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**ORIGINAL ARTICLE**

**The impact of gender-based microaggressions and internalized sexism on mental health outcomes: A mother–daughter study**

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**Abstract**

**Background:** Although research is emerging on the subtle slights that women experience, research is needed regarding the frequency with which gender-based microaggressions occur, their impact on mental health, and how views on gender roles may influence their impact.

**Objective:** The current study examined how mothers and daughters experienced gender-based microaggressions, internalized sexism, and mental health symptoms.

**Methods:** The sample included 102 predominantly White mother–daughter pairs. Adolescents were 14 to 18 years old, and mothers were 34 to 68 years old. Mothers and daughters answered surveys including a demographic questionnaire, the Gender-Microaggressions Scale, Ambivalent Sexism Inventory, the Patient Health Questionnaire—9 for depression, and the General Anxiety Disorder—7 for anxiety.

**Results:** Greater gender-related microaggressions experienced in the past month were related to higher levels of mental health distress associated with depression and anxiety among mothers and daughters ( $p < .05$ ). Mothers and daughters scores were significantly correlated ( $p < .05$ ) for microaggressions experienced in the past month, total score of the Ambivalent Sexism Inventory, depression, and anxiety. For mother's depression, a mother's level of ambivalent sexism approached significance in terms of moderating the relationship between microaggressions and mental health ( $p = .055$ ).

**Conclusion:** Our findings suggest that microaggressions are related to mental health distress in adolescent girls and middle-aged women.

**Implications:** Uncovering the chronic nature of gender-based microaggressions and how these may affect individuals and family systems may be useful in individual and family therapy as well as in efforts to change broader social processes.

## **KEYWORDS**

Gender, microaggressions, mothers and daughters, mental health, sexism

Although instances of overt sexism have become less frequent in the past decades, researchers have noted the emergence of more covert forms of gender bias and discrimination (e.g., assumption of traditional gender roles or inferiority; Capodilupo et al., 2010). Covert forms of discrimination can be corrosive in that they may leave the recipient feeling put down but unable to clearly articulate the reason (Sue et al., 2007). The term *microaggressions* has been described as brief, commonplace messages that devalue or degrade an individual because of their membership in an oppressed group (Sue et al., 2007). In the past decade, extensive research has emerged examining the prevalence and effects of microaggressions against individuals based on their race or ethnicity. Growing research highlights similar issues involving microaggressions against persons on the basis of other group memberships, such as women; lesbian, gay, bisexual, and transgender individuals; and individuals with disabilities (Sue, 2010; Sue & Capodilupo, 2008).

The current study focuses on gender microaggressions. Data were gathered to understand the relationship between gender microaggressions and women's mental health. We were particularly interested in mother-daughter dyads for their shared gender socialization and possibly common life experiences while also holding differences in generational status.

## **MICROAGGRESSIONS**

Research has documented the association between microaggressions and negative mental health outcomes (e.g., internalizing problems, stress/negative affect; Lui & Quezada, 2019). Sue et al. (2007) defined microaggressions as brief, everyday verbal, behavioral, and environmental acts

that communicate hostile, negative, and insulting messages to oppressed groups.

Microaggressions are believed to stem from stereotypes and negative views held by others, which often lead to the ambiguous nature of the microaggression. Often, the person who is saying the microaggression does not realize that they have offended someone, and sometimes they may even think they are being complimentary (e.g., saying to a Chinese American student “I can’t believe how well you speak English!”).

Microaggressions can be subtle to the receiver as well, sometimes leaving the receiver feeling bad without having an exact reason to pinpoint. Sue’s work on microaggressions began with examining microaggressions against individuals of oppressed racial and ethnic backgrounds. Since then, racial microaggressions have been associated with negative impacts on psychological and physical health (Flores et al., 2010; Lambert et al., 2009; Torres & Ong, 2010). In the past decade, the work has expanded to examine microaggressions regarding gender and sexual orientation (Sue, 2010), disability status (Keller & Galgay, 2010), gender identity (Nadal, 2013), and religious minorities (Nadal et al., 2012).

Research has clearly identified gender-based microaggressions themes that women may experience, including (a) sexual objectification, (b) second-class citizenship/invisibility, (c) assumptions of inferiority, (d) denial of reality of sexism, (e) assumption of traditional gender roles, (f) denial of individual sexism, (g) use of sexist language, and (h) environmental microaggressions or external evidence of systemic marginalization (Nadal, 2010; Sue & Capodilupo, 2008). In a study aimed at validating the prevalence of these themes, Capodilupo et al. (2010) found that women most frequently experienced sexual objectification and assumption of traditional gender roles. In terms of sexual objectification, women reported hearing sexist language in their workplace, or being “cat-called” as they walked down the street. Examples of

assumption of traditional gender roles that women endorsed were having family members telling them to “take care of the house” or “act more ladylike.” Both types of microaggressions, experiences of sexual objectification and assumption of traditional gender roles, were overwhelmingly endorsed by women in Capodilupo et al. study. Despite these findings, research has yet to examine the frequency with which gender-based microaggressions occur, their impact on mental health, and how views on gender roles may influence their impact on mental health outcomes among mothers and daughters.

Like race- or ethnicity-based microaggressions, gender microaggressions can be considered in their historical context. As social changes led away from overt forms of sexism, covert or subtle sexism has become more prevalent. These generational changes are observed at a social level, and they also could be seen at more microsocial levels, such as the family. Parents pass on to their children their attitudes about gender roles and also their understanding of appropriate and inappropriate behaviors (Cordero-Coma & Esping-Andersen, 2018). To that end, we hypothesized that mothers’ experiences and understandings of gender-based microaggressions could influence their daughters’ socialization and thus their own experiences with gender-based microaggressions.

