

Running head: RACIAL MICROAGGRESSIONS IN THERAPY

THE IMPACT OF RACIAL MICROAGGRESSIONS ON THERAPEUTIC
RELATIONSHIPS WITH PEOPLE OF COLOR

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MERCEDES JEAN OKOSI

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APPROVED: _____
Nancy Boyd-Franklin, Ph.D.

Anita McLean Ph.D., Psy.D.

DEAN: _____
Francine Conway, Ph.D.

RACIAL MICROAGGRESSIONS IN THERAPY

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Abstract

Microaggressions are defined as “unconscious and unintentional expressions of bias and prejudice toward socially devalued groups” (Sue, 2010a, p. vii). This qualitative exploratory research study examined the impact of perceived racial microaggressions on the therapeutic alliance from the perspective of adult persons of color. Psychological and sociocultural theoretical frameworks including the microaggression process model; rupture and repair in psychotherapy; critical race theory; racial identity development; social cognition; implicit bias; and affect-focused, and psychodynamic object relations theory, formed the foundation of the current study. The twelve participants, who identified as having experienced a microaggression as a patient in psychotherapy, were recruited through a network sample. Through semi-structured interviews, the study examined specific research questions regarding the type of microaggressions experienced, their impact, attempts or barriers to repair, attitudes toward therapy, and suggestions for clinicians to engage in more culturally effective work. A grounded theory approach (Corbin & Strauss, 2014) was used to organize data and develop categories into cohesive themes that informed conclusions and implications for future research and practice. Central themes resulting from the study included: a) significance of the subjectivity, including the social location, of both patient and therapist; b) hypervisibility and invisibility of people of color longing to be seen and heard authentically; c) therapist dismissal and emphasis on deficits in discussing race in therapy; d) patient hesitance to verbalize reactions; e) underrepresentation of clinicians of color in the mental health field; f) suggestions for therapists from the patient point of view; and g) potential conceptualization of rupture as a micro-trauma and repair as posttraumatic growth. The

limitations of the study and the implications for future research, clinical training, and culturally-informed practice are discussed.

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Chapter I: Introduction and Overview

Statement of the Problem

One impact of a series of historic civil rights achievements, brought about by movements organized by communities of color, is the belief by many people in the United States that the nation's alarming problem with racism has been eradicated. Several social justice movements have since emerged in response to situations attributed, in part or in whole, to racial disparities. These include police brutality (Black Lives Matter), hate crimes (I, Too, am...), disproportionate access to resources (Occupy Wall Street), barriers and stigma related to immigration (various sanctuary organizations). These movements have been met with forceful pushback, particularly during the heated 2016 presidential campaign and its aftermath.

Based on a history of genocide, displacement, slavery, Jim Crow laws, immigration discrimination and its institutional structure, Goldstein (2008) has described the United States as a fundamentally racist society. The barriers of racism continue to persist in both overt and covert ways that marginalize Black, Latinx¹, Native American, Asian, and other people of color despite gains in visibility and acceptance (Carr, 2017). Researchers (Sue, Capodilupo, Nadal, & Torino, 2008) have noted that perspectives on the continued endurance and severity of racism may be a function of an individual's race and/or ethnic background. For example, many Black peoples' beliefs about the continued existence of racism are informed by their personal experiences, while many White people

¹ The spelling "Latinx" is a purposeful transformation of the word "Latino" to illustrate the explicit inclusion of people of all genders, as the Spanish language typically has gendered conjugation for most parts of speech.

believe that discrimination is in decline, equality is “just around the corner,” and that racism is no longer a problem for people of color (Sue et al., 2008). When confronted with the idea of their potential bias, White people often express naïveté or defensiveness (Goldstein, 2008), and assert that they are free of biases. Yet many Black people have encountered even well-intentioned White people who act in ways ranging from insensitivity to conveying a sense of superiority or control (Sue et al., 2008).

Manifestations of racism exist in various forms. For example, microaggressions, often subtle interpersonal slights, arise out of everyday interactions and are covert expressions of bias (Sue, 2010a). Although the preface “micro” might suggest an inconsequential event, its impact on individuals may be significant, especially for those who may encounter bias on more than one level. For example, Lourdes Ashley Hunter stated that in light of holding multiple stigmatized identities as a Black Trans*woman² academic and activist, “there is nothing micro about aggression; it hurts” (personal communication, March 29, 2015).

