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“Sticks and Stones”:

Experiencing Microaggressions From the Perspectives of the Victim, Bystander, and Perpetrator

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Psychology

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“Sticks and Stones”: Experiencing Microaggressions From the Perspectives of the Victim, Bystander, and Perpetrator

Over half of American adults experience day-to-day stress associated with discrimination, where both the event of discrimination and the anticipation of possible discrimination have implications on the victims' stress levels (Bethune, 2016). However, overt discrimination has become more and more outdated, and expressions of prejudice are taking on a new form as covert discrimination, specifically microaggressions. Microaggressions have created an outlet of expression for socially outdated prejudices that society has been reluctant to let go of or of which individuals simply lack awareness. Because the perpetrator of such discriminatory ideologies may be able to express their beliefs subtly with ambiguous intent or even without their own awareness, microaggressions can be inflicted upon the victim daily, with usually no sign of relenting or remorse (Sue, 2010). While overt discrimination includes intentional macroaggressions like hate crimes and “old fashioned” discrimination, covert discrimination such as microaggressions are rarely acknowledged by the perpetrator. In the event that a bystander or victim were to verbally address a microaggression, they would most likely be invalidated, making the experiences with microaggressions isolating and demeaning (Sue, 2010).

The purpose of this study was to explore perceptions of participants' experiences with racial and ethnic, gender, and sexual orientation microaggressions (as perpetrators, bystanders, and victims), and measure the correlations between reported experiences and quality of health, measured by the presence of psychological distress, poor physical health, resilience, and self-efficacy.

Defining Microaggressions

Microaggressions are defined as “everyday verbal, nonverbal, and environmental

slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (Sue, 2010, p. 1). The term microaggressions was first coined by psychiatrist Dr. Chester Pierce in 1970. Dr. Pierce coined the term to describe the casual, everyday degradation of African Americans by non-African Americans. He compared microaggressions to macroaggressions, which are characterized as extreme forms of discrimination. For example, lynching and femicide would be considered macroaggressions (Pierce, 1970).

Many different populations have been researched in regard to the microaggressions that they experience. Such populations include racial and ethnic minorities, members of the LGBTQ community, women, those with disabilities, and individuals that receive mental health treatment (Gonzales, Davidoff, Nadal, & Yanos, 2015; Miyake, 2018; Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; Sue, 2010; Woodford, Chonody, Kulick, Brennan, & Renn, 2015). Sue (2010) hypothesizes that microaggressions are manifestations of societal perceptions of marginalized groups, acting as virtual reflections of hate and prejudice, and share similar aspects to those of assault. While perpetrators of microaggressions usually lack intent to wound the victim, an important aspect of an assault, victims do experience the same feelings of vulnerability, embarrassment, fear, stress, and emotional harm (Wells, 2013).

The Effects of Microaggressions

Microaggressions have been explored across a wide variety of identities, including racial and ethnic minorities, members of the LGBTQ community, gender minorities, those with disabilities, and mental health consumers. Microaggressions can influence an individual’s feelings of self-worth, among many other outcomes. Nadal et al. (2014) found a negative correlation between victims of racial microaggressions and self-esteem in undergraduate

students. Seelman, Woodford, and Nicolazzo (2017) found that the presence of microaggressions were associated with lower self-esteem, increased stress and increased anxiety among LGBTQ students.

The effects of microaggressions on health more broadly can be understood within the context of more general models of stress. Past research suggests that cumulative stressors, such as perceived discrimination, elicit a biological stress response, which has been termed allostasis (McEwen & Stellar, 1993). To adapt to an environment filled with stressors or potential stressors, the body will release stress hormones into the bloodstream and bring about a “fight or flight” response in a number of body systems. The goal of this biological response is to prepare for action and then return to homeostasis; however, if the response is provoked often or for prolonged periods of time, it creates an allostatic load, which wears the body down over time (McEwen & Stellar, 1993). This process of deterioration may result in some rather immediate symptoms, like headaches or gastrointestinal problems, and may further predispose individuals to chronic disease, including heart disease, stroke, hypertension and others (Karlman, Singer, & Seeman, 2006).

