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Sexist Microaggressions: Traumatic Stressors Mediated by Self-Compassion Ψ

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Abstract

Women regularly endure sexist microaggressions, which are often associated with anger, depression, anxiety, low self-esteem, and trauma. The cumulative effects of sexist microaggressions may result in internalized sexism and undermine self-compassion. Notably, prolonged exposure to sexism is associated with trauma symptoms; however, the traumatic effects of sexist microaggressions have remained largely theoretical. Thus, we examined the role of sexist microaggressions as a traumatic stressor and evaluated self-compassion and internalized misogyny as mediators of sexism-based traumatic stress. With a sample of 370 adult cisgender women, results suggested that sexist microaggressions significantly and positively predicted trauma symptomology, and that this relationship was partially mediated by self-compassion but not internalized misogyny. Results supported sexism as a traumatic stressor, and low self-compassion as a mechanism through which sexist microaggressions result in traumatic stress. We discuss implications for research and practice.

Keywords

microaggressions, sexism, trauma, self-compassion

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Significance of the Scholarship to the Public
This study highlights the traumatic effects of sexism on cisgender women, as well as factors (such as self-compassion) that may lessen or worsen such effects. Better understanding of the effects of sexism, as well as intermediary factors, may help inform preventative efforts as well as psychotherapy treatment for cisgender women.

Disparities in the treatment of women continue to be a problem in the United States (Sue, 2010), largely because of a specific form of oppression known as sexism. *Oppression* occurs when a group possesses greater access to power and privilege than another group, and when said inequity is used to uphold the dominance of the more powerful group over the other (David, 2014). Sexism is a form of oppression in which individual and systemic manifestations of prejudices, attitudes, and behaviors are intended to promote and maintain male dominance while suppressing women through socially, politically, and economically exploitative means (Hunnicutt, 2009). The present study examines these oppressive forces and their psychological effects on women through the lens of sexist microaggressions (Nadal, 2010) that encapsulate contemporary manifestations of sexism. Prior literature has used the term gender microaggressions; however, we intentionally use the term sexist microaggressions to clarify our focus on one aspect of the gender spectrum, to avoid conflating sexism with cisgenderism, and to directly link such microaggressions with sexism.

Sexist microaggressions may be defined as "brief and commonplace daily verbal, behavioral, or environmental indignities (intentional or unintentional) that communicate hostile, derogatory, or negative sexist slights and insults toward women" (Nadal, 2010, p. 158). Sue (2010) described three forms of microaggressions: microassaults (blatant, intentional discriminatory attacks that may be verbal, nonverbal, or environmental), microinvalidations (subtle, demeaning messages conveying the target's assumed inferiority), and microinsults (slights in the form of negating, nullifying, or excluding targets and their experiential realities; Sue, 2010). In addition to these three forms, sexist microaggressions are further delineated into eight themes: leaving gender at the door, sexual objectification, environmental invalidations, invalidating women's realities, denial of sexism, assumptions of traditional gender roles, expectations of appearance, and assumptions of inferiority (see Derthick, 2015). As noted by Sue (2010), sexist microaggressions have increased in prevalence as changes in social norms have led to significant social sanctions against more overt forms of sexism. Examining

these themes in sexist microaggressions provides an adequate picture of the breadth and depth of contemporary sexism. For example, sexist microassaults are evident in the recent resurgence in overt sexism seen in conjunction with the sexist behavior of, and support for, President Trump during his campaign and presidency (Schaffner et al., 2018).

Furthermore, campaigns like the #MeToo movement have exposed rampant sexual harassment and exploitation (Kearl, 2018) and demonstrate the timeliness and relevance of the present study. Simultaneous to the #MeToo movement, attempts by its critics to undermine the voices and experiences of victimized women exemplifies microinsults and microinvalidations. Even a cursory review of the extant literature provides a plethora of societal and individual examples of sex-based oppression. For example, women frequently endure unwanted sexual contact and/or physical abuse (see Breiding, 2015). In politics, academia, and the workplace, women have their competence doubted, authority challenged, experiences of ill-treatment invalidated, and are arbitrarily barred from positions of power (Sue, 2010). Meanwhile, media satirizes sexual harassment and denigrates women with objectification (Swim et al., 2001). Each of these commonplace occurrences are an instance of sexist microaggressions. Repeated exposure to these and other sexist microaggressions disadvantage women, erode women's rights and social status, and negatively impact societal treatment and views of women. Thus, it is important to understand sexist microaggressions, how they affect women, and how to address them.

Manifestation and Mental Health Effects of Sexism

Daily sexist microaggressions immerse women in a sea of discriminatory messages causing an accumulative strain that can lead to negative effects on mental health, self-esteem, identity, performance, and physical health outcomes (Sue, 2010). Research on oppression (e.g., racism, sexism, hetrosexism) has examined the traumatic effects that prolonged exposure to oppression has on the oppressed (e.g., Carter, 2007; Kira et al., 2015). According to trauma theory, trauma occurs when there are sudden, uncontrollable, negative experiences followed by a common set of symptoms, including distortions in beliefs about, and attitudes toward the self (van der Kolk et al., 1996). Given that, in accordance with trauma theory, sexist microaggressions degrade women's perceptions and beliefs about other women, as well as their own personal worth and value, it is hypothesized that sexist microaggression may constitute a traumatic stressor.

The present study proposed two mediating constructs (internalized misogyny and self-compassion), which are thought to capture these cognitive shifts,

and subsequently explain the relationship between sexist microaggression and trauma symptoms. *Internalized misogyny*, defined as women promoting male dominance or the devaluation of women through acts of horizontal oppression against other women (Piggot, 2004), represents internalized oppression, which has been argued to be the most harmful psychological effect of oppression (Speight, 2007). On the other hand, *self-compassion*, defined as warmly connecting with one's suffering from an understanding view (Neff, 2003), was selected because it represents the deep sense of unconditional worth and well-being that sexism works to erode (Leary & MacDonald, 2003).

Sexist trauma may be directly linked to traumatic stress, decreased self-compassion, and increased internalized misogyny, and may indirectly contribute to sexism-based traumatic stress (SBTS). The aim of our study was to assess the relationship between sexist microaggressions and SBTS, and identify mechanisms through which they act. We proposed that sexist microaggressions are related to trauma symptoms, and that part of this relationship is accounted for by the extent to which women experience changes in their sense of worth, measured by self-compassion, and attitudes about women, measured by internalized misogyny. Therefore, we tested a model of the relationship between sexist microaggressions and SBTS mediated by self-compassion and internalized misogyny.

Sexism-Based Trauma

SBTS is a form of identity-based trauma in which exposure to sex-based oppression produces trauma symptoms. Notably, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) definition of trauma overlooks nonimminently life-threatening traumatic stressors. However, supporting SBTS as a construct, theorists have suggested that beyond life-threatening events, trauma results from sudden, uncontrollable, complex painful experiences that profoundly distort one's self-concept and result in a common set of symptoms (see Carter, 2007). Research has demonstrated that the prevalence of full and partial posttraumatic stress disorder (PTSD) is higher among women than men and that the differences cannot fully be explained by contextual factors, such as rates of sexual assault, prior depression or anxiety disorders, and sex-related symptom reporting biases (Pietrzak et al., 2011). Thus, SBTS may provide an explanation for some of the sex-related differences in PTSD prevalence (Moradi & Subich, 2002). Additionally, by understanding the relationship between sexist microaggressions and posttraumatic stress, PTSD that may otherwise go un- or misdiagnosed may be more accurately identified and treated, which could ameliorate some of the psychological, physical, and economic costs of

improperly managed PTSD (Davidson, 2000). Although there is limited extant literature outlining why the relationship between sexism and trauma exists, Kira (2001) proposed a model explaining how identity-based traumas can have serious and enduring negative consequences due to their insidious, pervasive, and personal nature (Kira et al., 2015).