When vulnerable people experience pain, mental health professionals are often called upon to intervene and promote healing. According to Sue et al. (2008), the field of psychology has unfortunately failed to recognize racism’s evolution from primarily overt forms to more insidious, unintentional expressions (“aversive racism”) despite the influence of everyday microaggressions on the mental health and coping of those affected. As therapists are embedded in the nation’s social context of what Goldstein

² The asterisk in Trans* is intentionally used to acknowledge all gender nonconforming, gender non-binary, transgender, and transsexual identities and demonstrate that Trans* experiences and identities are not monolithic.

(2008), as discussed above, identified as a fundamentally racist society, they have a responsibility to remediate, not perpetuate racism (Goldstein, 2008), whether it is systematic racism or the individual experiences of racism disclosed by patients inside and outside of the therapy room. Therapeutic relationships entered into by individuals in the hope of healing, however, may be disrupted with harmful unintended words or behaviors.

Although issues of racial identity and experiences as a racial minority and person of color in the United States may not be at the core of the presenting problem, this population often confronts complex conflicts at macro and micro levels with great frequency. In addition, given the history of stigma with regard to mental health and communities of color, inequalities in accessibility to mental health services and the current social and political climate in the United States with regard to race and racial relations, culturally responsive interventions in therapeutic service delivery are imperative.

Multiple psychology-based theoretical frameworks contribute to the exploration of the factors that constitute microaggressions and their impact, such as critical race theory, racial identity development, social cognition, implicit bias, and affect-focused and psychodynamic object relations theory. To create a sound basis for the current study, other disciplines contribute their voices. These theories also point to the inevitability of the occurrence of microaggressions. An examination of the patient's perspective of perceived microaggressions on the therapeutic relationship informed the present study.

Research Questions in the Present Study

As the therapeutic alliance is not immune from the potential ruptures often caused by microaggressions, the purpose of this current study is to deeply investigate, through qualitative methods, the experience of, and impact of, racial microaggressions in the

therapeutic alliance from the perspective of patients of color. The hope is that the results of this study can build upon existing research, encourage the use of therapy as a restorative space where repairs along the lines of race can benefit both clinician and patient, and thus contribute to a professional paradigm shift and be incorporated into training.

With this in mind, the following research questions were explored:

1. What are the attitudes toward therapy in the patients of color who are participants in this study?
2. What types of racial microaggressions have the participants in this study experienced in therapy?
3. How did these microaggressions affect the therapeutic alliance?
4. Were attempts at repair made? If so, did such efforts impact the alliance?
5. To what extent, if any, do the attitudes of patients of color toward therapy change after experiences with microaggressions with and/or without repair?
6. What suggestions do participants have for mental health professionals with regard to working with patients of color?

Chapter II: Review of the Literature

Microaggressions

Microaggressions are complex in terms of definition, source, and function. There are several interpretations surrounding the perceived intentions or messages of the microaggression, such as “you do not belong,” “you are abnormal,” “you are intellectually inferior,” “you are not trustworthy,” and “you are all the same,” among many others (Sue et al., 2007). The first use of the term microaggression was by psychiatrist Chester Pierce in 1980, and the concept of what Sue defined as “unconscious and unintentional expressions of bias and prejudice toward socially devalued groups” (2010a, p. vii) has evolved over time to incorporate a larger range of actions and behaviors. For example, Pierce et al. and Sue et al. noted that while microaggressions uniformly display insensitivity, disrespect, and/or negligent attention to a salient aspect of an individual’s cultural identity, they can be communicated both verbally and nonverbally and need not necessarily be intentional (as cited in Owen, 2011, p. 204).

As manifestation of racism shift over time and the experiences of people of color become increasingly complex, definitions of microaggressions follow suit. Sue extended microaggressions beyond interpersonal interactions to include environments (as cited in Mazzula & Nadal, 2015, p. 312). An example of this might be a clinic waiting room where all the art on the wall and magazines in the office depict White individuals and families, conveying the impression that people of color might be out of place or unwelcome. Thus, microaggressions may exist along a spectrum of unconscious to conscious, nonverbal to verbal, ignoring to acknowledging identities, and individual to institutional/environmental. Sue’s model incorporated microaggression subtypes as well that may veer from the subtle communications inherent in earlier conceptions of

microaggressions, such as interpersonal relationships, to include microinvalidations (denial of racism or bias); microassaults (direct expressions of prejudice, such as use of racial slurs or oppressive symbols); and microinsults (derogatory or pathologizing beliefs about a person's race or cultural practices) (Sue, Lin, Torino, Capodilupo, & Rivera, 2009).