Minority-Stress Theory suggests that physical and psychological health disparities in marginalized groups may be preceded by minority stressors such as microaggressions and other forms of discrimination and stigmatization. For example, Lick, Durso and Johnson (2013) suggest sexual minorities experienced severe physical and psychological symptomology compared to a heterosexual majority as a result of experiencing homophobia and anti-gay victimization. In addition to the Minority-Stress Theory, the Double Jeopardy Health Hypothesis suggests the possibility of even more severe health disparities among those who are members of two minority groups (Ferraro & Farmer, 1996). A challenge that is noted in some of the research

on minority stress is that stressors that are simply perceived or anticipated, and not necessarily actually occurring, can still have effects over time. That means the simple fear or anticipation of being treated differently because of a marginalized identity could affect one's well-being.

A number of specific studies have looked deeper into the effects of microaggressions on health among a variety of samples. Berk's (2017) meta-analysis of provides impacts of microaggressions across a wide variety of identities, focusing especially on the impact of microaggressions among academic faculty. Among these impacts are feelings of isolation (Alexander & Moore, 2007), decreased productivity and problem solving (Salvatore & Shelton, 2007), physical and mental health issues (Wong, Derthick, David, Saw, & Okazaki, 2014), and contributions to a polarizing and hostile college campus (Caplan & Ford, 2014).

In sum, there is a growing research base that has established the potential impact of microaggressions on the health and well-being of a victim. However, few studies have explored the relationship between microaggressions across three marginalized identities (i.e. race/ethnicity, sexual orientation, and gender) and the impacts on physical health and well-being in college students. Even fewer studies have examined the subjective well-being across all three identity categories while comparing different perspectives of the victim, perpetrator, and bystanders.

Purpose of the Present Study

In the following research study, I explored these four research questions:

Research Question 1: How do victims, bystanders, and perpetrators characterize their experiences with microaggressions?

Research Question 2: Will students that have experienced racial, gender, or sexual orientation microaggressions report increased psychological distress and decreased

quality of physical health?

Research Question 3a and 3b: Will students who have been bystanders (3a) or perpetrators (3b) of microaggressions experience psychological distress or poor health?

Research Question 4: Will participants who have experienced microaggressions based on more than one minority identity report increased psychological distress and decreased quality of physical health that is more severe than participants who reported microaggressions in one category?

I anticipated that participants who report exposure to microaggressions will also report increased psychological distress and decreased quality of physical health compared to those who do not experience microaggressions. I also anticipated that participants who have experienced microaggressions targeted at more than one category of their identity would also report similar or more severe rates of psychological distress and quality of physical health. I anticipated that the experiences of the bystanders would be characterized by discomfort when witnessing microaggressions taking place, and perpetrators would more commonly characterize their experience with a general lack of awareness.

Methodology

Participants

Student participants (N = 200) were recruited through UTC's Sona system and received extra credit points that could be applied to Psychology courses. The sample was predominantly female (85.3%). Participants also identified as male (6.6%), trans-male (.5%), or gender non-binary of non-conforming (.5%). In terms of race, the sample was predominantly white (80.1%). Participants also identified as Black or African American (7.6%), Hispanic or LatinX descent

(4.7%), Asian (4.3%), Middle Eastern or North African (2.4%), or Native Hawaiian or another Pacific islander (.5%). In terms of sexual orientation, the sample was predominantly heterosexual (80.6%). Participants also identified as bisexual (7.6%), homosexual (1.4%), pansexual (1.4%), were questioning their sexuality (.5%), preferred not to answer the question (.5%), or their sexuality was not listed (.5%).

Procedure

Participants completed a survey constructed in QuestionPro composed of several measures. The survey contained opportunities to collect both qualitative and quantitative data by utilizing both self-report questionnaires with Likert scales and open-ended questions for participants to type in their individual answers so that they had the opportunity to describe their unique perceptions of microaggressions.

Participants who indicated that they were members of minority or traditionally marginalized groups, that is female gender identity, non-white racial or ethnic minority groups, and non-heterosexual sexual orientation minority groups, were automatically directed to complete the victim, bystander and perpetrator perspective of the appropriate microaggression questionnaires. The victim microaggression scales were specific to the minority identities they reported (i.e., white, heterosexual females would only receive the victim version of the gender-based microaggressions scale; black, homosexual males would only receive the victim version of the sexual-orientation and race-based microaggressions scales). These participants also answered all three of the categories in the qualitative questions section. Note, all participants answered questions regarding being a bystander or perpetrator of all three types of microaggressions, since anyone can witness or be involved in these acts.

