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Introduction

By the end of the year in which I wrote this book, approximately 5,000 news articles had been written about *microaggressions*—or subtle forms of discrimination that are often unintentional and typically target people of historically marginalized groups. Major news outlets, such as *The New York Times, HuffPost*, and *Los Angeles Times*, as well as websites, such as Buzzfeed and Salon, discussed whether microaggressions were real or perceived, and whether discrimination was even still a problem in the United States. Microaggressions were described in a variety of contexts—ranging from the experiences of students of color at predominantly White campuses to controversial platforms voiced by presidential candidates. Some writers argued that microaggressions led to a "victimhood culture," whereas others debated about whether microaggressions were bad for business. Some people who perceived or encountered microaggressions aimed to vocalize and

validate the realities and impacts of such experiences; others wanted to vehemently deny the existence of microaggressions, their possible consequences, or both.

Although Pierce, Carew, Pierce-Gonzalez, and Willis (1978) first conceptualized microaggressions in the late 1970s, the concept did not become popularized until 2007, when a seminal article by D. W. Sue et al. was published in *The American Psychologist*. Over the next 5 years, one analysis found that 73 empirical studies had been published on the concept of racial microaggressions (Wong, Derthick, David, Saw, & Okazaki, 2014), and another analysis estimated that between 2010 and 2015, 35 peer-reviewed articles or dissertations focused on the concept of microaggressions that target lesbian, gay, bisexual, transgender, and queer (LGBTQ) people (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016). Although most psychological concepts usually take decades for majority of academics and the mainstream to become familiar with, microaggressions quickly became a concept known throughout academia (most notably in psychology and higher education) and eventually became part of the mainstream vernacular. In fact, in 2017, the term *microaggressions* was officially added to the Merriam–Webster dictionary (Italie, 2017). Despite this growth in familiarity, naysayers have continued to invalidate others' perceptions of microaggressions, without acknowledging the abundance of empirical studies that support their existence and impact. Meanwhile, proponents have often used alternative or diluted versions of the term—resulting in further confusion and misunderstandings.

Throughout this book, I address the various controversies surrounding microaggressions that are debated through both the mainstream media and academia—exploring theoretical conceptualizations, research, and implications for clinical practice. I describe how microaggressions may have long-lasting effects on the psychological health of all people—especially individuals from historically oppressed groups and communities. Specifically, I discuss the ways in which microaggressions may lead to psychological trauma, notably for people who encounter discriminatory incidents regularly and intensely throughout their lives.

THE CHANGING FACE OF DISCRIMINATION IN THE UNITED STATES

Over the past 10 years, the United States has borne witness to a spectrum of historic incidents that changed the landscape of America. For instance, the election of President Barack Obama in 2008 and the U.S. Supreme Court's passing of same-sex marriage in 2015 both signified victories for historically marginalized communities. Decades prior, many people had never imagined a day that a Black American would be elected to the most powerful office in the country. Similarly, many lesbian, gay, bisexual, trans, and queer people never imagined that they would ever have the opportunity to legally marry the one they love and for their union to be recognized by the federal government. With the emergence of these monumental events, many people have hoped, or even believed, that discrimination would no longer be an issue in the United States and that all Americans would be treated as equals, regardless of their identities. Despite these optimistic viewpoints, many high-profile incidents demonstrate that discrimination is still alive, even rampant, in the United States. For instance, the Southern Poverty Law Center reported that in the month following the 2016 president election, violent hate crimes were at a record high—with an estimated 315 hate crimes targeting immigrants, 221 hate crimes toward Black people, 112 hate crimes toward Muslims, and 109 hate crimes toward LGBTQ people (Nadal, 2017).

Violence toward Black people has also remained steady across the United States. In 2013, the world watched as George Zimmerman was acquitted after killing Trayvon Martin, an unarmed 17-year-old Black American male in Florida. Shortly after, the #BlackLivesMatter movement was created and gained momentum—increasing awareness of anti-Black racism, as well as the disproportionately large number of Black people who have been murdered by police officers in the United States. Years following, the names Michael Brown, Eric Garner, Freddie Gray, Tamir Rice, Sandra Bland, Philando Castile, and Alton Sterling turned into social media hashtags and increasing awareness of the many Black people who died at the hands of police (Nadal, 2017).