Microaggressions tend to illustrate attitudes about the superiority/inferiority, normality/abnormality, and healthiness/unhealthiness between groups (Sue, 2010a), and are often committed from the vantage point of social privilege, e.g., White privilege. Microaggressions reflect the worldview, including ethnocentric assumptions, values, biases, and prejudices of the perpetrator (Sue et al., 2007; Sue, 2010a). Racial microaggressions are facilitated by the assumption of White supremacy or dominance of White cultural values. Dichotomous themes of superiority/inferiority, normality/abnormality and healthiness/unhealthiness, as discussed above, may also be seen in the hierarchical therapeutic relationship in which the psychologist or other mental health professional holds the expertise and the patient is a help seeker.

In the United States, where race is such a salient and divisive issue, it is not surprising that beliefs concerning White supremacy, or less explicitly prejudicial attitudes, e.g., colorblindness or unwillingness to discuss race, denial of individual racism and assumptions of stereotypes, may be prevalent (Altman, 2000; Altman, 2006; Mazzula & Nadal, 2015, Sue et al., 2008). Members of the privileged social group who identify as such view themselves as residing on the superior, normal, and healthy end of the spectrum, while others are viewed as inferior, abnormal, and unhealthy.

Perpetrators of microaggressions in many cases believe that their words and actions are not influenced by prejudice, and thus are unaware of the gravity of their

expressions toward individuals from less privileged groups. Nonetheless, the impact on the victims of microaggressions is all too real and powerfully influential:

[Microaggressions] invalidate group identity or experiential reality of a person, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten or intimidate, or relegate them to inferior status or treatment” (Sue, 2010a, p. 3).

In Sue’s continued exploration of microaggressions, it became evident that acts originally characterized as interpersonal and thus individual encounters had a larger societal impact in their perpetuation of social inequity and injustice.

Responses to Microaggressions

One of the reasons microaggressions are so complex is that they are not often direct statements that can only have a single interpretation, but indirect messages lending themselves to multiple interpretations and ambiguity about the intentions of the perpetrator. Despite this difficulty, Sue sought to create a microaggression model delineating the multifaceted and complex impact microaggressions had on the victim, particularly racial microaggressions. First, the recipient undertakes an evaluation of whether the incident was racially motivated or not when the incident occurs. If the individual determines that racial motivation was present, several immediate cognitive, behavioral, and emotional responses follow. *Healthy paranoia/suspicion* includes viewing events through the lens of an oppressed experience. It is common for people of color to be told that they are overly sensitive or overreacting. The *sanity check* is a verbal or nonverbal confirmation within the self, or in consultation with other people of color, to assess for misinterpretations or overvaluation of the situation. In this model, the group’s

power to define reality can counter the sense of powerlessness due to confusion in defining reality and an externalized locus of control.

Other common reactions include: a) a *sense of invisibility* arising out of the message that the presence of group members is less valued; b) a *loss of integrity* as a result of individuals in oppressed groups feeling compelled to present a false self; and c) *a pressure to represent one's group* and defy stereotypes (Sue et al., 2007). On the other hand, the chronic experience of microaggressions has some positive impacts on the psychology of people of color including: a) heightened perceptual wisdom, b) nonverbal and contextualized accuracy, c) bicultural flexibility, and d) a collectivistic sense of group identity and peoplehood (Sue et al., 2007).

Another reaction is an *empowerment* and *validation of the self* by shifting fault and shielding the self from the microaggression. For example, Asian Americans may be repeatedly asked where they are *really* from, and may instinctively see this not as a question requiring an answer, but as a statement revealing the ignorance of the questioner. While that reaction may be protective of recipients and allows them to shield themselves from potential feelings of shame and isolation, ascribing the statement to ignorance or socialization allows it to go unchecked. A more extreme reaction would be to *rescue the offender*. For example, when a White person defends the use of an indigenous person depicted as a sports mascot a Native American might brush off the comment or reassure the person that it is not racist. The process of perceiving microaggressions is somewhat systematic with common themes, as well as nuances related to individual context and culture.