## **SEXISM**

“Sexism is the systematic inequitable treatment of girls and women by men and by society as a whole” (Bearman et al., 2009, p. 11). Experiences of sexism and harassment have been shown to have negative effects on career outcomes and mental well-being in U.S. women (Fitzgerald et al., 1997). Some researchers have even speculated that the prevalence of women experiencing depression at twice the rate of men may be accounted for by women’s higher exposure to sexist events (Klonoff et al., 2000). Landrine and colleagues (1995) further defined sexist events as

stressors that can occur throughout one's life, which can be thought of as distal predictors of psychological distress or set the stage for those symptoms later in life. Examples of sexist events include traditional gender role stereotyping and prejudice, unwanted sexually objectifying comments and behaviors, and derogatory or demeaning remarks (Szymanski et al., 2009).

Contrary to the messages perpetrated by media and reinforced by individuals who believe that discrimination due to gender is a thing of the past, systematic data documents that sexist events are still very much present in women's lives (Hammond et al., 2018). Glick and Fiske's (1996) ambivalent sexism theory has been predominantly used to understand sexism. According to ambivalent sexism theory, the existence of male dominance in society (economic, political, and social institutions) conflicts with the intimate interdependence of sexual reproduction, thus creating ambivalence. Glick and Fiske introduced two complementary forms of sexism, *hostile sexism* and *benevolent sexism*.

Hostile sexism is an obvious and blatant negative view toward women often including the idea that women seek to control men through feminist ideology or seduction, are less competent than men, and are better suited for childcare (Dardenne et al., 2007; Glick & Fiske, 2001). These two types of sexism are supposed to be interrelated, a finding confirmed in recent research (Hammond et al., 2018). Past research also shows that hostile sexism is related to adopting negative stereotypes of women (Glick et al., 2000), as well as adopting traditional gender role beliefs that limit women's roles to nurturing children, doing housework, being in heterosexual unions, and sacrificing career for the husband's career (Chen et al., 2009).

In contrast, benevolent sexism is viewed as subjectively favorable, containing chivalrous ideology that supports protecting women who adopt traditional roles (Glick & Fiske, 2001). Although benevolent sexism may have a positive overtone, the underlying message advances an

ideology that restricts women's activities to traditional gender roles and stereotypes. Women's endorsement of benevolent and hostile sexism follows a different trajectory than men's. Women often reject hostile sexism but endorse benevolent sexism, and this benevolent sexism is shared by mothers and daughters (Montañés et al., 2012). Research to date has yet to examine the impact of these subtle messages of inferiority on mental health outcomes among women and their daughters.

## **INTERNALIZED SEXISM**

One of the most documented facets of internalized sexism is *sexual objectification* and *self-objectification*. Sexual objectification (SO) occurs when a person's body, specific body parts, or sexual functions are separated from their identity; that is, they are seen as objects often for the use and pleasure of others (Fredrickson et al., 1998). This can occur in direct encounters as well as in indirect, systemic environmental encounters.

Multiple studies show that women experience SO events more often than men (Swim et al., 2001; for reviews, see Fredrickson & Roberts, 1997, and Winn & Cornelius, 2020). The internalization of standards or beliefs that serve to limit a person's potential has been termed *internalized oppression* (David, 2014). Specifically, internalized oppression is "a set of self-defeating cognitions, attitudes, and behaviors that were developed as one consistently experiences an oppressive environment" (David, 2014, p. 14). This oppression includes a distorted view of one's potential, as well as the potential of others, on the basis of the particular dimension of identification (e.g., gender).

Self-objectification has been looked at as a mediator that links experiences of SO with various negative outcomes (Moradi & Huang, 2008). Body surveillance, or "habitual monitoring of the body's outward appearance" (Fredrickson & Roberts, 1997, p. 180), is considered to be a



core aspect of self-objectification. Researchers also believe there is a strong link between self-objectification and body shame or “an emotion that can result from measuring oneself against an internalized or cultural standard and perceiving oneself as failing to meet that standard” (Moradi & Huang, 2008, p. 378). Self-objectification has been found to vary by age, with younger *adult* women reporting higher rates than older women (Tiggeman & Lynch, 2001). In samples of adolescents and young adults, at least one study reported a statistically significant ( $r = .16$ ) relationship in mother’s and daughter’s self-objectification as measured by body surveillance (Arroyo & Andersen, 2016), but another noted no relationship on mothers and daughters body surveillance yet did find a significant relationship in the dyad’s body shame (Katz-Wise et al. 2013). These findings may be explained by other variables, such as the quality of the mother–daughter relationship (Katz-Wise et al., 2013). Research has yet to extend these findings on internalized sexism to determine whether it also moderates the potential relationship between gender-based microaggressions and mental health outcomes.

## **INTERGENERATIONAL TRANSMISSION OF BENEVOLENT SEXISM AND GENDER ROLES**

When considering the many environmental and interpersonal areas that expose women to sexist beliefs and traditional gender roles, it is vital to recognize the large influence that the family unit has on children’s developing views. The transmission of traditional gender roles has been studied in recent decades due to the socialized nature of these roles. In a meta-analysis of 43 studies conducted in the Asia, Europe, Israel, and North America, the authors concluded that certain child outcome measures are related to their parents’ gender-related thinking, or *gender schemas* (Tenenbaum & Leaper, 2002). Specifically, one finding of this analysis was a significant association ( $r = .19$ ) between parents’ gender schemas and their child’s occupation-related

attitudes. Children whose parents held more egalitarian beliefs (in contrast to traditional gender roles, i.e., breadwinner and homemaker) were less likely to hold gender-stereotyped views about occupations. Although both fathers and mothers have been shown to have influence on their children's gender-based attitudes, multiple studies reveal a positive correlation between a mother's gender-role attitudes and her daughter's (Ahrens & O'Brien, 1996; Kulik, 2005). Research is needed to determine whether levels of internalized sexism among mother and their daughters are correlated.