Regarding sexism and violence toward women, the Centers for Disease Control and Prevention (CDC) estimates that about one in five American women (or 19.3%) will report being raped at some point in their lives and that close to half of American women (or 43.9%) will face some other form of sexual violence in their lifetime (Breiding et al., 2014). The U.S. Department of Justice reported that women in 2010 experienced rape or sexual assault at much higher rates than men: 2.1 incidents of rape or sexual assault per 1,000 women, compared with 0.1 per 1,000 men (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). Further, the report stated that only 65% of rapes are reported to police (Truman & Langton, 2014). The CDC also estimated that at some point in their lives, one third of women will experience intimate partner violence and one sixth will experience stalking victimization (Basile et al., 2011). The United Nations Office on Drugs and Crime (2012) estimated that women and girls compose 75% of the 20 million total cases of human trafficking globally, with the majority involving sexual exploitation. As violence against women persists, many scholars have asserted that sexism has remained a normalized part of society (Nadal, Mazzula, & Rivera, 2017). For instance, when audiotapes were released of Donald Trump making lewd comments about women, many presumed his campaign would be ruined. Instead, he defeated his opponent Hillary Clinton—the first female presidential nominee of a major political party and who many pundits considered the most qualified presidential candidate in recent history (with her experience as secretary of state, senator, and First Lady).

In addition to racism and sexism, prevalence of violence toward LGBTQ people is also high. For instance, from 2012 to 2013, the years following the passing of legalized same-sex marriage in New York, anti-LGBTQ hate crimes increased. One prominent case involved the murder of Mark Carson, a 32-year-old gay Black man who was killed in New York City in May 2013. The assailant, Elliot Morales, accosted Carson and his boyfriend as they walked through the West Village of Manhattan, allegedly yelling homophobic slurs before shooting Carson point blank. A few months later, two men assaulted Islan Nettles (a Black, trans woman) in Harlem, after learning of her transgender identity; she died a few days

later. These types of anti-LGBTQ hate violence cases occur all over the United States, with the Federal Bureau of Investigation (2014) revealing that about 21% of the total number of reported hate crimes in the United States target LGBTQ people. The National Coalition of Anti-Violence Programs (2013) reported a higher number—estimating that 32% of all hate crimes are directed toward LGBQ people and 10.5% toward transgender people. Given that the LGBQ and transgender populations compose only about 3.5% and 0.3% of the U.S. population (Gates, 2011), respectively, it is evident that LGBTQ people are targeted for hate violence at disproportionately higher rates.

Further, the research on anti-LGBTQ bullying also illustrates ways that heterosexist discrimination still persists. According to the 2013 National School Climate Survey (which surveyed 7,800 self-identified middle school and high school students), 85% of students reported being verbally harassed, and 65% of these students heard homophobic language "frequently" or "often" (Kosciw, Greytak, Palmer, & Boesen, 2014). Further, in comparison with LGBTQ students who reported being victimized at their school, LGBTQ students who were not harassed reported better grades, a greater motivation to attend college, and higher levels of self-esteem. It thus appears that being bullied greatly contributes to poorer outcomes for LGBTQ students and thus anti-LGBTQ bias is still a national issue.

Finally, despite the passage of the Americans With Disabilities Act of 1990 (ADA; 1991), people with disabilities (PWDs) encounter violence at much higher rates than those without disabilities. According to the U.S. Department of Justice, in 2013, the rate of nonfatal violent victimization (e.g., rape, sexual assault, robbery, aggravated assault, simple assault) was twice as high for PWDs (36 per 1,000) than for people without disabilities (14 per 1,000; Harrell, 2015). The same report indicated that PWDs accounted for 21% of all violent crimes (1.3 million incidents), despite only composing 14% of the U.S. population (Harrell, 2015). In 2013, about 24% of PWDs who were crime victims reported that they were targeted because of their disability, which was much higher than the 13% who reported similar sentiments in 2009 (Harrell, 2015). Regarding specific disabilities, people with cognitive disabilities, more than any other

type of disability, were most likely to be targeted for violence. For every 1,000 people with a cognitive disability, 66.8 people report a violent incident, and 25.1 people report a serious violent incident (Harrell, 2015). Finally, about half of any violence toward PWDs (or 51%) occurs toward people with multiple disability types (Harrell, 2015), suggesting that having multiple disabilities increases risk of victimization.