Health Impacts Due to Microaggressions

As microaggressions place physical and psychological demands on individuals, they, like other stressors, often have significant effects on both mental and physical health. When a person's self-esteem, belief systems and identity are attacked, as in the case with microaggressions, the body's defenses activate in an alarm stage either to mobilize resources or settle into acceptance (Sue et al., 2007). The impact of chronic microaggressions can include: a) exhaustion/fatigue; b) decreased physical activity; c) lowered desire for life, and other emotional reactions, such as anger, anxiety, depression, rage, and hopelessness; d) withdrawal; e) decompensation of coping skills; e) functional impairment; and f) narrowing and decrease in alertness and cognitive functioning (Sue et al., 2007). For example, Salvatore and Shelton's 2007 study found that Black people did worse on the Stroop color word test after witnessing a discriminatory event (as cited in Sue et al., 2007). As with other stressors, social reassurance; support; preparation; coping skills, such as resilience in the face of adversity; and protective factors can help disrupt the unhealthy reactions to microaggressions (Sue et al., 2007).

The invisibility of whiteness, as a standard from which other cultures are deviations, shifts the responsibility from them and silences people of color dealing with racism (Sue et al., 2007). The privileged social location of Whites in the United States does not, however, protect them against the emotional, cognitive and moral impact of participation in microaggressions. Their emotional reactions may include guilt, fear, anxiety, apprehension, and low empathy. While some White people may become defensive about their biases and avoid interaction with the groups toward whom they have bias, others may feel a sense of powerlessness and impotence when they first realize

the pervasiveness of oppression in the United States and their privilege and role within society (Sue et al., 2007). Cognitive responses include strategic colorblindness, self-deception, and impression management based on fears of being perceived as racist. Some may also experience spiritual and moral conflicts if their self-image as promoting equality and democracy is at odds with their unequal treatment of marginalized people in order to maintain personal and in-group power (Sue et al., 2007).

Common racial microaggressions. Racism has been manifested both overtly and in more subtle ways across time and across social groups. The nation's history is replete with examples of prominent scholarly institutions upholding ideas of White supremacy and devaluing the capacities of people of color. Professionals in the field of psychology have also lent credence, unfortunately, to some of the ideas that underlie the microaggressions of today. For example, the creator of the Stanford-Binet intelligence scales stated that Black people, Mexicans, and Spanish-Indians were ineducable (Sue et al., 2007). In addition, the first president of the American Psychological Association, the organization responsible for setting the psychology profession's ethical principles and guidelines for clinicians, G. Stanley Hall, once stated that Africans, Indians, and Chinese were "adolescent races" (Sue, 2010b, p. 267).

Views prevalent in the field of psychology influenced others to adopt and expand upon such disparaging beliefs about race and intelligence. For example, physicist William Shockley's theories of eugenics promoted medical interventions targeted at minority groups that were intended to preserve and improve the dominant (White) race. Despite the amount of time that has elapsed since such views were openly expressed, they continue to resonate in common themes of microaggressions particular to different racial groups based on historical context and stereotypes. These include: a) ascription of

intelligence (assigning low or high intelligence on the basis of race), b) assumption of criminal status (belief a group is more prone to crime), c) pathologizing cultural values/communication styles, and d) treating others as “second-class citizens.” Further, four common microinvalidation themes could be traced to the historical underpinnings of White supremacy: a) people of color being alien in their own land, b) colorblindness, c) denial of personal racism, and d) the myth of meritocracy (Sue et al., 2008).

African Americans. The long history of slavery and segregation of people of African descent in the United States has been both influenced by and perpetuated racial stereotypes. Black immigrants to this country, e.g., those from the West Indies and Africa, often confront comparable experiences as Black Americans in addition to others unique to their identity as Black immigrants (McGoldrick, Giordano, & Garcia-Preto, 2005); however, given the wealth of information in the literature and the history of race in the United States, this section will focus on African Americans.