## **IDENTITY DEVELOPMENT IN ADOLESCENCE**

A primary psychological task of adolescence is the development of identity (Erikson, 1963). During this time period, adolescents are forming their sense of self and exploring personal values and forming beliefs and goals. Adolescence is a critical developmental period in which identities are highly malleable and critical incidents can shape the future self. Experiences of microaggressions, which provide external input regarding others' view of a person, can potentially shape how a person comes to see themselves. Identity theory states that the core of one's identity lies in their self-categorization into a role, as well as their perceptions of the meanings and expectations associated with that role (Stets & Burke, 2000). These categorizations and self-meanings define expectations toward behavior as well. Identity theory states that these behaviors, as well as group membership and role expectations, are all complex and intertwined aspects of identity development (Stets & Burke, 2000). The meanings of gender and gender roles, and the behaviors associated with gender identity and gender roles, are informed by external experiences such as microaggressions as well as a mother's influences and modeling of gender roles (Moen et al., 1997).

Social, cultural, and psychological processes largely influence gender identity. Gender identity can include sexist attitudes, adherence to gender stereotypes, and a belief about what is appropriate behavior for men and women. Adolescence is considered a primary period of socialization into gender-related practices (Bearman et al., 2009). Pipher (1994) found that by 14 years of age, girls have already been exposed and susceptible to internalized sexism. Adolescent girls continue to experience pressures of conforming to adult women roles throughout high school years (Alfieri et al., 1996). Many of these experiences and internalizations will set the pathway for the rest of a girl's life. Adolescent girls are at a higher risk for depression, anxiety, and suicide, and it is vital that the role of identity development be examined in relation to these factors. Additionally, studies have shown a direct link between women's experiences of gender discrimination and psychological distress (Landrine et al. 1995). This link also has been found in adolescents, highlighting self-esteem as a moderator of gender discrimination and psychological distress (Moradi & Subich, 2004). To date, internalized sexism has not been examined as a moderator for the relationship of gender-based microaggressions and mental health outcomes.

## **CURRENT STUDY**

Women's ability to recognize gender microaggressions may heavily depend on their own attitudes and beliefs about women's value in society and their adherence or nonadherence to gender roles (Capodilupo et al., 2010). In the examination of the relationship between microaggressions and women's mental health, it seems critical to examine internalized oppression as a mediator between the two. We hypothesized that the impact of microaggressions on a woman's mental health could be affected by her internalized sexism wherein higher levels of internalized sexism would buffer the negative impacts of microaggressions on mental health. A person who has internalized sexist attitudes might be more readily able to brush off

microaggression as “unintended” or “not that big a deal,” generating the typical invalidations (Sue et al., 2019) to such events internally and thus lowering their impact. Additionally, developmental considerations are critical to both experiences of discrimination and identity development (Smetana et al., 2006). Although many theories point to the family as a central unit of socialization, there are no known studies that examine the impact of mothers’ internalized oppression and experiences with microaggressions on their daughter’s mental health.

The current study aimed to (a) understand the impact of gender-based microaggressions on mental health outcomes among mothers and daughters, (b) determine whether internalized sexism moderates a potential relationship between gender-based microaggressions and mental health, (c) examine mothers internalized sexism and experiences of microaggressions on their daughters mental health, and (d) determine whether dyads’ reports were intercorrelated for internalized sexism, experiences of microaggressions, depression, and anxiety. On the basis of the literature, we hypothesized that experiencing more gender-based microaggression experiences would be associated with greater mental health distress for mothers and daughters. Internalized sexism was expected to moderate the relationship between gender-based microaggressions and mental health. Mothers internalized sexism and experiences of microaggressions were expected to be related to daughter’s mental health. Lastly, we expected dyads’ reports of internalized sexism, experiences of microaggressions, and mental health outcomes to be significantly correlated due to socialization processes.

## **METHOD**

### **Procedures**

The Utah State University Institutional Review Board reviewed and approved this study under the expedited mechanism prior to beginning participant recruitment. Prior to recruitment, a pilot

study was conducted that included three mother–daughter pairs. Feedback from the pilot indicated that adolescents understood the language of the questions and could complete the surveys in a timely manner. Recruitment for the current study used a research panel company (i.e., Qualtrics) to draw a sample of mother–daughter dyads from across the United States. Qualtrics panels include individuals who have registered to participate in research and have provided profile information that can be matched to study inclusion criteria. The principal inclusion criterion was that both mother and daughter participants identified as women. The age of the mother was not restricted, but in an attempt to survey mostly high school–age girls, the adolescent daughter had to be between the ages of 14 and 18 years. Inclusion criteria also required mothers and daughters to live in the same household at least 50% of the time. Participants were not excluded due to ethnicity, religion, or sexual orientation.

Mother–daughter dyads were recruited through the mother to expedite the process of consent. Study information stated that the study would be assessing adolescent perspectives on sexism, as well as current mental health measures. Mother’s electronically signed consent for both their participation and that of their daughters. Additionally, assent was obtained from the adolescent daughters. All information regarding the study, consent forms, and measures were completed online through the Qualtrics system. A page including additional information about the study was included on the end page. This included what the researcher was specifically looking at, resources for more information, and contact information. Care was taken to ensure that all identifying information was separated from the participant’s data, and the researchers never had access to this identifying information.

## **Participants**

Data for the present study included information from 102 mother–daughter dyads. Mothers ranged in age from 34 to 68 years ( $M = 48.36$  years,  $SD = 8.06$ ). Daughters ranged in age from 15 to 18 years ( $M = 16.45$  years,  $SD = 1.01$ ). The majority of mothers indicated that they were currently in a romantic relationship with one partner. As we would expect, fewer daughters indicated that they were currently in a relationship with one partner. The majority of mothers and daughters were White and identified as “heterosexual or straight.” Mothers and daughters identified predominantly as Christian or Catholic. See Table 1 for full demographic characteristics of the sample.