SYSTEMIC DISCRIMINATION IN AMERICAN SOCIETY

In addition to interpersonal violence and acts of overt discrimination, research supports that systemic discrimination persists in various sectors of contemporary American society. According to Zweigenhaft and Domhoff's (2014) analysis of the Fortune 500, only six CEOs were Black, 10 were Latino, and 10 were Asian American—accounting for only 5.2% of the total number of CEOs. The number of Fortune 500 female CEOs was also low; at the end of 2013, there were only 23 women CEOs (or 4.8% of the total number of CEOs)—almost all of whom were White. Given that the U.S. population consists of 13.6% Black Americans, 17.4% Latina/o/x Americans, and 5.4% Asian Americans (U.S. Census Bureau, 2015), and 50.8% are women (U.S. Census Bureau, 2010), the percentages of White and male CEOs are considerably disproportionate. Such numbers are especially bleak for women of color and other people with intersectional marginalized identities.

Socioeconomic status and wealth tends to be disproportionate for people of color and women. One study found that in 2010, White families were 6 times as wealthy as non-White families and White families earned, on average, about $2 for every $1 that Black and Latina/o/x families did (McKernan, Ratcliffe, Steuerle, & Zhang, 2013). In 2014, women's median weekly full-time earnings were 82.5% of men's weekly full-time earnings (Hegewisch, Ellis, & Hartmann, 2015), and Black and Latina women's weekly earnings were disproportionately lower than White men's (68.6% and 61.2%, respectively; U.S. Department of Labor, Bureau of Labor Statistics, 2015). So, although women are making relatively more money than

they were a decade ago, disparities based on race and gender, especially for women of color, clearly still exist in the United States.

Systemic discrimination negatively affects LGBTQ people as well. Although same-sex marriage was legalized in the United States in 2015, no federal laws prevent LGBTQ people from being fired from their jobs on the basis of sexual orientation or gender identity (Feder & Brougher, 2013). As of 2016, 28 states lacked clear, fully inclusive protections for LGBTQ people; thus, in the majority of U.S. states, LGBTQ people can be fired from their jobs because of their sexual orientation or gender identity. Further, although President Obama signed the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act in 2009 (which made it a federal crime to assault individuals based on sexual orientation and/or gender identity), the majority of the 50 states do not recognize sexual orientation or gender identity as protected identity classes in hate crime legislation (Plumm, Terrance, & Austin, 2014).

Systemic discrimination may negatively affect PWDs as well, specifically regarding unemployment and poverty. In comparison with the 7.2% of the general population who are unemployed, approximately 14.7% of PWDs (who are interested in and eligible for work) are unemployed (U.S. Department of Labor, Bureau of Labor Statistics, 2014). Further, PWDs, on average, earn less than $25,000 per year, and about one fifth of people with severe disabilities live in poverty (Yee, 2011). Many PWDs report how health care facilities do not accommodate their needs (e.g., do not have proper equipment, do not have proper accessible entryways), and others believe health care providers are not sensitive in providing services and do not provide adequate services (Sharby, Martire, & Iversen, 2015). So, although the ADA was created to protect the civil rights of PWDs, access to health care and other resources is still not equitable or available.