A Mediated Model of SBTS

Kira et al. (2015) theorized that individuals affected by identity-based traumas often internalize discriminatory messages, adopt the demeaned persona, and legitimize experiences of discrimination, which can contribute to feelings of worthlessness and/or self-loathing. The authors found a significant relationship between gender discrimination and trauma symptoms; further, this relationship was partially and significantly mediated by changes in self-esteem, self-efficacy, and self-concept. Unfortunately, Kira et al.'s (2015) model was hindered by theoretical and methodological limitations. For example, they claimed to be assessing self-concept per Core Self Evaluations (CSE) theory (Judge et al., 1997), but only used the two most intercorrelated factors (i.e., self-esteem and self-efficacy; $r = .86$) of the four original CSE aggregate factors (Johnson et al., 2008). Additionally, they formed an internalized gender discrimination subscale using four cumbersome items with low internal consistency (.60). The final model contained several unexplained correlated error variances, which may evidence indiscriminate model respecification to improve model fit (Byrne, 2010). This increases the parameters to be estimated, which risks an overfitted model and can result in unstable effects, significant standard error inflation, and equivocal alterations to primary parameters (Byrne, 2010). As such, a different approach to modeling the traumatic effects of sexist microaggressions and potential mediators is warranted.

Carter's (2007) model of race-based traumatic stress (RBTS) provides an additional theoretical lens supporting the relationship between sexist microaggression and SBTS. Carter (2007) draws from trauma theory (van der Kolk et al., 1996) to propose RBTS as a form of oppression-based trauma. It is these theoretical underpinnings that set the foundation for conceptualizing SBTS. Carter (2007) explained how racist microaggressions affect the psyche of people of color, illustrating how oppression-based trauma is derived from identity-based microaggressions. Carter's theory provides indirect support to test the sexist microaggression and SBTS hypothesis; however, to date, researchers have yet to specifically test this relationship. Carter argued that RBTS is separate from PTSD and is a unique form of psychological injury. Because of this, Carter developed a scale to assess the unique phenomena of RBTS, rather than assessing RBTS with PTSD measures. In addition to informing how we conceptualized SBTS (i.e., as

a form of psychological injury), it led us to consider forgoing using standard PTSD measures. Although Carter created an RBTS scale, it is important to not obfuscate sexism with racism and errantly appropriate a scale developed specifically to assess RBTS. Thus, in the present study we tailored existing trauma measures to assess SBTS. To address the measurement issues in the Kira model, we consulted research on potential mediators.

Self-Compassion. Self-compassion is a promising, yet understudied, construct in relation to sexism. Most studies examine the moderating or mediating effects of self-esteem in the relationship between sexism and mental health outcomes (Jones et al., 2016), yet these studies assume self-esteem is a universally desirable and stable construct, despite evidence to the contrary (Neff & Vonk, 2009). Additionally, using self-esteem as a mediator assumes self-esteem exists independently of perceived sexism, yet research suggests that experiences of sexism degrade self-esteem (Kira et al., 2015). As a mediator, self-esteem's malleability also makes it vulnerable to influences other than encounters with sexism, which can create issues with internal validity. In light of the drawbacks of self-esteem, Leary et al. (2007) argued for self-compassion as an alternative to the study of self-esteem.

Self-compassion and self-esteem are both regarded as relevant to feelings of self-worth (Neff & Vonk, 2009), but are empirically and conceptually distinct (Leary et al., 2007). Self-esteem is rooted in feeling good about oneself, based in comparative evaluation, and believing that other people value them as well; self-compassion involves noncontingent care for oneself (Leary & MacDonald, 2003), which makes it more stable, and it has stronger inverse relationships with social comparisons, public self-consciousness, self-rumination, and anger (Neff & Vonk, 2009). Self-compassion also disables the threat system and engages the self-soothing system, whereas self-esteem operates as a scale of relative supremacy and social status (Gilbert, 2005). Indeed, self-compassion predicts secure self-worth better than self-esteem and is not constrained or influenced by contingencies of worth (Neff & Vonk, 2009). Research has also found that self-compassion was positively related to women's internal sense of empowerment (Stevenson & Batts Allen, 2017). Given that sexism disempowers women, this finding supports self-compassion as a potential mediator of the relationship between sexist microaggressions and SBTS. Additionally, contemporary trauma theory posits that trauma distorts self-concept (see van der Kolk, et al., 1996), which is linked to self-compassion and further supports self-compassion as a potential mediator.

Prior research suggests that self-compassion is related to PTSD symptoms (Hoffart et al., 2015; Kearney et al. 2013; Maheux & Price, 2015; McLean et al., 2018). Looking at the relationship between DSM-5 PTSD symptoms

and self-compassion, researchers have found that self-compassion was significantly related to each of the DSM-5 PTSD symptoms (Maheux & Price, 2015). Hoffart et al. (2015) extended these findings with results suggesting that specific aspects of self-compassion (i.e., self-judgement, isolation, and over-identification) were the strongest sustaining factors of PTSD, and that increases in self-kindness were associated with reductions in trauma symptoms. Similarly, Kearney et al. (2013) found that self-compassion significantly mediated the pre- and post-treatment PTSD and depression scores of veterans in a 12-week self-compassion intervention meant to cultivate their sense of kindness and compassion toward themselves and others.

Although there is support for the relationship between self-compassion and PTSD, the relationship between sexist microaggressions and self-compassion has yet to be examined. The most proximal study examined the relationship between self-compassion and PTSD symptoms among women who had experienced interpersonal trauma (McLean et al., 2018), in which they found significant negative correlations between self-compassion and PTSD symptoms among women who had endured unwanted physical or sexual contact. Although the study offers promising results, the limitations of their statistical analysis preclude any definitive empirical conclusions. However, given that unwanted physical and sexual contact stems from the same roots of sexism as sexist microaggressions, further examination of whether self-compassion mediates the relationship between sexist microaggressions and trauma symptoms is warranted.