## **Measures**

Mothers and daughters completed an online survey containing demographic questions, a self-report microaggressions scale, an ambivalent sexism self-report measure, and a mental health self-report questionnaire. The online survey first presented a letter of information for the mother and then the mother’s portion of the survey began. At the end of the mother survey, the mother was instructed to pass the survey to her daughter and provide privacy to the daughter. The daughter then viewed a letter of information, and if she assented to participate, began her section of the survey. The mother and daughter portions of the survey were identical. These measures are described in more detail subsequently. Means, standard deviations, minimums, maximums, and ranges for all the variables are found in Table 2.

## **Demographics**

Mothers and daughters were asked to self-report their gender, age, sexual orientation, religion, and ethnicity. Questions were carefully worded based off of current recommendations proposed by Hughes et al. (2016) to maximize inclusivity in demographic descriptions. For the purpose of

this study, the researcher hoped to identify current gender identity with the question “How do you currently describe your gender identity?” and providing an inclusive set of possible responses.

Age was assessed with an open-ended format to aid the researcher in obtaining exact age, not simply age ranges. In accordance with Hughes et al. (2016), along with guidelines in consideration for the 2020 Census, the researcher eliminated the terms *race* and *ethnicity*, and instead asked participants to report which categories they identified with (e.g., White, Black, Latinx). Mothers and daughters were asked to report which category of education applied to them. The wording of this question was recommended by Hughes and is considered to be more positive. For example, the common wording of *less than high school* was changed to *some high school*.

Because of the method in which participants were recruited throughout the country, a location question was added. Last, both mother and daughter were asked separately to report on their *sexual identity*. Although Hughes et al. (2016) stated that the term *sexual orientation* can involve sexual identity, *sexual behavior*, and *sexual attraction*, for the purpose of this study involving adolescents, it was believed that only sexual identity should be asked. Multiple categories were available to be chosen, along with the option to not respond. Religion, marital status of the mother, relationship status of the adolescent, and socioeconomic status were asked also following the same format as above questions.

### **Gender microaggressions**

Gender microaggressions were measured with the Gender Microaggressions Scale (Cushwa, 2013). This is a self-report measure of a woman’s perception of microaggression experiences.

The scale was adapted for gender by Cushwa from a racial/ethnic microaggression measure

created by Blume et al. (2012). The items were rated on a 7-point Likert-type scale ranging from 0 (*never*) to 6 (*often*). The total scale has 49 items and three subscales. The first subscale had 26 items (Cronbach's alpha = .96) and included questions pertaining to the frequency of specific gender-based microaggressions experienced in the past month. The second subscale had six items that examined the frequency of specific microaggressions in the past year (Cronbach's alpha = .61). A third subscale of items was specific to gender-based microaggressions that women experience in the past year (17 questions, Cronbach's alpha = .95). Mothers and daughters responded to this scale separately. The monthly, yearly, and female-only scales were each summed. Higher scores indicated a higher frequency of gender-based microaggression experiences. Total microaggression scores have been associated with lower self-efficacy and greater anxiety and depression (Cushwa, 2013). For mothers in the present sample, internal consistency estimates were  $\alpha = .98$  for the total scale, .962 for the scales pertaining to experiences in the past month, and .97 for those in the past year. For daughters, the overall scale's internal consistency was  $\alpha = .98$ , with .98 for those in the past month and .97 for those in the past year.

## **Sexism**

The Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996) is a widely used self-report measure that provides scores in both hostile sexism (e.g., "women seek to control and manipulate men") and benevolent sexism (e.g., "women should be cared for and protected by men"). In its initial creation, the researchers gathered 2,250 respondents to establish convergent, discriminant, and predictive validity. Participants were asked to mark the extent to which they *strongly agree* (5) or *strongly disagree* (0) with 22 statements on a 6-point Likert-type scale. Items 3, 6, 7, 13, 18, and 21 are reverse-coded. The ASI elicits two composite scores, one averaging the 11



benevolent sexism items and one averaging the 11 hostile sexism items. Reliability for the ASI total score was found to be acceptable across six studies (alpha range from .83 to .92). Reliability for each individual subscale was also found to be acceptable, although it was lower for the benevolent sexism scale (alpha range of .73 to .85) than the hostile sexism scale (alpha range of .80 to .92). In this study, we focused mostly on the benevolent sexism score, although past research indicates a positive correlation between both scores (Glick & Fiske, 1996). Mothers and daughters both completed this scale separately. Each participant's total ASI score was calculated by averaging the score for all items after reversing the six reverse-coded items. The benevolent and hostile subscales were calculated by averaging the item scores for the respective 11 items in each subscale. For mothers in our sample, the Cronbach's alpha for ASI total, hostile, and benevolent was  $\alpha = .71$ ,  $.79$ , and  $.72$ , respectively. Daughters in our sample had the following Cronbach's alphas,  $\alpha = .77$  for ASI total,  $\alpha = .77$  for hostile, and  $\alpha = .79$  for benevolent sexism.

### **Mental health**

Current levels of mental health distress in both mothers and daughters were assessed through two self-report mental health-screening tools. The first tool was the Patient Health Questionnaire—9 (PHQ-9; Kroenke et al., 2001), which assessed current levels and severity of depressive symptoms. This scale has nine self-report items, which allowed the participant to rank an item's frequency from *not at all* (0) to *nearly every day* (3). The scale was summed. Cutoffs for the PHQ-9 are: 5 (*mild depression*), 10 (*moderate depression*), 15 (*moderately severe depression*), and 20 (*severe depression*). Scores equal to or greater than 10 have a specificity of 88% and a sensitivity of 88% in regard to indicating depressive symptoms in a patient who has been diagnosed with depressive disorder. The internal consistency is excellent with a Cronbach's alpha of .89 (Kroenke et al., 2001). Test-retest reliability also is excellent with an in person

interview and telephone interview 48 hours later having a correlation of .84 (Kroenke et al., 2001). The measure also has established criterion validity via interviews by mental health professionals (Kroenke et al., 2001) and has been validated for use with adolescent populations (Richardson et al., 2010). In the present study, mother's ( $\alpha = .96$ ) and daughter's ( $\alpha = .96$ ) PHQ-9 reliability was excellent.