MICROAGGRESSIONS IN EVERYDAY LIFE

Despite these examples of systemic and interpersonal discrimination, the United States has come a long way since the days of slavery and its aftermath. No longer is it legal for people to willfully initiate any

type of violent attack, let alone any violence that is based on someone's race, gender, sexual orientation, ability status, religion, or any other identity group. For the most part, it is also generally socially unacceptable to be overtly biased and discriminatory, specifically if it involves inflicting any physical hurt or pain on other people. For example, in previous generations, it was common (or forgivable) for men to sexually assault women; however, current societal norms consider rape to be a horrendous and punishable act. Similarly, because most Americans do not participate in violent hate crimes, they view perpetrators of hate violence as bigots, racists, homophobes, or other similar labels.

Many authors have posited that American society has become more "politically correct" and that most people are aware of what is socially acceptable to say or do, particularly when it comes to issues related to race, gender, and religion (D. W. Sue, 2010b). Most White people tend to view themselves as "good" people, while classifying overtly discriminatory people (e.g., Ku Klux Klan members, neo–Nazis) and behaviors (e.g., hate crimes, racist jokes) as "bad" (D. W. Sue et al., 2007). Similarly, heterosexual and *cisgender* (i.e., people whose gender identity matches their assigned sex at birth) people who do not actively partake in homophobia or transphobia view themselves as fair and unbiased, without realizing the ways in which their heterosexist or transphobic biases may manifest in their language or behaviors (Nadal, 2013).

For the past several decades, psychology researchers have found that individuals' biases and prejudices manifest in more subtle and unconscious ways. In general, White people believe they do not have any racial biases and instead value racial and ethnic equality; yet, studies reveal that many White people still subconsciously hold negative feelings toward people of color or maintain implicit biases about these groups (Jost et al., 2009). For instance, although many White people may profess to not view Black people as inferior or criminal, they might struggle if their child were to date or marry a Black person. Similarly, although many heterosexual or cisgender people claim they do not hold any biases against LGBTQ people, they might have difficulty accepting it if their child came out as queer or transgender.

Because of implicit bias and the societal taboo of overt discrimination, scholars have described how "old-fashioned," or blatant, forms

of discrimination are no longer commonplace, and that subtle discrimination emerges more frequently. Although there have been numerous terms to describe these phenomena (e.g., *modern racism*, *aversive racism*, *covert racism*), these subtle forms of discrimination more recently have been conceptualized as microaggressions (Nadal, 2011, 2013; D. W. Sue, 2010a; D. W. Sue et al., 2007). *Microaggressions* are verbal, behavioral, and environmental manifestations of bias; although they are often unintentional or unconscious, they communicate a spectrum of negative messages, primarily to people of historically marginalized groups. Research has found that microaggressions affect communities of color (see Wong et al., 2014, for a review), LGBTQ people (see Nadal et al., 2016, for a review), women (Capodilupo et al., 2010; Nadal, 2010), and PWDs (Keller & Galgay, 2010)—resulting in myriad psychological consequences, such as depression, anxiety, and trauma (Nadal, 2013; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Torres & Taknint, 2015).

THE CONNECTION BETWEEN MICROAGGRESSIONS AND TRAUMA

Before understanding how microaggressions may be related to trauma, it is necessary to first clarify the definition of *trauma*. I provide two definitions—one offered by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*), which is published by the American Psychiatric Association (2013), and the other by the *International Classification of Diseases* (10th ed.; ICD–10), which is published by the World Health Organization (WHO; 1992). Although the ICD–10 has been mandated for use in the United States by general health practitioners, the *DSM–5* tends to still be used more in the training of psychologists in the United States. Further, the 11th edition of the ICD (ICD–11) is expected to be released soon and to include more rigid definitions of trauma—potentially resulting in fewer posttraumatic stress disorder (PTSD) diagnoses (Sachser & Goldbeck, 2016). Thus, I offer both definitions and provide specific implications when applicable.