Internalized Misogyny. A second hypothesized pathway that may also affect self-concept is internalized misogyny. As Germer (2009) noted, "We're like fish in the water of our culture, and when the water is polluted with racism, sexism, and ageism, we draw those prejudices inside" (p. 203–204). Internalized misogyny exemplifies this point, demonstrating how sexism can manifest as a persistent internal criticism that distorts women's perspectives about themselves and other women (Stevenson & Batts Allen, 2017). Internalized misogyny involves shifts in how women view and understand themselves, their situations, and their world, and therefore can insidiously alter women's meaning-making systems. Sexism relies on political, external, and corporal methods to sew fear and internalized psychological self-debasement into women (Sue, 2010). Internalized oppression is designed to maintain the dominant system by imposing control and instilling submissiveness. This internalization is not the fault of the oppressed; rather, it is a sociocultural phenomenon of mediated action and appropriation (see Tappan, 2006). Research supports the theorized link between exposure to sexist events and internalized misogyny (Hammond et al., 2016; Szymanski et al., 2009). In the absence of proactive resistance,

women may internalize benevolently sexist views (Hammond et al., 2016), internalized misogyny, which has in turn been found to be significantly related to depression, low self-esteem (Piggot, 2004), psychological distress, and internalized objectification (Szymanski et al., 2009).

As a form of internalized oppression, internalized misogyny has important implications for the relationship between sexist microaggressions and trauma. However, internalized misogyny has yet to be examined in relation to sexist microaggressions and or traumatic stress. The most relevant study examines the relationship between internalized misogyny and general mental health outcomes (Szymanski et al., 2009). The researchers found significant results suggesting that internalized misogyny moderated the strengthen of the relationship between sexist events and psychological distress (Szymanski et al., 2009). Conceptually comparable studies examining the relationship between depression and three forms of oppression (i.e., sexual objectification, racism, and gendered racism; Carr et al., 2014) also used internalized discrimination as a mediator.

Notably, additional studies of internalized oppression, including internalized racism (Graham et al., 2016) and internalized heterosexism (Dworkin et al., 2018), also treat internalized oppression variables as mediators. Thus, research suggests that the internalization process is a form of coping strategy that mediates the relationship between minority group members' experiences of oppression and psychological distress (Szymanski & Obiri, 2011). Considering these findings, internalized oppression theory, and trauma theory, we proposed that internalized misogyny represents a distortion in women's attitudes about other women and themselves, and that this distortion mediates the relationship between sexist microaggressions and traumatic stress.

Present Study

Given that trauma has been described as a mediated process in which a stressor distorts one's self-concept and results in trauma symptoms (Kira, 2001; Kira et al., 2015), we posited that sexist microaggressions may serve as traumatic stressors. Further, we posited that self-compassion and internalized misogyny would mediate the relationship between sexist microaggressions and trauma symptomatology. A model was specified and tested wherein sexist microaggressions were hypothesized to positively relate to SBTS symptoms, and this relationship was hypothesized to be mediated by self-compassion and internalized misogyny. It was hypothesized that self-compassion would be negatively related to sexist microaggressions and SBTS, and that internalized misogyny would be positively related to sexist microaggressions and SBTS. General trauma, as well as socioeconomic status, were controlled for as covariates.

Method

Participants

An a priori power analysis suggested a minimum sample size of 168 participants. Weston and Gore (2006) recommended a minimum sample size of 200 when conducting structural equation modeling (SEM); thus, the more conservative minimum sample size of 200 was adopted. In all, 567 cisgender women were recruited via snowball sampling on social media, email, and listservs, as well as from undergraduate courses at a medium-sized southern public university. Participants missing more than 20% of scale data ($n = 195$), who did not meet the inclusion criteria ($n = 1$), or were deemed an outlier ($n = 1$) were removed. The final sample was $N = 370$.

Participants' ages ranged from 18 to 72 years old ($M_{age} = 38.64$, $SD = 15.20$). In terms of race and/or ethnicity, 81.1% of the participants identified as White ($n = 300$), 5.4% as Latina or Hispanic ($n = 20$), 5.1% as biracial or multiracial ($n = 19$), 4.3% as Black or African American ($n = 16$), 3% as Asian or Asian American ($n = 11$), 0.3% as Native American ($n = 1$), and 0.8% identified with a different identity ($n = 3$). As for sexual orientation, 88.4% identified as heterosexual ($n = 327$), 6.8% as bisexual ($n = 25$), 1.9% as gay/lesbian ($n = 7$), 1.6% as pansexual ($n = 6$), 0.8% as asexual ($n = 3$), and 0.5% as a different identity ($n = 2$). Over half (50.8%) of participants identified as Christian ($n = 118$), 21.6% did not identify with a religion ($n = 80$), 12.7% identified as Catholic ($n = 47$), 4.3% Jewish ($n = 16$), 2.4% Buddhist ($n = 9$), 0.5% Muslim ($n = 2$), 0.5% Hindu ($n = 2$), and 7% with a different religion ($n = 26$). Much of the sample (32.2%) had obtained a master's degree ($n = 119$); 19.7% were college seniors ($n = 73$), 13% attained a doctoral degree ($n = 48$), 5.9% were college sophomores ($n = 22$), 4.9% were college freshmen ($n = 18$), 4.3% were college juniors ($n = 16$), and 20% identified as "other" ($n = 74$). Participants rated their socioeconomic status (SES) using the MacArthur Scale of Subjective Social Status (Adler et al., 2000), consisting of two, 10-point Likert-type questions presented as a ladder, on which participants rated themselves relative to others in their community and to people in the United States. The scale is from 1 (*those worst off* [relative to United States] or *those with the lowest standing* [relative to community]) to 10 (*those best off* or *those with the highest standing*). Participants' average community status was 6.05 ($SD = 1.63$), approximately middle class. The self-ratings relative to the nation were nearly identical ($M = 6.02$, $SD = 1.79$).

Measures

Sexist Microaggressions. Experiences with sexist microaggressions were assessed using the Sexist Microaggression Experiences and Stress Scale (SMESS; Derthick, 2015). The SMESS is a 44-item self-report scale measuring the frequency (SMESS-F) and stressfulness (SMESS-S) of sexists microaggressions using a 4-point, Likert-type rating, with higher scores suggesting greater frequency and/or impact of sexist microaggressions; for example, "A male stranger has complimented your body." All items are rated in terms of frequency and impact. Potential scale scores range from 44 to 176 for both the SMESS-F and SMESS-S. The present study used microaggression frequency and stress appraisal total scores as indicators to estimate total sexist microaggression impact. The psychometric properties of the SMESS have been demonstrated to be adequate among North American women in collegiate and community settings (Derthick, 2015). Item factor loadings ranged from .45 to .88; α for the seven factors ranged from .65 to .89 and demonstrated good concurrent validity with the Schedule of Sexist Events (Klonoff & Landrine, 1995) and the Feminist Identity Development Scale (Bargad & Hyde, 1991). In the present study, Cronbach's α of SMESS-F and SMESS-S were .94 and .96, respectively.

Self-Compassion. Self-compassion was measured using the Self-Compassion Scale (SCS; Neff, 2003), a 26-item self-report scale that assesses six aspects of self-compassion: self-kindness, self-judgment, common humanity, mindfulness, isolation, and over-identification. It uses a 5-point, Likert-type scale; higher scores suggest greater levels of self-compassion. The SCS total score had good reliability of $\alpha = .92$. Its factor structure has been supported by multiple confirmatory factor analyses (CFAs; see Neff, 2003) and it has been used with international and U.S. gender and racially diverse samples. In the present study, the SCS total score α was .94.