Differences among racial groups became a focus of interest among scholars as psychology emerged as a field. Psychological theorists were not isolated from the societal context and used their positions to support attitudes of the essential racial inferiority of Blacks by asserting that the brains of Blacks were smaller and that their psychological makeup was more rudimentary. For example, they propounded the view that subservience was beneficial to Black mental health as freedom would be an unnatural state to them, and thus cause them to suffer unwarranted anxiety. In addition, scientists set out to prove that Black people were inferior anatomically and neurologically due to smaller, less developed brains that were not prone to mental illness or capable of producing anything other than juvenile, noncomplex dreams (Sue et al., 2007).

This discredited historical pseudo-science nevertheless survives in present common microaggressions and stereotypes based on the assumption of intellectual inferiority, second class citizenship, the universality of the Black experience, and the superiority of White cultural values and communications styles (Sue, 2010b). These include the ascription of dangerousness/criminality to Black people and assumptions that Black people have difficulty controlling anger, are untrustworthy, and are unmotivated (Sue et al., 2007). Everyday manifestations of such verbal and nonverbal microaggressions would include Black youth being labeled as thugs; a White woman clutching her purse or crossing the street when a Black person, especially a Black man, approaches; and the “angry Black woman” being told she is too sensitive. A variation of this may be disguised as a “compliment,” e.g., group members being told they are “very articulate” when they speak standard American English.

The impact upon recipients of microaggressions is chronic and cumulative . Race-related stress not only impacts the physical health of African Americans, as discussed above, but also results in psychological effects, such as depression, lowered life satisfaction, low self-esteem, rage, anxiety, paranoia, and helplessness (Sue et al., 2008; Sue, 2010b). Additionally, Black Americans may face alienation from personal identity, one’s own humanity, and culture; internalized racism, race-related trauma (which has a similar effect to being exposed to a physical hate crime); race-related fatigue (a depletion of energy that can impact functioning); and racial mistrust (Sue, 2010b). Racial mistrust is of particular concern in cross racial therapy dyads. It is not uncommon for people of color to seek treatment to help them cope with experiences of racism. It would be especially harmful to confront them in the therapeutic relationship as well.

Research has demonstrated that exploring the process of microaggressions for particular groups is valuable in that their impact on society and the individual may be greater than more blatant forms of racism (Sue et al., 2008). For example, when microaggressions are outside of the awareness of the perpetrators, they may easily influence institutional and social policies that perpetuate inequality. In addition, the ambiguous nature of microinvalidations and microinsults often hides the intent of the perpetrator, so microassaults—where the content is more explicit and intention more clear—might be easier to process (Sue et al., 2008).

Latinxs. Latinxs represent a wide variety of races and mixtures of races with countries of origin throughout Central America, South America and the Caribbean, and, according to the U.S. Bureau of Census Statistics, are the fastest growing racial/ethnic group in the United States (as cited in Sue, 2010b). Latinxs have disproportionately high levels of poverty and unemployment; suffer greater health problems than the general population; and are often perceived by others in a deficit context, e.g., they are less warm, less competent, of lower social status; and are unskilled and unwelcome newcomers (Sue, 2010b). Latinxs generally believe that prejudice, stereotyping, and discrimination negatively impact their well-being and lower their standard of living (Sue, 2010b).

Latinxs face physical and mental health consequences similar to those experienced by African Americans (Sue, 2010b). Some common stereotypes about Latinxs are that they are illegal aliens, drug dealers, poor rural workers, domestic help, welfare recipients, criminals, dangerous, untrustworthy, sloppy, lazy, uninhibited, uneducated, speak poor English, and overly religious. Microaggressions surround themes of denigration of intelligence, ascription of second class citizenship and are aliens in their own land status, criminality, pathologizing of communication style and cultural values,

and invalidation of the Latinx experience (Sue, 2010b). An example of one of these microaggressions in the therapeutic context might be the therapist's conceptualization that the patient is dramatizing her report and presentation beyond the level of distress expected.

Asians and Pacific Islanders. As with Latinxs, Asians in the United States also represent a wide variety of cultures and nations of origin. The dominant American culture, however, makes little or no effort to learn about and distinguish between the groups (e.g., assuming, based on appearance, that every East Asian is “Chinese” and every South Asian is “Indian”), thus invalidating the unique experiences of Asians and Pacific Islanders (Sue, 2010b). Mio, Nagata, Tsai, and Tewari explained that there is also an erasure or denial of the racism and discrimination Asians have faced, including hate crimes; Japanese internment camps; discrimination in land, citizenship, and voting; torture; and enslavement (2007).