To fit the *DSM–5* criteria, a *traumatic event* involves "actual or threatened death, serious injury, or sexual violation" (American Psychiatric Association, 2013, p. 271). The trauma must be either directly felt by an individual (e.g., someone who is physically assaulted), witnessed by an individual (e.g., someone who watches a family member being killed), felt after learning that a traumatic event occurred to a loved one (e.g., someone who discovered their father died in the World Trade Center attacks), or endured after firsthand repeated or extreme exposure to aversive details of the traumatic event (e.g., a first responder who meets survivors and victims of brutal accidents or tragedies). When symptoms are pervasive and persist over time, the disturbance may cause significant distress or impairment in the person's life, including romantic or social relationships, work or school functioning, and basic everyday functioning (e.g., getting out of bed, bathing). The ICD–10 defined *trauma* as a "stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (WHO, 1992, p. 147). Although both the ICD–10 and *DSM–5* require a stressful situation as the main criteria, the *DSM–5* requires an emotional reaction to the stressful situation too. Previous research found that survivors of trauma often display many psychological symptoms, including, but not limited to, (a) shock, denial, or disbelief; (b) guilt, shame, or self-blame; (c) anger, irritability, mood swings; and (d) sadness and hopelessness (D. Sue, Sue, Sue, & Sue, 2015).

In many cases, incidents of overt discrimination and physical violence fit the criteria of trauma. When individuals are targeted by hate crimes, especially violent instances in which they are fearful for their lives, clinicians might easily classify the events as traumas because the encounters were frightening and caused significant distress. Similarly, when working with a survivor of a sexual assault, therapists are likely to assess for symptoms of PTSD. When people are diagnosed with PTSD, psychologists and other clinicians create various treatment plans to alleviate their symptoms; they also tend to validate or normalize survivors' reactions or PTSD symptoms as a natural and expected response to trauma.

On the other hand, when clients describe the persistent discrimination they face in their lives (which might not endanger their physical being in the same way that hate violence or sexual assault does), many therapists

would not label these incidents as trauma. Although the discrimination is consistent, intense, and threaten individuals' feelings of safety, clinicians might argue that the event itself was not traumatic, hence negating the possibility of a PTSD diagnosis. Although the client might present with symptoms that are similar, or exactly equivalent, to PTSD symptoms, clinicians instead tend to impart a diagnosis of depression, anxiety, or some other unfitting psychological disorder. As a result, treatment may focus on changing the client's cognitive or behavioral reactions to discrimination, or exploring and analyzing the reasons the client is having such a negative reaction to discrimination. In other words, although people who experience PTSD are taught that external reasons are the causes for their mental illness, people who face discrimination are taught that internal reasons are why they are suffering.

When people face discrimination in their lives that is (a) intense, (b) extensive and enduring, (c) threatening to one's sense of safety, and (d) causal of symptoms that are aligned with PTSD (e.g., avoidance, dissociation), their experiences might be labeled as *traumatic discrimination*. Traumatic discrimination can manifest through blatant instances of victimization, which fit the current *DSM–5* criteria for trauma (e.g., racial hate crimes, sexual assault) but which may also occur through nonviolent overt discrimination (e.g., bullying, sexual harassment). Traumatic discrimination can also result from excessive and intense microaggressions (i.e., repeated exposure to subtle discrimination that persists throughout an individual's life), as well as from blatant and subtle forms of systemic microaggressions (e.g., enforced policies or practices in government or institution that continually marginalize certain groups of people). In this text, I also introduce the term *microaggressive trauma*, or the excessive and continuous exposure to subtle discrimination (both interpersonal and systemic) and the subsequent symptoms that develop or persist as a result. Although not all microaggressions are life threatening, they can certainly be pervasive and compromise one's sense of psychological and emotional safety, resulting in typical symptoms associated with trauma.

Further, I describe the ways that individuals' past histories with microaggressive trauma might manifest in their present lives and thus affect their daily life stressors and current mental health. Because many people

do not fully heal from past traumas, they may internalize an array of negative emotions—including anger, sadness, worry, resentment, hopelessness, regret, and self-doubt. These emotions may then affect one's self-esteem, one's susceptibility to develop mental health problems, and even one's ability to succeed or function (Bedard-Gilligan et al., 2015). Additionally, people's present-day encounters with overt discrimination or microaggressions might serve as triggers to past memories of discrimination. When a person is triggered, they might experience a retraumatization, which causes psychological distress that is above and beyond whatever the current situation may entail (Duckworth & Follette, 2012). In other words, when people face microaggressions, they are not only reacting to the situations that are occurring in the moment but also might be reliving and reacting to unresolved, emotionally intense microaggressions of the past.