Internalized Misogyny. Internalized misogyny was assessed using the Internalized Misogyny Scale (IMS; Piggot, 2004). The IMS is a 17-item self-report measure that uses a 7-point Likert-type rating, with higher scores suggestive of greater levels of internalized misogyny. In studies of international and U.S. heterosexual, lesbian, and bisexual women in collegiate and community settings, the IMS demonstrated good psychometric properties, with item factor loadings ranging from .35 to .87, good total score reliability of $\alpha = .88$, and concurrent validity with measures of depression ($r = .24$), self-esteem ($r = -.27$), modern sexism ($r = .36$), and negative body image ($r = .26$) (Piggot, 2004). In the present study, the IMS total score α was .92.

Trauma Symptomology. Trauma symptomology was assessed using a modified version of the PTSD Checklist-5 (PCL-5; Weathers, Litz, et al., 2013). The original PCL-5 is a 20-item, 5-point, Likert-type rating scale, measuring the four PTSD symptom clusters (intrusion symptoms, avoidance, negative mood and affective change, and hyperarousal). The PCL-5 total scores are obtained by adding the items; higher scores suggest elevated PTSD symptomology. In the present study, retained items were used as indicators to estimate the latent variable total SBTS and account for potential measurement error. The PCL-5 has been shown to have good reliability ($\alpha = .94$) and one-week test-retest reliability ($r = .82$), as well as good convergent and discriminant validity (see Blevins et al., 2015). A principal components analysis supported its four-factor structure with α ranging from .87 (hyperarousal) to .91 (avoidance). The scale has been widely used with U.S. and international military and civilian samples. At the time of this study there were no known scales that assessed SBTS, therefore the PCL-5 was modified to assess SBTS. The prompt of the PCL-5 was changed to assess reactions to distressing sexist events and included brief examples of sexist behavior for clarification. The original prompt read, "Below is a list of problems that people sometimes have in response to a very stressful experience." The prompt was modified for the present study to read as follows:

> Below is a list of problems that people sometimes have in response to experiencing a distressing sexist event. A sexist event could include, but is not limited to: experiencing "catcalling," unsolicited physical contact; being excluded from activities because of your sex; being told that you are too sensitive when confronting sexual harassment or a sexist joke; being told that sexism no longer exists; or receiving less acknowledgement than your male peers.

The instructions were also changed and asked participants to rate if, and to what extent, their experience(s) of sexism elicited posttraumatic stress symptoms. The original instructions read, "Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month." The instructions were modified to read as follows: "Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month specifically related to your experience(s) of sexism." An example item is: "Having strong negative feelings such as fear, horror, anger, guilt, or shame?" Given the changes to the measure, an exploratory factor analysis using principal axis factoring extraction and direct oblimin oblique rotation was performed. The

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) was .96, which suggested an adequate sample was achieved for the analysis. Bartlett's Test of Sphericity ($\chi^2(190) = 6{,}257.64$, $p < .001$) suggested that the items were suitable for data reduction. Communalities were examined first; three items did not meet the .5 communalities threshold (Tabachnick & Fidell, 2013) and were therefore removed.

The analysis was conducted again with the remaining 17 items. Sampling adequacy (KMO = .95) and Bartlett's Test of Sphericity ($\chi^2(136) = 5{,}567.63$, $p < .001$) suggested the data were still suitable for reduction. Examination of the scree-plot and eigenvalues suggested a potential two-factor structure for the modified PCL-5. Factor 1 had an eigenvalue = 10.20 and that accounted for 61.93% of the variance. Factor 2 had an eigenvalue = 1.02, exceeding the recommended value of 1, and that accounted for 7.81% of the variance. Examining the pattern matrix with a factor-loading threshold of .40, yielded 10 items for Factor 1 and 7 items for Factor 2. Both the one- and two-factor solutions for the dependent variable were assessed in the measurement model of the main analysis. Only the one-factor solution yielded reasonable fit statistics, $\chi^2[183, N = 370] = 687.51$, $p < .001$; comparative fit index (CFI) = .912; root-mean-square error of approximation (RMSEA) = .086; standardized root-mean-square residual (SRMR) = .056; adjusted goodness-of-fit index (AGFI) = .808. Therefore, in the present study, the 10 items from the one factor solution had an α of .96 and were used as indicators to estimate SBTS symptomology.

Potentially Traumatic Events. To control for general trauma, potentially traumatic events were assessed with the Life Events Checklist-5 (LEC-5; Weathers, Blake, et al., 2013). The LEC-5 is a self-report measure designed as a checklist of potentially traumatic events that may occur throughout the lifespan (Gray et al., 2004). Participants were given a list of 16 Criterion A traumatic events and one general item, and were asked to indicate for each item whether they had: experienced the trauma, witnessed it, learned about it, encountered it through their job, were unsure if it applied to them, or if it did not apply to them. Total trauma exposure scores can be computed by summing item responses or dichotomizing whether or not participants directly experienced the trauma (see Gray et al., 2004). In the present study, exposure to potentially traumatic events was dichotomized such that participants who indicated they had experienced or witnessed trauma or encountered trauma in their jobs were deemed trauma-exposed. The "learned about it" category was excluded because it is often misinterpreted, resulting in overreporting. This

approach was used to account, and statistically control, for a wide range of potentially traumatic events. Since the LEC-5 is a checklist of multiple traumatic events, it is not a unitary construct; thus, reliability could not be evaluated (Gray et al., 2004). However, the utility of the LEC-5 has been supported through good one-week test-retest reliability ($r = .82$), adequate convergent validity ($r = -.55$) with the Traumatic Life Events Questionnaire (Gray et al., 2004), and adequate convergent validity with measures of PTSD ($r = -.48$; Gray et al., 2004).

Procedure

After receiving institutional review board approval, participants were recruited to participate in an online survey via social media (e.g., Facebook) and listservs. Additionally, undergraduate instructors at a mid-sized southern public university were emailed with a request to forward the study recruitment email to their students. Professors who allowed their classes to be sampled also disseminated the study link and a brief recruitment email to their students. Professors used their discretion to determine whether they would incentivize their students with extra credit; of the students who completed the survey and were retained after data cleaning, 19 participants indicated that they were offered extra credit. After consenting to participate in the study, participants were directed to the assessments, followed by a request to refer other potential participants to the study.

Results

Preliminary Analyses

The final sample contained 370 adult cisgender women. Prior to statistical analysis, and after removing incomplete surveys, missing data were analyzed using Little's missing completely at random test ($N = 371$ prior to removal of a multivariate outlier). The results were nonsignificant, suggesting that missing data were likely missing completely at random ($\chi^2[11{,}548\ N = 371] = 11{,}518.32$, $p = .576$). Therefore, the missing data were imputed using expectation maximization (Tabachnick & Fidell, 2013); missing categorical data were estimated using expectation maximization in conjunction with an ad hoc method (Allison, 2002). In the present study, item-level mean scores on the SMESS-F ($M = 1.14$) and SMESS-S ($M = 1.17$) were comparable to those in the original study ($M = 1.09$ and

$M = 1.20$, respectively; Derthick, 2015). The mean IMS score ($M = 39.08$) was lower than the original ($M = 44.20$; Piggot, 2004), whereas the mean SCS score ($M = 18.20$) was comparable to that of the original study ($M = 17.72$; Neff, 2003). The average PCL-5 score ($M = 17.59$) was somewhat greater than in its validation study ($M = 15.42$; Blevins et al., 2015). A summary of scale means, standard deviations, α coefficients, and bivariate correlations are provided in Table 1. Outliers and influential data points were assessed using Mahalanobis Distance, Centered Leverage, and Cook's Distance. One case met the outlier criteria and was removed. Variance inflation factors and tolerance values suggested the absence of multicollinearity. Assumptions of the general linear model were tested and generally met. On a scatterplot of standardized residuals and predicted values, the plot points were generally evenly distributed, but with one flattened side, implying mild heteroscedasticity. No transformations were made so as to not significantly distort data interpretation.

