuse, and suicidal thoughts as independent factors for the two health results to account for the likelihood that those who are suffering these symptoms may regard provider care more poorly than those who are not.

Considering their strong, substantial connection, we also computed an interaction effect between depressive symptoms and microaggressive events. We start by looking at the findings where the dependent factor is a heart condition. As demonstrated, individuals expressing depression, drug abuse, and suicidal symptoms were far more prone also to have a previous heart assault as well as a greater prejudice, rejection, and aggression after controlling for the control factors and microaggressions. The link between microaggressions and self-reported heart

problems is weaker when depressive symptoms are taken into account (OR = 1.32 in Model 1 and OR = 1.28 in Model 2), but it is still statistically meaningful.

Regarding the "Hospitalization" concept, after depression, drug abuse, and suicidal symptoms were taken into account, the link between microaggressions and recent hospitalizations ceased to be relevant. This shows that individuals who reported more microaggressions and depression signs were much more prone to have been hospitalized in the previous year. Moreover, hospitalization estimates for people who scored greater on the microaggression scale changed significantly based on their depressive symptom scores. Those who reported fewer microaggressions saw less of an impact from depression, drug abuse, and suicidal signs on hospitalization.

Discussion

These results show links between reports of poorer physiological, psychological, and behavioral disorders for a sample of Pakistani persons with microaggressions faced in medical facilities. Over 36% of interviewees said their medical professional had microaggressions against them (s). In these other actions, more than 1 in 3 patients in this research experienced a healthcare contact in which a clinician (knowing or unknowingly) sent a microaggressive message through their words or actions. These

microaggressions were linked to complaints of hospitalization, cardiac event history, depression, drug usage, and suicidal thoughts after controlling for a variety of variables in multivariate models. As a result, we found cross-sectional relationships between microaggressions in medical and poorer mental and physical health results that were statically important.

On reporting microaggressions for medical outcome measures like Heart Attacks and Previous Year Hospitalizations, we additionally looked at any potential confounding or interaction impacts of depressive and substance abuse signs. The same tendency, based on the report, also exists in mental healthcare facilities. In a 2014 survey (Paradies, 2006), more than half of therapy clients from underrepresented racial and cultural groups admitted to experiencing microaggressions from their clinicians. Our findings demonstrated that however after taking depression rates and drug abuse into consideration, there was still a relationship between microaggressive interactions and a past of heart attacks.

On the other hand, when depressive signs were taken into account, the link between microaggressions and hospitalization lost statistically significant. Microaggressions' stressful character may have a greater effect on diseases like coronary heart disease, where stress is an etiology health risk. A study of 138 studies (Lee & Kronenfeld, 2009; Blair, et al., 2013) from the years 2007 to 2020 found that there is a lot of proof of racist microaggressions occurring in a variety of contexts. Findings from the questionnaire and interviewing data indicate that racial microaggressions negatively impact the mental and physical well-being of persons of color. To lessen the impact of racial microaggressions, the scientists also identified useful coping mechanisms (Blair, et al., 2013). Only the Hospitalization model demonstrated a substantial interaction between depressed signs

and microaggressions in our research. We discovered that participants who scored higher on the microaggression and depressive episodes measures were more inclined to say that they had been hospitalized in the previous year.

Moreover, for those individuals who indicated greater rates of microaggression, depression, drug abuse, and suicide rate condition seems to have the largest impact on hospitalization. One explanation for this tendency is that elements that may help to prevent depressed symptoms (such as a strong sense of cultural identification, support networks, spirituality, etc.) could also help to counteract the upsetting consequences of microaggressions (Constantine, 2007). Individuals may be concurrently and differently more exposed in the lack of those protective benefits to the medical implications of both depressive episodes and microaggressions, which could affect help-seeking behaviors like making and keeping frequent doctor or clinic appointments. This could therefore lead to the deterioration of medical issues that raise the likelihood of hospitalization (Batool & Kashif, 2022).

Considering the primary focus of prior study (Schiller & Bernadel, 2004; Piette & Schillinger, 2006) on psychological health solely, as well as the established links between discrimination and ill psychological and physiological health, this study makes a difference. The ramifications of our results are concerning for chronic illness sufferers. The patient connection may be suffering as a result of microaggression, which may lead to comorbidity and medical problems (Nordmarken, 2014).

We are unable to identify a temporal sequence of microaggressive events and health effects because of the cross-sectional dataset. We don't know if, as we hypothesize, microaggressions cause worse results or if deteriorating health increases the likelihood of encountering microaggressions with healthcare professionals. The survey results are also susceptible to self-

report error, and this could affect our outcome and clinical factors, that were not realigned using information from medical records. We are unsure if the observed microaggressions happened more frequently at off-reservation medical services or whether they primarily happened during infrequent trips (Nguyen, 2008; Sue, et al., 2007).

To fully understand the possible effects of these encounters on health behaviors and results, additional studies ought to investigate the variety of microaggressive events in on- and off-reservation situations. To gain a better knowledge of the form, response to, and direct impact of microaggression interactions, we also advise qualitative examination of microaggressions in healthcare settings along a variety of populations.

Conclusion

In light of mounting evidence that unfavorable interactions between patients and providers have a detrimental influence on patients' health, the idea of patient-centered healthcare has seen a resurgence in popularity in recent years. Hence, microaggressions harm patient-centered results and demand consideration in the social dialogue. The implemented changes have an influence on patient/provider interaction in part because they make providers more aware of subconscious prejudices, socio-cultural difficulties, and how to negotiate different interaction styles while still establishing a basis of mutual respect and cooperation. A crucial first step in this direction is to comprehend how racism is evolving to incorporate the subtle, frequently unintended, yet repressive aspect of microaggressions.

Cultural awareness becomes alienating and stereotypical to particular groups if an excessive emphasis is placed on memorizing, racial/ethnic differences and behaviors, potentially encouraging microaggressive behavior. Cultural modesty and culturally safe are some alternatives. Both viewpoints are comparable in that they both view care delivery as a fluid, a continuing process in which doctors can

sympathize with the individual disease as they are experiencing it and work to comprehend it from their viewpoint. The social power imbalance that exists in doctor-patient interactions emphasizes the need for clinicians to be aware of the likelihood and effects of microaggression interactions and, eventually, to establish a cultural safety health system for all.

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