Those who identified as members of majority or traditionally unmarginalized groups (i.e.,

male, non-white, and heterosexual) were directed to complete only the bystander and perpetrator sections of the microaggressions questionnaires. These participants also completed only the bystander and perpetrator qualitative questions. This form of survey branching ensured that each participant answered the most appropriate questionnaires.

Measures

Demographics included gender, sex, age, sexual orientation, race and ethnicity, school grade level, socioeconomic status (participants reported estimated income range for their household), and current GPA.

Quality of physical and psychological health was measured by two scales: the RAND Healthcare Short Form 36 Health Survey Questionnaire (Brazier, et. al, 1992) and Spector and Jex's (1998) Physical Symptom Inventory (PSI). The RAND Healthcare SF-36 measures health with a 36-item scale which lists several questions on an individual's general daily health quality, with response formats such as Likert scales and true or false. From this measure, I focused on three specific health measures. The item that measured general poor health was "In general, would you say your health is: 1) Excellent, 2) Very Good, 3) Good, 4) Fair, 5) Poor." The single item assessing the experience of pain was, "How much bodily pain have you experienced in the past 4 weeks? : 1) None, 2) Very Mild 3) Mild, 4) Moderate, 5) Severe, 6) Very Severe." Nine items measured poor psychological health. An example item that measures psychological health is "Have you felt so down in the dumps that nothing could cheer you up?" These items were averaged to create a poor psychological health score. The scale demonstrated acceptable reliability (Cronbach's alpha = .88).

Spector and Jex's (1998) Physical Symptom Inventory (PSI) measures physical health symptoms with an 18-item scale which listed various physical health symptoms that they could

have experienced that day. Participants could respond with no (did not have symptom), yes (had symptom but did not see a doctor) and yes (had symptom and saw a doctor). A sample item was “stomach pain.” Responses to these items were summed to create a physical health symptoms score, with higher values being more symptoms with greater severity.

Resilience was measured by Smith et al.’s(2008) Brief Resilience Scale. The Brief Resilience Scale is a 6-item scale with a Likert response scale from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicated higher sense of resilience among participants. A sample item is “I tend to bounce back quickly after hard times.” Items were averaged to create a scale score. The scale demonstrated acceptable reliability (Cronbach’s alpha = .85).

Self-Efficacy was measured by the New General Self Efficacy Scale (NGSE; Chen, Gully, Eden, 2001). The NGSE is an 8-item questionnaire scored on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). A sample item is “I will be able to achieve most of the goals that I have set for myself.” Higher scores indicated higher sense of self-efficacy among participants. Items were averaged to create a scale score. The scale demonstrated acceptable reliability (Cronbach’s alpha = .92).

Racial and Ethnic Microaggressions were measured by Nadal’s (2011) Racial and Ethnic Microaggressions Scale (REMS). The REMS is a 55 item scale with response options 1) I did not experience this event in the past six months, 2) I experienced this event 1–3 times in the past six months, 3) I experienced this event 4 – 6 times in the past six months, 4) I experienced this event 7–9 times in the past six months, and 5) I experienced this event 10 or more times in the past six months. A sample item is “Someone assumed that I would have a lower education because of my race.” This scale was adapted and provided in three formats to measure whether these events had been experienced by the participant (victim), observed by the participant

(bystander), or committed by the participant (perpetrator). Responses were summed to create an overall microaggressions score for the each of the three perspectives, resulting in a victim microaggressions sum, bystander microaggressions sum, and perpetrator microaggressions sum. Higher scores indicated more frequent experiences with microaggressions.

Sexual Orientation Microaggressions were measured by Woodford et al.'s (2015) LGBQ Microaggressions On Campus Scale, a 45-item scale with response items measured on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). A sample item is "Straight people assumed that I would come on to them because they thought or knew I am lesbian, gay, bisexual, or queer." Again, these items were provided in three formats, to reference victim, bystander, and perpetrator experiences. Items were summed to create a total microaggressions score for each perspective. Responses were summed to create an overall microaggressions score for the each of the three perspectives, resulting in a victim microaggressions sum, bystander microaggressions sum, and perpetrator microaggressions sum. Higher scores indicated more frequent experiences with microaggressions.