Another module of the PHQ, the seven-item Generalized Anxiety Disorder Scale (GAD-7) was used to assess current levels of anxiety symptoms (Spitzer et al., 2006). This scale asked participants to rate the severity of an item, such as "feeling nervous, anxious, or on edge" on a 4-point Likert-type scale from *not at all* (0) to *nearly every day* (3). The participant's score was summed and interpreted according to the following scale: 5 (*mild anxiety*), 10 (*moderate anxiety*), and 15 (*severe anxiety*). It is recommended that a score greater than or equal to 10 be evaluated further for potential generalized anxiety disorder. This measure has a sensitivity of 89% and specificity of 82% in regard to indicating anxious symptoms in individuals who are diagnosed with generalized anxiety disorder (Spitzer et al., 2006). Internal consistency was excellent (Cronbach's alpha = .92) and construct validity was high via a strong association with a Short-Form General Health Survey (Spitzer et al., 2006). In our study, the GAD had high internal consistency for mothers and daughters,  $\alpha = .97$  and  $.95$ , respectively.

### **Sample size, power, and precision**

The sample size was calculated based on the statistical power needed to answer the questions of interest. Statistical power refers to how sensitive a null hypothesis test is to detect an effect when an effect is present (Fritz & MacKinnon, 2007). The power is calculated as 1 minus the Type II error, or the probability of failing to reject a null hypothesis when it is present (Fritz & MacKinnon, 2007). A G\*Power analysis (Faul et al., 2009) for the moderation question included

three predictors (benevolent sexism, hostile sexism, microaggressions). The effect size was set a medium ( $f = .15$ ), alpha at .05, and power at .80. G\*Power returned a needed sample size of 77 to be able to detect an effect.

### **Data analysis plan**

To examine the research questions, three regression tests were conducted using IBM Statistical Package for Social Sciences (SPSS). The first regression tested whether gender-based microaggressions predicted mental health outcomes. The second regression tested whether gender-based microaggressions predicted internalized sexism. The third regression tested whether gender-based microaggressions and internalized sexism predicted mental health outcomes. Moderation analyses were conducted using PROCESS procedures in SPSS (Model 1; Hayes, 2013).

### **RESULTS**

To understand the relationship between experiences of gender-based microaggressions and mental health outcomes for daughters and mothers separately, correlations were calculated between the variables of interest. Results indicated that there was a significant relationship between mothers' and daughters' experiences with gender-based microaggressions and their current mental health levels. When looking at the relationship between mother's microaggressions experiences in the past month and their mental health, correlations were significant for depression and anxiety. Correlation between mental health and mother's microaggression experiences in the past year were also significant for depression and anxiety. Results further indicated a relationship between microaggressions events and mental health for daughters. Daughters microaggressions experienced in the past month had a significant relationship with depression and anxiety. Microaggressions experiences in the past year were

also significantly associated with daughters depression and anxiety. See Table 3 for complete correlations.

The second research question was: Does internalized sexism moderate the relationship between experiences of gender-based microaggressions and mental health outcomes in daughters or mothers? Each individual's Benevolent Sexism score was examined as a moderator between microaggressions experienced in the past month and both anxiety and depression for mothers and daughters separately. Overall, results did not indicate that Benevolent Sexism scores significantly interacted with microaggressions to predict outcomes. However, the results approached significance ( $p = .055$ ) for benevolent sexism moderating the relationship between microaggressions and mother's depression. See Table 4 for moderation analysis results.

In regard to the third research question (i.e., what is the relationship between mothers and daughters on (a) internalized sexism, (b) experiences of microaggressions, (c) depression, and (d) anxiety), there were significant correlations between mothers and daughters for several measures. First, the relationship between mother and daughter scores on the Ambivalent Sexism Inventory was examined. For the Hostile Sexism subscale, mother and daughter scores were significantly related. The dyads were also significantly related in terms of the Benevolent Sexism subscale, as well as the overall ASI measure. This indicates that mothers and daughters may have similar beliefs about sexism.

Second, the relationship between mothers' and daughters' experiences of gender-based microaggressions was examined. These correlations indicated that mothers and daughters both report similar experiences of past year and past month microaggressions. Last, evidence was found that mothers' and daughters' mental health impairment was highly correlated for

depression and anxiety. Correlations for mothers and daughters can be found on the midline portion of Table 3.

The final research question was: Does a mother's level of internalized sexism and/or her experiences of gender-based microaggressions predict her daughter's mental health outcomes? In the multiple regression models predicting daughter's anxiety, ASI Total, ASI Benevolent, and ASI Hostile scores were entered into six independent models (i.e., depression, anxiety), followed by mother's experiences of microaggressions in the past month. The model examining mother's ASI total score and exposure to microaggressions as predictors of daughter's anxiety was significant,  $R = .342$ ,  $F(1, 99) = 11.087$ ,  $p < .001$ . However, mother's total ASI score did not significantly predict daughter's anxiety scores. Mother's experiences with microaggressions in the past months contributed significantly to the model. The results of the regression analysis predicting daughter anxiety as measured by mother's ASI total scores and microaggressions experienced in the past month indicated that both mother variables contributed to the prediction of daughter anxiety, accounting for 1.8% and 9.9% of the variance, respectively.

The full model examining mother's ASI total and microaggressions experienced as predictors of daughter depression also was significant,  $R = .323$ ,  $F(1, 99) = 8.508$ ,  $p = .004$ . Mothers ASI scores were not significantly related to daughter depression. Consistent with anxiety, microaggressions experienced by mothers was significantly associated with daughter's depression. These variables predicted part of the variability for depression, with ASI total contributing 2.8% and microaggressions in the past month contributing 7.7%. Mothers report on ASI Hostile and Benevolent subscales was not significantly related to daughter's anxiety or depression. See Table 5 for multiple regression analysis results.