Between-group differences were assessed by performing analyses of variance. Only SES relative to the U.S. population was substantial and significant ($F[1, 9] = 3.66$, $p < .001$, $r^2 = .06$). Thus, it was included as a covariate in the final model. Concomitantly, exposure to potentially traumatic events was included as a control variable to account for its relationship with participants' reported SBTS. Although general trauma exposure itself was not statistically significant ($F[1, 1] = .87$, $p = .351$, $r^2 = .00$), it was included to account for even the mildest variance in the dependent variable associated with any other potentially traumatic events.

Primary Analysis

A SEM was analyzed to estimate all of the parameters simultaneously. SEM is comprised of two major elements, the measurement model (assessed by CFA) and the structural model (assessed by path analysis; Weston & Gore, 2006). Within the measurement model, the relationships between the instruments and latent variables are estimated, whereas within the structural model, the pathways or relationships among the measured constructs are estimated. A bias-corrected bootstrap procedure, using a 95% confidence interval (CI) and 2,000 bootstrap samples, was used to assess the model viability and to determine the significance and magnitude of the hypothesized direct and indirect effects. We assessed model fit by examining chi-square, CFI, RMSEA, SRMR, and AGFI. Acceptable model fit was determined a priori, to be demonstrated by a nonsignificant chi-square statistic, CFI $\geq .95$, SRMR $\leq .08$, RMSEA $\leq .07$ (Hu & Bentler, 1999), and

Table 1. Bivariate Correlations Between Study Variables and Scale Means, Standard Deviations, and Alpha Coefficients

						M sum[a]		Scale *M*[b]		
	IMS	SMESS-F	SMESS-S	PCL-5	SBTS	*M*	*SD*	*M*	*SD*	α
SCS	−.083	−.18*	−.17*	−.31*	−.27*	78.58	18.93	18.20	4.36	.95
IMS		−.22*	−.40*	−.04	−.04	39.08	17.06	39.08	17.06	.92
SMESS-F			.85*	.46*	.44*	50.35	19.91	1.14	0.45	.94
SMESS-S				.42*	.41*	51.40	28.59	1.17	0.65	.96
PCL-5					.96*	17.59	17.19	17.59	17.19	.96
SBTS						9.71	9.70	9.71	9.70	.95

Note. IMS = Internalized Misogyny Scale; SMESS-F = Sexist Microaggression Experiences and Frequency Scale; SMESS-S = Sexist Microaggression Experiences and Stress Scale; PCL-5 = PTSD Checklist-5; SBTS = Modified PTSD Checklist-5; SCS = Self-Compassion Scale.
[a]Means of the summed subscales. [b]Means of the computed subscale scores.
*$p < .001$.

AGFI ≥ .90 (Hooper et al., 2008). Notably, however, since χ^2 and AGFI are sensitive to sample sizes, the other indices were regarded as better fit indicators (see Hooper et al., 2008).

Measurement Model. The measurement model examined the relationships between the latent variables (i.e., sexist microaggressions, internalized misogyny, self-compassion, and traumatic stress) and their indicators. To assess the measurement model fit, a CFA was conducted. The χ^2 was significant, $\chi^2(183, N = 370) = 687.51$, $p < .001$. The CFI of .91 was fair, the RMSEA of .086 was fair, the SRMR of .056 was good, and the AGFI of .808 was poor. Although SRMR was acceptable, CFI, RMSEA, and AGFI did not meet the thresholds for good fit. Post hoc analyses were conducted using modification indices (MIs) to inform potential respecification. MIs suggested adding four error covariances: PCL items 10 and 11; PCL items 6 and 7; PCL items 2 and 3; and SCS Mindfulness and SCS Judgement. A fifth MI suggesting error covariances for SCS Isolation and SCS Identification, although statistically significant, was not added due to a lack of theoretical rationale. The final measurement model (Model 4) demonstrated good overall fit (see Table 2) and all indicators had statistically significant standardized regression weights (from .64 to 1.04) and squared multiple correlations (from .42 to 1.08). Notably, the standardized regression weight for stress appraisal ($\beta = 1.079$) was greater than the one due to the aforementioned heteroscedasticity; because ad hoc adjustments would produce a spurious result, no additional changes were made (see Deegan, 1978). In total, the model was respecified four times; see Figure 1 for the final measurement model.

Structural Model. A bootstrap analysis with 2,000 samples was conducted to assess the structural model. The χ^2 coefficient was significant, $\chi^2(221) = 564.47$, $p < .001$, as expected in large samples. The CFI of .94 was adequate, RMSEA of .06 was good, SRMR of .07 was good, and AGFI of .85 was fair. Taken together, the indices suggest adequate model fit.

Direct Effects. After controlling for general traumatic events and SES, the magnitude and significance of the direct effects, regression weights (unstandardized and standardized), squared multiple correlations, and bootstrap confidence intervals from the structural model were assessed. All indicator regression weights, except for internalized misogyny to SBTS and general trauma (LEC-5) to SBTS, were significant (see Figure 2). Squared multiple correlations were calculated to determine how much variance the predictors accounted for in their respective endogenous variables. Five percent or more of variance accounted for

Table 2. Measurement Model Specification and Fit Indices

Model	Comparison model	χ^2	*df*	CFI	RMSEA	SRMR	AGFI	Δdf	$\Delta\chi^2$	ΔCFI
Baseline	—	687.51	183	.912	.086	.056	.808	—	—	—
Model 1	Baseline	634.18	182	.921	.082	.056	.818	1	−53.33*	.009
Model 2	Model 1	550.33	181	.936	.074	.056	.836	1	−83.85*	.015
Model 3	Model 2	514.72	180	.942	.071	.056	.844	1	−35.62*	.006
Model 4	Model 3	485.86	179	.947	.068	.055	.854	1	−28.86*	.005

Note. CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation; SRMR = Standardized Root Mean Square Residual; AGFI = Adjusted Goodness of Fit Index.
*$p < .001$.