Gendered Microaggressions was measured by Miyake's (2018) Female Microaggressions Scale (FeMS), a 34-item questionnaire with response options from 1 (never) to 4 (often/frequently). A sample item is "Someone assumed I want children because of my gender." Items were again adapted for the perspective of victims, bystanders, and perpetrators. Responses for each of the perspectives were summed for total microaggressions scores. Responses were summed to create an overall microaggressions score for the each of the three perspectives, resulting in a victim microaggressions sum, bystander microaggressions sum, and perpetrator microaggressions sum. Higher scores indicated more frequent experiences with microaggressions.

Qualitative Data Questions (Open-Ended). I asked open-ended questions of participants about their experience as a bystander, perpetrator, and/or victim of microaggressions. Participants who answered any of the microaggression questionnaires from the victim perspective were asked, “Describe a situation where you may have been treated differently because of your race/gender/sexual orientation.” “Describe how you reacted to this situation, including what you said or did and how it made you feel.” and “Describe the relationship you had with any of the parties involved in this situation.” Participants who were not directed to answer any of the microaggression questionnaires as victims were asked the same questions, but were more appropriately worded for the perspectives of a bystander or perpetrator (i.e. “Describe a situation in which you witnessed someone being treated differently or treated someone differently yourself because of their race, sexual orientation, or gender.”)

Results

All of the following results were obtained by conducting correlational and frequency analyses via SPSS. I explored the relationships between race, gender and sexual orientation microaggressions from the perspectives of victims, bystanders and perpetrators and measures of psychological distress, physical health, pain, physical health symptoms, resilience and self-efficacy. Tables 1, 2, and 3 provide a summary of these correlations between health and microaggressions from the perspective of the bystander, victim, and perpetrator. I also examined qualitative responses reported by participants on the subject of microaggressions. Specifically, responses were coded by two independent raters to determine a) if a microaggression was present and what type of microaggression it was, b) how the individual responded, and c) what (if any) emotions were conveyed in their response. I looked for agreement among the two independent raters and resolved discrepancies by acting as a third rater.

Observing racial microaggressions (i.e., as a bystander) was significantly associated with poor psychological health ($r = .17, p < .05$), general poor health ($r = .23, p < .01$), pain ($r = .14, p < .05$) and physical health symptoms ($r = .30, p < .05$). Bystander racial microaggressions were not significantly associated with resilience ($r = -.14, p > .05$) or self-efficacy ($r = -.11, p > .05$).

Bystander gender microaggressions were significantly associated with poor psychological health ($r = .22, p < .01$), general poor health ($r = .19, p < .01$), and physical health symptoms ($r = .27, p < .01$). Bystander gender microaggressions were not significantly associated with pain ($r = .08, p > .05$), resilience ($r = -.08, p > .05$) and self-efficacy ($r = .05, p > .05$).

Bystander sexual orientation microaggressions were significantly associated with poor psychological health ($r = .22, p < .01$), general poor health ($r = .22, p < .01$), pain ($r = .12, p < .05$), physical health symptoms ($r = .27, p < .01$), and resilience ($r = -.16, p < .05$). Bystander sexual orientation microaggressions were not significantly associated with self-efficacy ($r = -.12, p > .05$).

Experiencing racial microaggressions as a victim was significantly associated with general poor health ($r = .31, p < .01$). However, victim racial microaggression were not significantly associated with poor psychological health ($r = .04, p > .05$), pain ($r = .13, p > .05$), physical health symptoms ($r = .19, p > .05$), resilience ($r = -.08, p > .05$), and self-efficacy ($r = -.11, p > .05$).

Victim gender microaggressions were significantly associated with poor psychological health ($r = .31, p < .01$) and physical health symptoms ($r = .32, p < .01$). Victim gender microaggressions were not significantly associated with general poor health ($r = .12, p > .05$), pain ($r = .13, p > .05$), resilience ($r = -.13, p > .05$), and self-efficacy ($r = -.05, p > .05$).

Victim sexual orientation microaggressions were significantly associated with general

poor health ($r = .41, p < .05$). Victim sexual orientation microaggressions were not significantly associated with poor psychological health ($r = .03, p > .05$), pain ($r = .34, p > .05$), physical health symptoms ($r = .31, p > .05$), resilience ($r = -.15, p > .05$), and self-efficacy ($r = .19, p > .05$).