## **DISCUSSION**

Findings from the current study bring attention to the complex relationships among gender-based microaggressions, internalized sexism, and mental health outcomes in the context of mother–daughter relationships. This research adds to the existing literature by expanding our knowledge regarding the frequency and scope of gender-based microaggressions that adolescent women experience. The study also surveyed a population of women older than 35 years regarding their experiences with gender-based microaggressions, a population that is often not investigated.

Descriptive data from this study provided ample information regarding the occurrence of gender-based microaggressions and their impact on mental health outcomes among women and their daughters. In regard to experiencing microaggressions, daughters had higher mean scores than mothers for microaggressions experienced in both the past month and the past year, but only past year differences were statistically significant. These results suggest that adolescents are aware of these events and reporting that they happen to them even more than their mothers, which point to a real need for intervention. Some may argue that adolescents are too young to experience and be affected by these events, but our findings potentially debunk this idea. Adolescent girls may have a unique intersection of gender and youth in which they experience more self-objectification (Karsay et al., 2018), as well as objectification by others (Davis, 2018), yet may have a unique way to respond to these message in critically protective ways (Eschmann, 2021). Another piece of descriptive data was related to the mental health outcomes. For mothers, the mean scores for anxiety and depression were both in the mild range, suggesting that most of the mothers in the study had at least mild anxiety or depression. These results highlight the need for more mental health services and outreach in middle-aged women.

Falling in line with what would be expected from previous studies, mothers and daughters were related on a number of measures. Overall, anxiety and depression symptoms in

mothers were related to those symptoms in their adolescent daughters. This is consistent with the literature, and multiple reasons for this relationship have been suggested such as genetic predisposition and dysfunctional family practices (Loeber et al., 2009). Scores on the ASI were correlated also between mothers and daughters, which adds to the literature suggesting that gender schemas between mothers and daughters are related (Tenenbaum & Leaper 2002). This study expands those notions by providing evidence that both hostile and benevolent sexism are related in mothers and daughters. These relationships are correlational, not causal. At this point it is unknown whether these internalized beliefs originate from mother, daughter, or stem from a complex reciprocal relationship. Relatedly, the ASI was normed using an adult population and had not been used to assess adolescents. The use in this study suggests that it might be an adequate measure to use with adolescents over 14 years of age.

The result indicating that there is a positive correlation between mother and daughter experiences of gender-based microaggressions is new to the literature. The reason for this relationship is unknown and should be investigated further. Perhaps these similarities stem from family units being exposed to similar media, hearing statements from shared family members, or a shared awareness regarding microaggression events.

In regard to the moderation analysis, levels of benevolent sexism were not found to significantly interact with the relationship between microaggressions and mental health. However, results did approach significance for mother's depression ( $p = .055$ ). This may be due to the subtle nature of microaggressions, which requires an ability to recognize something that may be brief and covert.

It may be that internalized sexism might be better conceptualized as a predictor of participants' ability to recognize microaggressions. The moderation analysis made sense in a

self-report context. However, experimental research on microaggressions has shown that even experts can miss detecting microaggressions (Owen et al., 2018), suggesting that the self-reports in this study may be a conservative estimate of the microaggressions women experience. Further experimental research suggests that exposure to racial microaggressions might shift people's colorblind attitudes (Patterson & Domenech Rodríguez, 2019). Using an experimental paradigm to examine gender microaggressions could be important to understand the relationship between these exposures, internalized sexism, and mental health. For example, perhaps participants could fill out ratings on benevolent sexism and then be put in an experimental condition in which a gender microaggression occurs, and pre and post affect measures could help determine whether the women were affected by the microaggression independently from their ability to name it as such.

The final set of findings point to the importance of a mother's experiences with microaggressions in predicting her daughter's anxiety and depression. We find it meaningful that a mother's experiences rather than her attitudes drove the models that predicted her daughter's mental health. Although the impact is modest at 7.7% to 9.9% of variance accounted for, this finding seems eerily consistent with findings on the intergenerational transmission of trauma that document how the trauma experiences of a parent can be evident in their child's mental health (e.g., Schickedanz, 2020). A mother's experiences with gender microaggressions could shape how she parents, especially around her daughter's gendered socialization. Although some might balk at equating gender microaggressions with trauma, there is literature pointing to that very connection (Bryant-Davis, 2018) in ways that are extremely relevant to gender microaggressions for both their chronicity and their potential acuity. Further research to understand the nature of



mothers' experienced microaggressions could help elucidate the nature of their impact on daughter's mental health.

The importance of what our data explain about adolescents' and women's experiences of microaggressions cannot be understated. For those who claim that sexism is in the past, this study provides another piece of evidence demonstrating the true burden of overt and covert sexism on the lives of women. Currently, on any day in the United States, one can turn on a news station and hear about workplace sexual harassment, unwanted sexual advances by coworkers of power, or sexual objectification of women in the media. These issues are vastly important to the population represented by our sample, due to women older than 35 beginning to speak out about past experiences of sexual harassment, often that they started experiencing in adolescence. A point could also be made that internalized oppression against women is still highly prevalent. In our study, many women endorsed benevolent sexism ideas such as "women should be cherished and protected by men." Furthermore, many women in the United States publicly display internalized sexism by vouching for and voting for an elected official who publicly bragged about sexual assault. To put it simply, the items being investigated here are alive and well, and could be causing great harm to women.