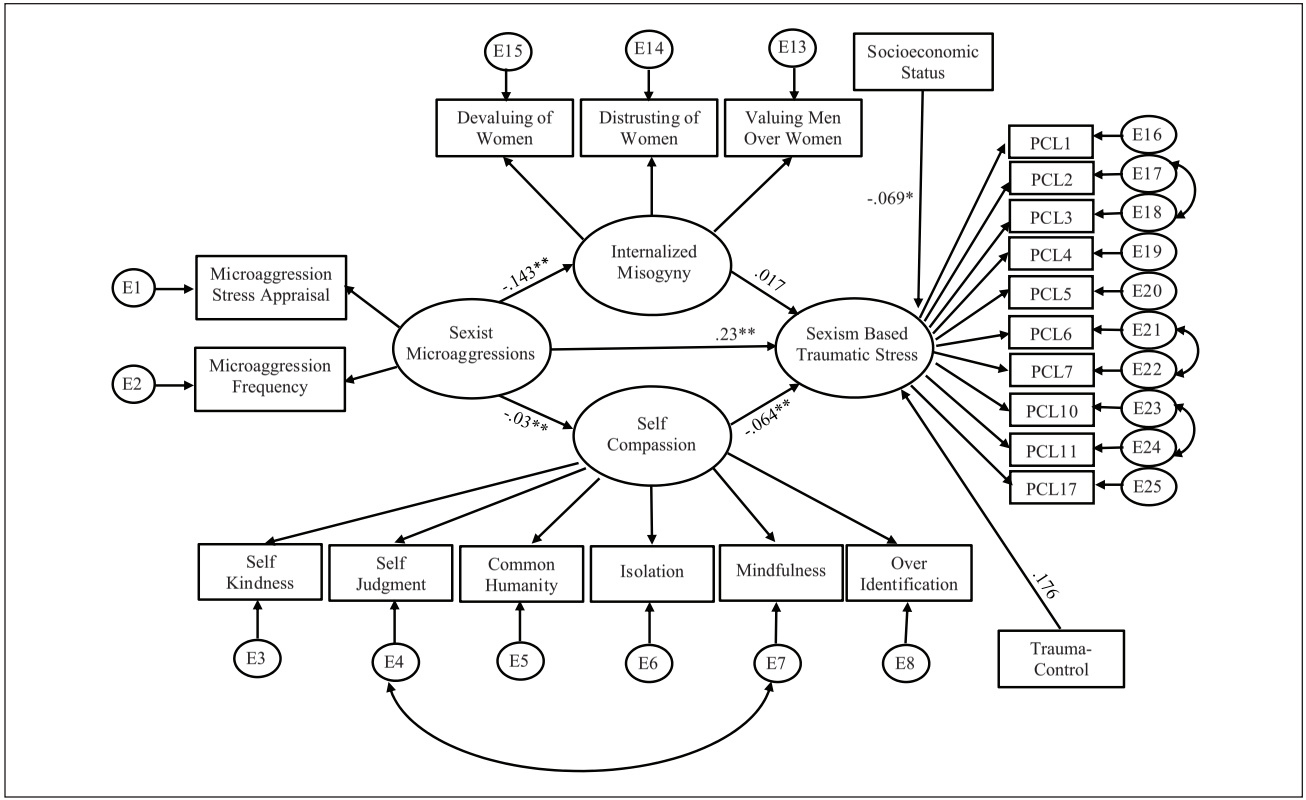

Figure 1. Final respecified measurement model examining the relationships between the latent variables and their indicators.

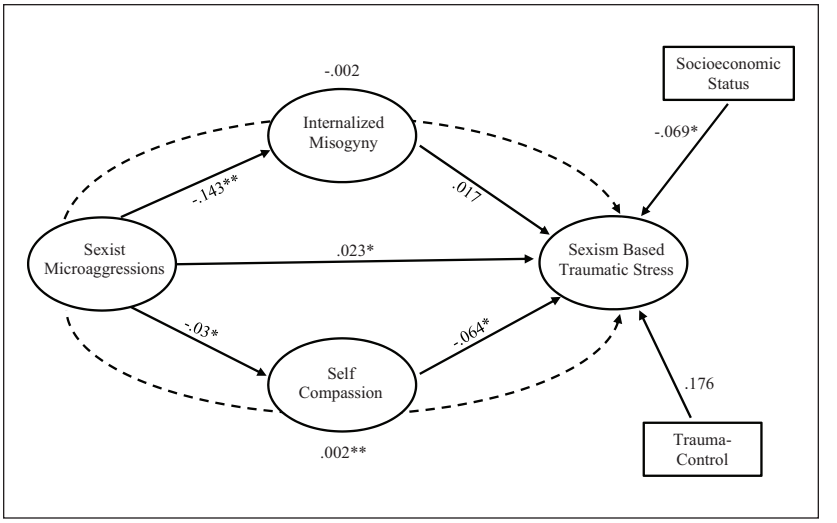

Figure 2. Structural model of mediation.
[a]Values are based on bootstrap unstandardized standard errors. [b]Dashed lines represent indirect effects.
*$p < .01$. **$p < .001$.

is generally considered to be substantial (Tabachnick & Fidell, 2013). Squared multiple correlations ranged from .031 to .226. Only the relationship between self-compassion and sexist microaggressions was insubstantial.

The strongest direct effect was between sexist microaggressions and internalized misogyny ($B = -.143$, SE = .019, $\beta = -.475$, $p < .001$, 95% CI for B [−.179, −.104]). The SMESS accounted for 22.6% ($r^2 = .226$) of the variance in internalized misogyny. The direct effect between sexist microaggressions and SBTS had the next strongest direct effects ($B = .023$, SE = .005, $\beta = .374$, $p < .001$, 95% CI for B[.012, .031]). Together, the SMESS, IMS, and SCS accounted for 18.9% ($r^2 = .189$) of the variance in the modified PCL-5. The pathway between self-compassion and SBTS demonstrated the third-largest beta coefficient ($B = -.064$, SE = .023, $\beta = -.2181$, $p < .001$, 95% CI for B[−.112, −.022]). The specific variance in SBTS accounted for by self-compassion could not be determined, as it could not be isolated in the model from the other predictors. The relationship between sexist microaggressions and self-compassion was fourth highest ($B = -.03$, SE = .009, $\beta = -.176$, $p < .001$, 95% CI for B[−.048, −.011]). The SMESS accounted for 3.1% ($r^2 = .031$) of the variance in self-

compassion. The pathway between internalized misogyny and SBTS was not statistically significant and had the smallest beta coefficient ($B = .017$, SE = .015, $\beta = .084$, $p = .267$, 95% CI for B[−.014, .045]). As with self-compassion, the IMS could not be isolated to determine the specific variance it accounted for in SBTS. Lastly, SES was significantly related to SBTS, such that lower SES was associated with higher reported SBTS, $B = -.069$, $SE = .032$, $p < .001$, $\beta = -.127$, 95% CI for B[−.133, −.010].

Indirect Effects. Because the model included two mediators, phantom modeling was used to specify indirect effects. Phantom modeling is used for estimating specific effects of pathways in SEM that otherwise could not be measured (Macho & Ledermann, 2011), using latent variables to create specific effects that are examined as total effects. This approach forces SEM programs to estimate specific indirect effects when there are multiple mediators. Additionally, since the parameters are all constrained, the overall model is not affected by the phantom pathways. Phantom modeling cannot calculate standardized indirect effects; therefore, the unstandardized values are reported (see Macho & Ledermann, 2011). The indirect effect of sexist microaggressions on SBTS through internalized misogyny was not statistically significant ($B = -.002$, SE = .002, $p = .234$, 95% CI for B[−.006, .002]). However, the indirect effect of sexist microaggressions on SBTS through self-compassion was statistically significant ($B = .002$, SE = .001, $p < .001$, 95% CI for B[.001, .004]). See Table 3 for a summary.