Perpetrating racial microaggressions was significantly associated with physical health symptoms ($r = .25, p < .05$). Perpetrator racial microaggressions were not significantly associated with poor psychological health ($r = .03, p > .05$), general poor health ($r = .06, p > .05$), pain ($r = .12, p > .05$), resilience ($r = -.02, p > .05$) and self-efficacy ($r = -.14, p > .05$).

Perpetrator gender microaggressions were significantly associated with physical health symptoms ($r = .62, p < 0.05$). Perpetrator gender microaggressions were not significantly associated with poor psychological health ($r = .42, p > .05$), general poor health ($r = .29, p > .05$), pain ($r = -.11, p > .05$), resilience ($r = .33, p > .05$), and self-efficacy ($r = -.05, p > .05$).

Perpetrator sexual orientation microaggressions were significantly associated with physical health symptoms ($r = .16, p < .05$) and self-efficacy ($r = -.25, p < .01$). Perpetrator sexual orientation microaggressions were not significantly associated with poor psychological health ($r = .01, p > .05$), poor general health ($r = .05, p > .05$), pain ($r = .06, p > .05$), and resilience ($r = -.03, p > .05$).

To consider the experience of individuals with intersecting minority identities, I created a variable where individuals were coded as experiencing any microaggressions as a victim in one category (1), two categories (2), or three categories (3). Experiencing microaggressions based on more minority identities was significantly associated with poor general health ($r = .80, p < .05$) and physical health symptoms ($r = .96, p < .01$). Microaggressions based on more than one category were not significantly associated with poor psychological health ($r = .38, p > .05$), pain

($r = .15, p > .05$), resilience ($r = .24, p > .05$) and self-efficacy ($r = .37, p > .05$).

We conducted qualitative analyses of participants' responses to questions such as "Describe a situation where you may have been treated differently because of your race/gender/sexual orientation/other identity," "Describe a situation where you may have witnessed someone being treated differently because of their race/gender/sexual orientation/other identity," or "Describe a situation where you may have treated someone differently because of their race/gender/sexual orientation/other identity." We also asked participants to note their relationship to the parties involved and also how the experience made them feel and whether or not they responded to it.

For responses about witnessing microaggressions (bystander), 24.2% described witnessing a racial microaggression, 16.6% described a gender microaggression, 11.8% described a sexual orientation microaggression, and 4.3% described an intersectional microaggression (i.e., based on the intersection of or belonging to two or more minority identities). The most common response to witnessing these events was a passive or emotion focused response (26.5%). The most common emotion experienced was "upset or sad" (18.5%).

In terms of responses about experiencing a microaggression (victim), 11.8% described experiencing a racial microaggression, 46.8% described a gender microaggression, 3.8% described a sexual orientation microaggression and 2.8% described an intersectional microaggression. The most common response to experiencing these events was an active or targeted at confronting the perpetrator (31.3%). The most common emotion experienced was indifference (14.2%).

For responses about perpetrating microaggression (perpetrator), about half of the participants opted to not respond. The next most common response was reporting that no

microaggression had ever been perpetrated by the participant (17.5%), which was closely followed by reports of perpetrating gender microaggressions 13.3%, though many examples were not actually in relation to a gender minority. Interestingly, many participants especially reported treating men differently, such as crossing the street to avoid walking by a man. Of those who responded, the most common perpetrator response to microaggressions was a neutral response (10.9%). For example, statements like “I wouldn’t change my behavior,” or “I would do the same in the future,” were used frequently. Of those who responded, the most common emotion experienced by the perpetrator was regret (14.2%). However, the next most common emotional response reported was indifference (12.8%). These responses are described more in detail in Tables 5a through 7c.

Discussion

The goal of the present study was to explore the effects of microaggressions from the three parties involved, victims, bystanders and perpetrators, and the power that these experiences have to affect physical and mental wellbeing.

Research question 1 concerned how participants characterized their experiences with microaggressions. Victims of microaggressions most commonly reported responding actively, such as addressing the perpetrator directly. Victims were also more likely to report feelings of indifference, possibly because they were more likely to take advantage of confronting the perpetrator rather than internalize their emotional experience. These victims may also be more accustomed to experiencing these interactions and have developed coping strategies to respond to such encounters.