### **Limitations and future directions**

This study has limitations. The gender-based microaggression measure has not been widely used, and there is limited information on its validity and reliability across samples. Participants in the study were recruited through a Qualtrics marketing panel that may not represent the general U.S. population (see Stewart et al., 2015). Although the sample was adequate to test the hypotheses, it did not include a representative number of women of various racial/ethnic groups or sexual orientations. Thus, our findings may be most generalizable to White, heterosexual, and

Christian/Catholic mothers and daughters. Research is needed to understand the experiences of mothers and daughters with greater intersectionality (e.g., race, ethnicity, sexual orientation, socioeconomic status). Future research should examine the impact of gender-based microaggressions on mother–daughter dyads using larger samples and methods such as structural equation modeling to account for multivariate relationship between intercorrelated variables (Loehlin & Beaujean, 2016).

This study highlights the work that stills needs to be done in prospective research to understand the impact of gender-based microaggression on the health of adolescents and adult women. Future studies could experimentally manipulate conditions in which women experience a gender-based microaggression and evaluate mental health distress before and after to establish causality. Researchers could further observe the interactions between mothers and daughters following experimental stimuli. For example, what impact might a mother’s response or advice about handling microaggressions have on her daughters’ mental health outcomes? Another future direction for this research would be to examine whether microaggressions are experienced during earlier developmental periods (middle school or elementary age).

## **Conclusion**

Our findings begin to unravel the extremely complex relationship that exists between mothers and their teenage daughters in the context of common experiences of sexism, specifically in the realm of gender-based microaggressions, internalized oppression, and mental health. The current study highlighted that covert sexism and internalized oppression, issues that women have been experiencing for centuries, are still occurring in the lives of women today. Previous literature focused on young adult women experiencing gender-based microaggressions, and the current study expands these findings to mother–daughter dyads. The relationship between adolescent

daughters and their mothers was related with experiences of microaggressions, levels of internalized sexism, and anxiety/depression symptoms all being correlated between dyads. Mother–daughter relationships may be a good intervention area for these societal and personal issues.

## **Implications**

Findings have implications for individual, community, and social interventions. It appears that internalizing sexism might be an important consideration when examining the factors that cause and maintain depression and anxiety. Indeed, the examination of external factors grounded in sexism are already present in feminist theory and intervention (Brown, 2018). In addition to this conceptualization, it may be valuable to incorporate psychoeducation on microintervention (Sue et al., 2019) strategies. Indeed, there is evidence that active coping, such as that offered by microintervention approaches, can mitigate the impact of microaggressions on stress (Torres et al., 2010). In addition to these treatment considerations, it may be relevant for therapists working within family systems to address gender-based microaggressions as contextual stressors that mother and daughters both experience and that may play a role in their relationship. The internalized oppressions that women carry have been known to cause disruptions in relationships between women (Bearman et al., 2009; Pheterson, 1986). In addition to addressing the within-family intergenerational impact of gender-based microaggressions, these findings support broader efforts to address these issues in work, social, and other settings (Uzzi, 2019). Gender-based microaggressions are commonplace in our society. Their impact is felt within individuals and family systems and disrupts mental health.

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**Table 1** Demographic characteristics of mothers and daughters in the sample

	Mothers ( <i>n</i> = 102)		Daughters ( <i>n</i> = 102)	
	<i>n</i>	%	<i>n</i>	%
Ethnicity				
American Indian	0	0.0	1	1.0
Asian	1	1.0	1	1.0
Black	7	6.9	9	8.8
Latinx	7	6.9	8	7.8
White	86	84.3	82	80.4
Other	1	1.0	1	1.0
Religion				
Agnostic	6	5.9	8	7.8
Atheist	2	2.0	3	2.9
Buddhist	2	2.0	1	1.0
Catholic	31	30.4	31	30.4
Christian	44	43.1	43	42.2
Lutheran	1	1.0	1	1.0
Methodist	4	3.9	5	4.9
Mormon	3	2.9	3	2.9
Pagan	1	1.0	1	1.0
Presbyterian	4	3.9	1	1.0
Sexual orientation				
Heterosexual	100	98.0	94	92.2

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Gay or lesbian	1	1.0	0	0.0
Bisexual	1	1.0	5	4.9
Pansexual	0	0.0	1	1.0
Asexual	0	0.0	1	1.0
Questioning	0	0.0	1	1.0
Social class				
Poor	12	11.8	14	13.7
Working class	32	31.4	31	30.4
Middle class	57	55.9	53	52.0
Affluent	1	1.0	4	3.9
Geographic region				
Midwest	27	26.5	27	26.5
Northeast	19	18.6	19	18.6
South	36	35.3	36	35.3
Relationship status				
In a relationship	83	81.4	24	23.5
Not in a relationship	19	18.6	78	76.5

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**TABLE 2** Means, standard deviations, and paired-sample *t* tests for main variables

Variables	<i>N</i>	<i>M</i>	<i>SD</i>	Min	Max	Range	<i>t</i> values
ASI Total							$t(99) = 1.171, p = .245$
Mothers	102	79.11	15.92	27.00	106.00	79.00	
Daughter	100	77.79	16.13	36.00	107.00	71.00	
ASI Hostile							$t(99) = 0.641, p = .523$
Mothers	102	37.40	10.79	9.00	61.00	52.00	
Daughter	100	37.05	10.76	11.00	64.00	53.00	
ASI Benevolent							$t(99) = 1.253, p = .213$
Mothers	102	41.71	9.14	17.00	60.00	43.00	
Daughter	100	40.74	10.45	11.00	61.00	50.00	
MA past month							$t(99) = -1.590, p = .115$
Mothers	102	58.25	37.57	0.00	148.00	148.00	
Daughter	100	63.79	43.08	0.00	156.00	156.00	
MA past year							$t(98) = -2.306, p = .023$
Mothers	102	34.00	33.51	0.00	130.00	130.00	
Daughter	99	39.53	35.66	0.00	129.00	129.00	
PHQ-9							$t(101) = 3.458, p = .001$
Mothers	102	6.58	7.72	0.00	27.00	27.00	
Daughter	102	4.29	6.41	0.00	24.00	24.00	
GAD-7							$t(101) = 2.942, p = .004$
Mothers	102	5.20	6.67	0.00	21.00	21.00	
Daughter	102	3.48	5.20	0.00	21.00	21.00	

*Note.* ASI = Ambivalent Sexism Inventory; GAD-7 = Generalized Anxiety Disorder Scale; MA = microaggressions; PHQ-9 = Patient Health Questionnaire—9.