Hypothesized Relationships

It was hypothesized that sexist microaggressions would be significantly positively related to sexism-based trauma symptoms, and that this relationship would be significantly mediated by internalized misogyny and self-compassion. The overall model fit was adequate, and all hypothesized paths were statistically significant, except the direct effect of internalized misogyny on SBTS and the indirect effect of sexist microaggressions on SBTS through internalized misogyny. Squared multiple correlations indicated that the predictors (i.e., SMESS, IMS, and SCS) accounted for a sizeable portion of the variance in SBTS ($r^2 = .189$), supporting the main effect hypothesis. Although sexist microaggressions were significantly and substantially negatively related to both internalized misogyny and self-compassion, the negative relationship between sexist microaggressions and internalized misogyny was inverse to the directional hypothesis. Conversely, the negative relationship between sexist microaggressions and self-compassion was in the hypothesized direction.

Table 3. Structural Model Bootstrap Analysis of Statistical Significance and Magnitude of Direct and Indirect Effects

Independent variable	Mediator	Outcome	*B*	SE[a]	β	*z*	95% CI[b] (lower, upper)
SMESS		Compassion	−0.030**	0.009	−0.176	−3.527	−.048, −.011
SMESS		Misogyny	−0.143**	0.019	−0.475	−9.046	−.179, −.104
SMESS		SBTS	0.023**	0.005	0.374	6.538	.012, .031
Compassion		SBTS	−0.064**	0.023	−0.181	−3.571	−.112, −.022
Misogyny		SBTS	0.017	0.015	0.084	1.356	−.014, .045
Trauma exposure		SBTS	0.176	0.181	0.040	0.825	−.167, .547
Socioeconomic Status		SBTS	−0.069*	0.032	−0.127	−2.633	−.133, −.010
SMESS	Misogyny	SBTS	−0.002	0.002	—	—	−.006, .002
SMESS	Compassion	SBTS	0.002**	0.001	—	—	.001, .004

Note. Standardized indirect effects were unavailable with phantom modeling (Macho & Ledermann, 2011). SMESS = Sexist Microaggression Experiences and Stress Scale (Derthick, 2015); SBTS = Sexism Based Traumatic Stress.

[a]Values are based on bootstrap unstandardized standard errors. [b]Bootstrap confidence intervals based on unstandardized regression coefficients. *$p < .01$. **$p < .001$.

Internalized misogyny was not significantly related to SBTS, which did not support the hypothesized relationship. However, self-compassion was significantly positively related to SBTS, consistent with the hypothesis. Only one mediation hypothesis was supported, the path between sexist microaggressions and SBTS through self-compassion was significant. However, the path between sexist microaggressions and SBTS through internalized misogyny was not significant, suggesting that internalized misogyny did not mediate the relationship. These results partially support the hypothesized model: sexist microaggressions were positively related to SBTS, which was partially mediated by self-compassion but not internalized misogyny.

Discussion

The present study sought to examine sexist microaggressions as a traumatic stressor and evaluate the mediating role of internalized misogyny and self-compassion on SBTS. As hypothesized, women who reported experiencing more sexist microaggressions reported higher levels of SBTS. Not only were sexist microaggressions related to lower self-compassion, those lower in self-compassion reported greater SBTS. Further, self-compassion mediated the relationship between sexist microaggressions and SBTS. This finding was not only consistent with trauma theory, it also added empirical support for sexist microaggressions as a traumatic stressor that may be buffered by self-compassion.

Sexist microaggressions indeed appear to serve as one form of oppression-based trauma that results in trauma symptomology. That self-compassion mediates the relationship between sexist microaggressions and trauma symptomology, is consistent with the notion that changes in self-regard as a result of traumatic stressors are partially responsible for subsequent trauma symptomology. In the present study, although sexist microaggressions were related to trauma symptomology, participants' self-compassion partially accounted for this relationship. Altogether, our results lend broad support to the theory of oppression-based trauma: experiencing oppression may result in trauma symptomology, and this trauma symptomology occurs at least in part, due to the effects of oppression on the self-regard of the oppressed.

Contrary to the hypothesis, those who reported more sexist microaggressions reported less internalized misogyny; internalized misogyny was not related to SBTS; and internalized misogyny did not mediate the relationship between sexist microaggressions and SBTS. One explanation is that internalized misogyny may mask the perceptibility of sexist microaggressions. For example, women who are more aware of sexist microaggressions may perceive and report more sexist microaggressions, and possess less internalized

misogyny, which is consistent with the feminist identity development (FID) model (Downing & Roush, 1985). Research on perceived sexist events have found that, as FID progressed, awareness and reporting of sexist experiences increased. It is possible that participants with greater FID were also lower in internalized misogyny and would more readily report sexist events (Moradi & Subich, 2002). Additionally, it is possible that, regardless of the level of internalized misogyny, perceived sexist microaggressions are related to SBTS. This interpretation accounts for the insignificant mediation effect as well.

Another possibility, particularly given the unexpected, inverse relationship between internalized misogyny and sexist microaggressions, is that internalized misogyny may be a moderator rather than a mediator. Internalized misogyny as a moderator would be consistent with the FID model. Specifically, it is possible that women who are farther along in FID may both perceive more sexist microaggressions and have lower internalized misogyny (consistent with the results of the present study); women who are less progressed in FID may perceive fewer microaggressions and be higher in internalized misogyny; and, internalized misogyny as an indicator of FID may result in a different relationship between perceived (and thus reported) sexist microaggressions and SBTS. Overall, the results partially supported the proposed model of SBTS. As such, the present study provides a foundation for future research to further examine how other constructs, such as FID, may influence the relationship between self-compassion, internalized misogyny, and SBTS.

Strengths and Limitations

The present study had several strengths. It explicitly examined and supported the relationship between sexist microaggressions and trauma symptoms, a relationship previously implied but untested, while also controlling for the influence of SES and general potentially traumatic events. The sample was large and demonstrated some diversity, increasing the external validity of the findings. Further, the modified PCL-5 allowed for a specific focus on SBTS. The present study adds to the foundation for a theoretically and empirically tenable model of SBTS that elucidates the deleterious effects of the systemic oppression of women. The model also shows that sexist microaggressions may undermine self-compassion and subsequently foster SBTS. Trauma is often defined in terms of Criterion A of the PTSD diagnosis in the DSM-5 (American Psychiatric Association, 2013), which is to say, directly experiencing or witnessing a discrete traumatic event characterized by threat to life or of injury or violence, having a close friend or relative experience a discrete traumatic event, or chronic exposure to this type of

trauma such as in the case of first responders. Notably, the present study theoretically and empirically elucidates trauma criterion A's limitations by finding that trauma symptoms occur beyond the contexts for which it accounts. The use of SEM is a strength as well, as the relationships between the constructs were estimated while accounting for measurement error, improving internal and statistical conclusion validity. High αs for the study's measures increased the internal validity.