Bystanders, on the other hand, were more likely to report passive responses, such as ignoring or internalizing feelings and emotions about witnessing the microaggression event.

Bystanders also more commonly reported feeling upset, angered or sympathetic on behalf of the victim. Bystanders may be particularly sensitive to these encounters because of increased attention to social justice in recent years (e.g., #MeToo movement, Black Lives Matter movement). Those directed to the perpetrator question were the least likely to respond to the qualitative question. Those who responded were more likely to have neutral responses to their actions and were likely to feel either regret or indifference and would likely not act on those emotions in future similar situations. I anticipated that perpetrators would be the group that was least likely to be emotionally affected by microaggressions. These responses also often included treating men differently, which would not qualify as a microaggression in the typical sense.

Research question 2 and research question 4 were both concerned with the health effects of microaggressions for the victims of only one identity as well as individuals with two or more minority identities. I found that victims tend to experience general poor health, however, they did not tend to report poor psychological health as often. Specifically, both victims of only one identity and intersectional individuals reported either general poor health or physical health symptoms. The correlation between experiencing more than one category of microaggressions and poor general health and physical health symptoms was very strong. This may indicate that individuals who experience attacks on multiple areas of their identity may experience deficits in general health as well as experience more physical health symptoms.

Research question 3a and 3b were both concerned with the health of bystanders and perpetrators of microaggressions. I found that there was a significant correlation between bystanders and poor psychological health, poor general health, pain, and physical health symptoms. These results are consistent with how bystanders characterize their experiences with microaggressions as explored in research question 1, with bystanders being more likely to

internalize their experiences in a more passive manner rather than practice active or problem focused responses. Perpetrators of microaggression also had a significant association with experiencing physical health symptoms. This was a rather unexpected finding and I hypothesize that a third variable exists within this relationship, such as general hostility, trait anger, or experiences with Adverse Childhood Experiences (ACEs), which would be interesting to explore in a future study.

Limitations

The primary limitation of this study was a lack of diversity in terms race and ethnicity (white, 76%) and sexual orientation (heterosexual, 77%), though I was able to have a high representation of females (81%). Future research with larger and more diverse sample sizes in terms of race and ethnicity and sexual orientation may duplicate our methods and yield more representative results. In particular, several effects may achieve statistical significance with larger samples, given moderate strength correlations that were not significant for analyses with very small sample sizes, such as for racial and sexual orientation minorities.

Another limitation was the refusal to participate or denial of participants who were routed to the perpetrator qualitative question. While this may have been a product of participant exhaustion as these questions are located at the end of the survey, participants who were routed to the perpetrator questionnaires were more likely to leave these questions blank or respond with answers like “N/a” or “I would never do this,” than the bystander and victim groups. I believe this may be a product of social desirability bias, in that admitting to an experience where the participant did perpetrate a microaggression would be seen as socially unacceptable. This type of question may be best delivered in a focus group setting or in a format other than a survey.

Implications and Future Directions

This study supports the findings of previous research in that it provides evidence of the consequences of microaggressions on the health of victims, as well as bystanders and perpetrators, whose experiences have been minimally researched. The results from this study further support the importance of understanding microaggressions and why it is important to bring awareness to their ramifications, especially in terms of preserving general health of those impacted, including victims and bystanders.

One of the more unexpected findings of this study was the significant positive correlation between the physical health symptoms of perpetrators across all three categories of microaggressions. Future studies could further explore this correlation and analyze possible third variables such as arousal, aggression, and ACEs. Another interesting topic for future research to explore is the possible association between bystander health and witnessing microaggressions in media or entertainment. Areas such as comedy or television series where microaggressions are scripted may have similar consequences on victim and bystander well-being. In addition, future studies should also make an effort to recruit more diverse samples with inclusion of a variety of different identities.

The implications of the findings of this study could support intervention programs with the goal of educating and ameliorating the effects of microaggression, especially on college campuses, which was where this study rendered its participants. Future educational initiatives such as on-campus training could be added to college curriculums in effort to intercept potential biases and remnants of overt racism, sexism and other discriminatory behaviors and beliefs, gradually unburdening academia and the workforce. Curriculum could include biases training, support groups, and exercises to encourage community engagement. Such efforts would contribute to creating an environment where it is more conducive for all to succeed.