**TABLE 3** Correlations and intercorrelations between primary variables for mothers and daughters

Variables	ASI:T	ASI:H	ASI:B	MA:m	MA:y	PHQ-9	GAD
ASI:T	<b>.661**</b>	.768**	.752**	.049	.138	.151	.143
ASI:H	.833**	<b>.701**</b>	.156	.243*	.257*	.189	.158
ASI:B	.758**	.271**	<b>.671**</b>	-0.174	-0.047	.039	.057
MA:m	.220*	.204*	.143	<b>.679**</b>	.812**	.487**	.485**
MA:y	.166	.150	.111	.814**	<b>.736**</b>	.560**	.549**
PHQ-9	.137	.199*	.004	.428**	.408**	<b>.568**</b>	.927**
GAD	.163	.216*	.029	.407**	.330**	.925**	<b>.531**</b>

*Note.* The correlations below the midline are the correlations between variables for mothers. The correlations above the midline are the correlations between variables for daughters. The correlations at the midline are the correlations between mothers and daughters on each predictor or outcome. ASI = Ambivalent Sexism Inventory; ASI:T = ASI Total Score; ASI:H = ASI: Hostile Sexism; ASI:B = ASI: Benevolent Sexism; MA:m = Microaggressions: last month; MA:y = Microaggressions: past year; PHQ-9 = Patient Health Questionnaire; GAD-7 = Generalized Anxiety Disorder Scale.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

**TABLE 4** Summary of moderation analyses for mental health outcomes

Model	F or F			$R^2$ or $R^2$			
	change	<i>df</i>	<i>p</i>	change	Coefficient	<i>t</i>	<i>p</i>
Daughter's anxiety							
Microaggressions: past year	15.124	3, 95	<.001	.323	.017	0.361	.719
Benevolent sexism					-.244	-0.366	.715
Interaction	1.908	1, 95	.170	.014	.002	1.381	.170
Daughter's depression							
Microaggressions: past year	15.442	3, 95	<.001	.328	.042	0.711	.479
Benevolent sexism					-.021	-0.256	.798
Interaction	1.122	1, 95	.292	.008	.001	1.059	.292
Mother's anxiety							
Microaggressions: past year	4.322	3, 98	.007	.117	-.012	-0.140	.889
Benevolent sexism					-.068	-0.701	.485
Interaction	0.848	1, 98	.359	.008	.002	0.921	.359
Mother's depression							

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Microaggressions: past year	8.131	3, 98	<.001	.200	-.086	-0.899	.371
Benevolent sexism					-.179	-1.681	.096
Interaction	3.761	1, 98	.055	.031	.004	1.940	.055

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**TABLE 5** Multiple regression models predicting daughter’s mental health through mother’s internalizing sexism and experiences of gender-based microaggression

Model	Variables	$\beta$	<i>SE</i>	Beta	<i>t</i> value	<i>p</i> value
Anxiety through mother’s total ASI score <sup>b</sup>	Constant	−0.756	2.496		−0.303	0.763
	ASI total	0.021	0.032	0.064	0.656	0.513
	MA <sup>a</sup>	0.045	0.013	0.322	3.330	0.001
Anxiety through mother’s Benevolent Sexism <sup>c</sup>	Constant	−0.083	2.337		−0.036	0.972
	ASI benevolent	0.022	0.054	0.038	0.396	0.693
	MA <sup>a</sup>	0.046	0.013	0.331	3.464	0.001
Anxiety through mother’s Hostile Sexism <sup>d</sup>	Constant	−0.215	1.819		−0.118	0.906
	ASI hostile	0.029	0.046	0.060	0.625	0.534
	MA <sup>a</sup>	0.045	0.013	0.324	3.358	0.001
Depression through Mother’s total ASI score <sup>e</sup>	Constant	−1.814	3.100		−0.585	0.560
	ASI total	0.041	0.039	0.103	1.058	0.293
	MA <sup>a</sup>	0.049	0.017	0.284	2.917	0.004
Depression through Mother’s benevolent Sexism <sup>f</sup>	Constant	−0.754	2.906		−0.260	0.796
	ASI benevolent	0.050	0.068	0.072	0.746	0.458
	MA <sup>a</sup>	0.051	0.016	0.297	3.081	0.003
Depression through mother’s hostile sexism <sup>g</sup>	Constant	−0.550	2.262		−0.243	0.808
	ASI hostile	0.053	0.058	.089	0.913	0.363
	MA <sup>a</sup>	0.049	0.017	.289	2.970	0.004

*Note. Note.* ASI = Ambivalent Sexism Inventory; MA = microaggressions.

<sup>a</sup>Past year. <sup>b</sup> $R = 0.342$ ,  $R^2 = 0.117$ , adjusted  $R^2 = 0.099$ . <sup>c</sup> $R = 0.338$ ,  $R^2 = 0.115$ , adjusted  $R^2 = 0.09$ . <sup>d</sup> $R = 0.342$ ,  $R^2 = 0.117$ , adjusted  $R^2 = 0.099$ . <sup>e</sup> $R = 0.323$ ,  $R^2 = 0.104$ , adjusted  $R^2 = 0.086$ . <sup>f</sup> $R = 0.315$ ,  $R^2 = 0.099$ , adjusted  $R^2 = 0.081$ . <sup>g</sup> $R = 0.319$ ,  $R^2 = 0.102$ , adjusted  $R^2 = 0.084$ .