There were also some limitations. As an ex post facto design, causality could not be established. Study design limitations also included self-report, mono-method, and mono-operation biases, which may threaten the internal validity of the study. Additionally, the study sample was somewhat homogenous and primarily composed of White, heterosexual, upper-middle class, educated, Christian-identified women, which could have limited the variance in scores. Further, participants' average age and level of education may have particularly influenced internalized misogyny scores. Future research should recruit more heterogeneous samples to increase generalizability. It is also possible that by bringing sexism to the foreground of social consciousness, the resurgence of sexist microassaults and subsequent media coverage, may have dampened the internalized misogyny scores. Sexist microaggressions were estimated with only two indicators, at least three indicators per latent variable is generally recommended. As well, sexist microaggressions are only one of many ways to conceptualize sexism as a whole. Thus, the traumatic effects of sexism at large are not fully represented by the present study. This is coupled with limitations to the SMESS measure, which, though promising, has yet to undergo extensive CFA. A third measurement limitation is the lack of a specific measure of SBTS. At the time of this study, no scales existed that specifically examined the traumatic effects of sexism. Although this issue was mitigated by modifying the PCL-5, it will be important to develop a more directly applicable way to measure SBTS.

Implications for Practice, Advocacy, Education/Training, and Research

Practice. Results of the present study highlight the importance of conceptualizing sexism-based trauma, as well as the importance of self-compassion interventions in the treatment of sexism-based trauma. Trauma theory proposes that prolonged exposure to oppression has traumatic effects on the targets of oppression (Carter, 2007). The present study suggests that sexist microaggressions may indeed function as traumatic stressors for women and may at least partially account for PTSD symptomology. Thus, when women

present with trauma symptoms but do not meet Criterion A, clinicians may consider assessing clients' experiences of sexist microaggressions. Understanding SBTS can inform PTSD interventions and aid in adapting them to women's unique needs while ameliorating some of the psychological, physical, and economic costs of previously unaddressed PTSD. Self-compassion interventions are particularly important given the results of the present study, which attend to the distortions in self-regard that are associated with prolonged exposure to sexist microaggressions.

The present study also suggests that therapists should consider that internalized misogyny may influence the degree to which clients perceive sexist microaggressions; and, further, that sexist microaggressions may still have deleterious effects on women even when they are outside of awareness. In addition to Moradi and Subich's (2002) aforementioned results, our results suggest the possibility that women who experience higher internalized misogyny perceive less sexist microaggressions, but still experience residual psychological distress from them. Thus, in addition to self-compassion interventions, it may be important to provide awareness-building and empowerment-focused interventions through multiple modalities, such as individual therapy, group therapy, and outreach. Such interventions should take into consideration that individuals' unique intersectional positionalities may have differing implications for the relationship between sexist microaggressions and SBTS, as well as the mediating role of self-compassion.

Advocacy. Given the deleterious mental health effects of sexist microaggressions as demonstrated in the present study, advocacy related to the prevention of sexist microaggressions, interventions when microaggressions occur, and the early recognition of SBTS are of particular importance. For example, advocacy for the inclusion of teaching about microaggressions (and microinterventions) in K–12 and postsecondary curricula may not only reduce the frequency and severity of microaggressions, but may also increase the likelihood of bystander intervention as well as recognition of the effects of microaggressions. Further, advocacy for such psychoeducation is important outside of classroom settings such as in community settings, business, and in the media.

Beyond simply educating about microaggressions, advocating for the inclusion of microinterventions (Sue et al., 2019) into curricula and elsewhere would help to provide bystanders with tangible knowledge and skills with which to intervene when sexist (or other) microaggressions occur. Sue et al. (2019) define microinterventions as "the everyday words or deeds, whether intentional or unintentional, that communicates to targets of

microaggressions (a) validation of their experiential reality, (b) value as a person, (c) affirmation of their racial or group identity, (d) support and encouragement, and (e) reassurance that they are not alone" (p. 134; see Sue et al., 2019). Within the mental health fields, it is also critical that psychologists advocate for more appropriate conceptualizations of trauma. As previously noted, our nosological understanding of trauma (and the criteria for PTSD) is overly simplistic and often does not account for the myriad traumatic stressors experienced by members of marginalized groups, including sexist microaggressions. This limits the appropriate diagnosis and, thus, treatment, of trauma symptomology and PTSD. Given empirical evidence for the relationship between oppression and trauma, including the results of the present study, it is clear that we must advocate for a better, more complete understanding of trauma-related diagnoses.

Education and Training. The results of the present study highlight the role of sexist microaggressions as a traumatic stressor, and the role of self-compassion in mediating the effects of sexist microaggressions. As aforementioned, the results also emphasize an overly-simplistic nosological understanding of trauma and PTSD. Thus, it is important that psychologists-in-training (as well as practicing psychologists) understand the relationship between experiences of oppression and trauma. It is also important that training programs integrate into the curriculum research on oppression-based trauma, strategies for the assessment of oppression-based trauma, and appropriate intervention strategies. The present study also suggests that specifically teaching self-compassion strategies for the treatment of sexism-based trauma may be important; and, that understanding the role of identity development stage may also be important. Such education and training should not be limited to a single multicultural counseling course; rather, training programs should address the effects of oppression-based trauma (such as the results of the present study) throughout the curriculum, such as in psychopathology and practica.

Research. For future research, scholars should consider developing a measure specifically designed to capture SBTS. Although the modified PCL-5 provided a basis for assessing SBTS, because it was based on a general trauma inventory, it may be excluding unique characteristics of SBTS. Future research would benefit from further testing the modified PCL-5 and developing a more comprehensive SBTS scale. Furthermore, to strengthen empirical support for sexist microaggressions as a traumatic stressor, future studies should address some of the limitations related to how the SMESS was used in the present study. One way would be to consider using the proposed seven factors for the SMESS-F

scale and SMESS-S scale as indicators of SMESS. The present study was unable to accommodate this due to sample size constraints. If appropriate samples cannot be achieved to test such an elaborate model, future research should examine alternative models (e.g., sexist microaggression frequency and stress appraisal could be examined separately and compared to see which better predicts SBTS). Future research should also seek to address potential self-report, mono-method, and mono-operation biases by varying how data are obtained (e.g., measuring variables with multiple scales, assessing implicit attitudes, or recording biofeedback responses to witnessing sexist microaggressions). Inclusion of more diverse samples would also increase generalizability.

Future research should also examine SBTS from an intersectionality perspective. It is possible that the relationship between sexist microaggressions and SBTS, as well as the mediating role of self-compassion, may function differently based on individuals' unique positionalities. For example, Lewis et al. (2017) found that experiencing gendered racial microaggressions was detrimental to the psychological and physical well-being of women of color, and Lewis et al. (2013) found that Black women college students employed specific strategies to cope with gendered racial microaggressions. Future research should not only continue to examine the ways in which oppression is experienced intersectionally and the detriments caused, but also specifically whether and how the oppression experienced at these intersections—for example, gendered racial microaggressions—serve as traumatic stressors. As well, results of the present study can also inform future research on interventions for SBTS. Of the two mediation hypotheses, only self-compassion mediated the relationship between sexist microaggressions and SBTS. Future research may benefit from clarifying this relationship by examining what effects, if any, self-compassion interventions have on SBTS. Finally, future research would benefit from examining internalized misogyny as a moderator, as well as the role of FID alongside internalized misogyny. It is critical for future research to extend and test the model described herein and others like it, to continue to highlight and understand the insidious psychological toll that oppression takes on its targets.

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