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Table 1. Correlations between bystander racial, gender, or sexual orientation based microaggressions and health.

	Mean	SD	1	2	3	4	5	6	7	8	9
1. Race microaggression	81.63	41.51	--								
2. Gender microaggression	95.55	40.33	.604**	--							
3. Sexual Orientation microaggression	73.49	36.39	.735**	.659**	--						
4. Poor Psychological Health	3.42	.913	.165*	.221**	.221**	(.88)					
5. Poor General Health	2.40	.88	.231**	.190**	.220**	.325**	--				
6. Pain	1.55	.77	.144*	.075	.144*	.297**	.397**	--			
7. Physical Health Symptoms	24.51	3.86	.304**	.366**	.270**	.340**	.330**	.344**	--		
8. Resilience	19.39	4.31	-.14	-.084	-.155*	-.510**	-.233**	-.174*	-.162*	(.85)	
9. Self-Efficacy	31.72	5.15	-.112	.046	-.119	-.313**	-.184**	-.201**	-.071	.444**	(.92)

Notes. * = $p < .05$. ** $p < .01$. $N=193-197$. $N=194$ for analyses involving gender microaggressions, $N=189$ for analyses involving racial microaggressions, $N=190$ for analyses involving sexual orientation microaggressions. Cronbach's alpha is displayed along the diagonal.

Table 2. Correlations between victim racial, gender, or sexual orientation based microaggressions and health.

	Mean	SD	1	2	3	4	5	6	7	8	9
1. Race microaggression	.35	.98	--								
2. Gender microaggression	90.34	36.93	.501**	--							
3. Sexual Orientation microaggression	82.96	44.56	.940**	.666**	--						
4. Poor Psychological Health	3.42	.913	.035	.309**	.026	(.88)					
5. Poor General Health	2.4	.88	.508**	.122	.409*	.325**	--				
6. Pain	1.55	.77	.131	.126	.336	.297**	.397**	--			
7. Physical Health Symptoms	24.51	3.86	.193	.322**	.306	.340**	.330**	.344**	--		
8. Resilience	19.39	4.31	-.082	-.134	-.15	-.510**	-.233**	-.174*	-.162*	(.85)	
9. Self-Efficacy	31.72	5.15	-.106	-.047	.19	-.313**	-.184**	-.201**	-.071	.444**	(.92)

Notes. * = $p < .05$, ** $p < .01$. N=173 for analyses involving gender microaggressions, N=173 for analyses involving race microaggressions, and N=25 for analyses involving sexual orientation microaggressions. Cronbach's alpha is displayed along the diagonal.

Table 3. Correlations between perpetrator racial, gender, and sexual orientation microaggressions and health.

	Mean	SD	1	2	3	4	5	6	7	8	9
1. Race microaggression	46.16	15.23	--								
2. Gender microaggression	51.19	16.17	.247	--							
3. Sexual Orientation microaggression	36.62	15.57	.802**	.447	--						
4. Poor Psychological Health	3.42	.913	.028	.419	.015	(.88)					
5. Poor General Health	2.4	.88	.059	.29	.048	.325**	--				
6. Pain	1.55	.77	.118	-.11	.059	.297**	.397**	--			
7. Physical Health Symptoms	24.51	3.86	.245**	.615*	.158*	.340**	.330**	.344**	--		
8. Resilience	19.39	4.31	-.022	.326	-.034	-.510**	-.233**	-.174*	-.162*	(.85)	
9. Self-Efficacy	31.72	5.15	-.137	-.054	-.250**	-.313**	-.184**	-.201**	-.071	.444**	(.92)

Notes. * = $p < .05$. ** $p < .01$. $N = 16-197$. $N=166$ for analyses involving gender microaggressions, $N=16$ for analyses involving race microaggressions, and $N=163$ for analyses involving sexual orientation microaggressions. Cronbach's alpha is displayed along the diagonal.

Table 4. Experiencing microaggressions in more than one category correlated with health.