WHAT THIS BOOK COVERS AND WHOM IT IS FOR

Throughout this book, I argue that exposure to microaggressions may lead to symptoms, characteristics, or behaviors that are typically associated with PTSD: difficulty in concentrating; susceptibility to developing negative, internalized emotions (particularly of worthlessness, self-doubt, and distrust); and even potential difficulty in basic daily life functioning. Examples demonstrate how microaggressions can be intensely distressing if (and when) such discrimination is encountered on a frequent basis; if they are paired with past experiences of overt discrimination or violence; and if present-day microaggressions trigger past traumatic events with microaggressions or discrimination.

This book is grounded in two main theories. First, microaggression theory (D. W. Sue, 2010a, 2010b) is a philosophy that frames contemporary discrimination in the United States and many other parts of the world. I review the current theoretical and empirical literature involving microaggressions and discrimination toward various marginalized groups, as well as the impact of these types of discrimination on trauma and other mental health issues. Second, the book is also positioned in

intersectionality theory (Crenshaw, 1989), which focuses on how the combination of one's race, sexual orientation, gender, gender identity, and other identities affect how one encounters, or copes with, microaggressions and trauma. In understanding intersectionalities, I also refer to critical race theory (Crenshaw, Gotanda, Peller, & Thomas, 1995), feminist theory (hooks, 2000), and queer theory (Jagose, 1996).

The book offers multiple examples of microaggressions and practical guidance on how to identify and deal with microaggressions as they occur. In Chapter 1, I cover what has traditionally been viewed as trauma, as well as ways that trauma may manifest differently, specifically in the context of overt systemic and interpersonal discrimination. Further, I introduce theoretical approaches to clinical treatment with trauma survivors of various marginalized identities. In Chapter 2, I discuss microaggression theory in detail—focusing on theoretical and empirical literatures that reveal the existence and impact of microaggressions. In Chapters 3 through 6, I discuss how microaggressive trauma may manifest uniquely in different communities and identity groups—namely focusing on people of color, LGBQ people, transgender people, and women. In these chapters, I provide examples from research, anecdotal experience, and media and popular culture to provide readers with examples of how microaggressive trauma may manifest, as well as to strategize different clinical approaches and interventions on how to address them. I also introduce several case studies (loosely based on real-life examples derived from my colleagues in the field). Cases include scenarios in which the encounters with discrimination are subtle, incidents in which the discrimination is much more overt, and instances in which there is a mix of overt and covert discrimination. Although a core identity may appear to be the focus of the discrimination or trauma, each case reflects intersectional identities too. Further, although not every identity group will be covered in this text, it is hoped that concepts can be applied to clients with other historically marginalized identities (e.g., PWDs, Muslims, people with mental illness). Finally, in Chapter 7, I conclude with recommendations on how to address microaggressive trauma—individually, institutionally, and systemically—while advocating for changes in psychology and education.

This book is intended for two types of audiences. First, practitioners and students in mental health fields (e.g., psychology, social work, counseling) will learn about how microaggressions can be traumatic and negatively affect mental health. Theory- and evidence-based recommendations or strategies are provided throughout, which I encourage practitioners to integrate into their therapeutic work with clients. Second, this book is written for people who have encountered microaggressions, as well as those who are committed to combatting them. Therapists may suggest this text to their clients who are struggling with microaggressive trauma and may need validation that their experiences are normalized. Educators, students, researchers, activists, and community leaders may benefit from the comprehensive reviews of discrimination and trauma, while gaining insight into the relationship between the two concepts. Regardless of the type of reader, it is my hope that the book will be a jumping point for more conversations in families, therapy rooms, classrooms, workplace environments, and anywhere that microaggressions may occur. By naming the relationship between microaggressions and trauma, we can begin to advocate for social change.