	Mean	SD	1	2	3	4	5	6	7
1. Intersectional	1.26	.58	--						
2. Poor Psychological Health	3.42	.91	.381	(.88)					
3. Poor General Health	2.40	.88	.800*	.325**	--				
4. Pain	2.15	1.04	.149	.297**	.397**	--			
5. Physical Health Symptoms	24.51	3.86	.958**	.340**	.330**	.344**	--		
6. Resilience	3.23	.72	.244	-.510**	-.233**	-.174*	-.162*	(.85)	
7. Self-Efficacy	3.96	.64	.365	-.313**	-.184**	-.201**	-.071	.444**	(.92)

Notes. * = $p < .05$. ** $p < .01$. $N = 8$. Cronbach's alpha is displayed along the diagonal.

Table 5a. Types of bystander microaggressions witnessed.

Category	Frequency	Percent
Participant opted not to respond	64	30.3%
Potential microaggression but unclear	9	4.3%
Racial microaggression	51	24.2%
Gender microaggression	35	16.6%
Sexual orientation microaggression	25	11.8%
No microaggression	1	0.5%
Intersectional microaggression	9	4.3%
Other	2	0.9%

Table 5b. Types of bystander responses to witnessed microaggressions.

Category	Frequency	Percent
Participant opted not to respond	64	30.3%
Neutral response	19	9%
Passive response or emotion focused response	56	26.5%
Active response or problem focused response	45	21.3%
Future response predicted	1	0.5%
Giving support	11	5.2%

Table 5c. Types of emotions experienced by bystanders in response to witnessed microaggressions.

Category	Frequency	Percent
Participant opted not to respond	64	30.3%
Anger	17	8.1%
Upset, sad	39	18.5%
Irritation, frustration	6	2.8%
Fear	6	2.8%
Indifference	15	7.1%
Sympathetic	17	8.1%
Uncomfortable	2	0.9%
Surprised, shocked	5	2.4%
Embarrassed	1	0.5%
Devalued	2	0.9%
Other	22	10.4%

Table 6a. Types of victim microaggressions experienced.

Category	Frequency	Percent
Participant opted not to respond	31	14.7%
Potential microaggression but unclear	14	6.6%
Racial microaggression	25	11.8%
Gender microaggression	98	46.4%
Sexual orientation microaggression	8	3.8%
No microaggression	10	4.7%
Intersectional microaggression	6	2.8%
Other	4	1.9%

Table 6b. Types of victim responses to experienced microaggressions.

Category	Frequency	Percent
Participant opted not to respond	38	18%
Neutral response	21	10%
Passive or emotion focused response	56	26.5%
Active or problem focused response	66	31.3%
Future response predicted	2	0.9%
Seeking support	5	2.4%
Other	8	3.8%

Table 6c. Types of emotions experienced by victims in response to microaggressions.

Category	Frequency	Percent
Participant opted not to respond	41	19.4%
Anger	19	9%
Upset, sad	25	11.8%
Irritation, frustration	16	7.6%
Fear	3	1.4%
Indifference	30	14.2%
Sympathetic	1	0.5%
Uncomfortable	8	3.8%
Surprise, shock	2	0.9%
Embarrassed	1	0.5%
Nervous, anxious	2	0.9%
Discouraged, disappointed	4	1.9%
Devalued	21	10.7%
Other	23	11.7%

Table 7a Types of microaggression perpetrated

Category	Frequency	Percent
Participant opted not to respond	76	36.0%
Potential microaggression but unclear	4	1.9%
Racial microaggression	23	10.9%
Gender microaggression	28	13.3%
Sexual orientation microaggression	22	10.4%
No microaggression	37	17.5%
Intersectional microaggression	4	1.9%
Other	2	0.9%

Table 7b Types of perpetrator responses to microaggressions

Category	Frequency	Percent
Participant opted not to respond	106	50.2%
Neutral response	23	10.9%
Passive or emotion focused response	10	4.7%
Active or problem focused response	1	0.5%
Future response predicted	19	9.0%
Negative or bad intention	4	1.9%
Positive or good intention	16	7.6%
Self-reflective response	17	8.1%

Table 7c Types of emotions experienced by perpetrators after microaggressions

Category	Frequency	Percent
Participant opted not to respond	107	50.7%
Upset, sad	5	2.4%
Fear	1	0.5%
Indifference	27	12.8%
Regret	30	14.2%
Sympathetic	2	0.9%
Uncomfortable	3	1.4%
Surprise, shock	2	0.9%
Embarrassed	3	1.4%
Nervous, anxious	3	1.4%
Discouraged, disappointed	1	0.5%
Other	12	5.7%