Stereotypes about Asians may, to a certain extent, mirror stereotypes about other groups, as discussed above, such as they are subhuman, speak poor English, and are perceived to have undocumented immigration status. Additional stereotypes encompass gender discrepancies (unmasculine men, exotic domestic women), character deficiencies (sneaky, backstabbing, disloyal, stingy), relate to appearance (slanted eyes), and are associated with behavioral style (passive, poor interpersonal skills). The microaggressive themes that emerge include: alien in their own land, second class citizenship, denial of racial reality, eroticization of women, invalidation of interethnic differences, pathologizing of cultural values and communication styles, invisibility, and the positive ascription of intelligence (Sue, 2010b). An example in therapy might be a therapist's naïve reference to a visit to South Korea in an attempt to relate to a Chinese patient. Little

research exists regarding the physical effects of racism on Asians, but they do experience low self-esteem, interpersonal career problems, distress, anxiety, depression, belittlement, anger, rage, frustration, and alienation. On the other hand, they also experience feelings of social competence, perhaps related to their unique status as a “model minority” and consequent positive stereotypes that distinguish them from other groups of people of color (Sue, 2010b).

Native Americans. In comparison to other groups of people of color who were captured and enslaved from their homelands or immigrated to the United States, the heterogeneous tribal groups of Native Americans have a unique history of having been displaced from their homes by settler colonialism. In addition, genocide and disease have reduced their population. Common stereotypes about Native Americans influence the themes of the microaggressions used against them, including that they are alcoholics, nonverbal, uneducable, retarded, savage, uncivilized, blood-thirsty, primitive, subhuman, superstitious, poor, passive, and noncompetitive. Researchers have not explored microaggressive themes for this population; however, given their history and current status in America, their culture, spirituality, and values faced invalidation (Sue, 2010b). One controversial example of this is the use of caricatures of Native Americans as mascots for sports teams.

Theoretical Framework of Racial Microaggressions

Critical race theory. Critical race theory,³ which calls for the transformation of society as opposed to incremental change (Delgado & Stefancic, 2012), also emphasizes

³ Critical race theory guided the research in the present study and was instrumental in the analysis of the findings.

a commitment to social justice, the centrality of experiential knowledge, and the transdisciplinary perspective (Solorzano, 2000). The theory was introduced and developed by Derrick Bell, a professor of law at New York University, and subsequently expanded upon by other scholars and activists subsequent to Bell's groundbreaking work in the 1970s (Delgado & Stefancic, 2012). Critical race theory contested the ways in which race was traditionally examined by researchers by examining the relationships between the components of race, racism and power in multiple contexts, including economics, history, group interests, self-interests, feelings, and the unconscious (Delgado & Stefancic, 2012). Clinicians, especially those of the psychodynamic orientation, explore many of these areas in the therapeutic relationship.

Basic tenets of critical race theory are in stark contrast to then-prevailing thought and include the following concepts, many of which : a) race is ordinary in our society, not aberrational; b) White supremacy serves purposes of psychic and material gain; c) race is socially constructed; d) differential racialization occurs for each group and serves purposes specific to the group; e) there are critical intersections between identities and no essential, static characteristics of race; and f) people of color have a unique voice that has authority when it comes to speaking about racism (Delgado & Stefancic, 2012). This theory supports the defining characteristics of microaggressions, e.g., microaggressions happen every day, perpetrators of microaggressions gain and maintain power through such interactions, racial stereotypes are constructed and evolving, and the voices of people of color need to be heard in the conversation about racism. This is especially important in relationships where a differential in power exists, such as the therapeutic relationship.

There are intrapsychic and interpsychic barriers, however, to achieving the ideal of critical race theory—fundamental change in the long-embedded system of race, power, and privilege in the nation. In Leary’s analysis (2007), race is a “closed system.” In the closed system of race, where racial categories are seen as static and all encompassing, we cannot grow closer and appreciate nuance. In an open system, love for example, we appreciate particularity, e.g., we are drawn close to and love others because of particular characteristics, experiences, attachments, and memories developed with them. Therefore, everyday racial experiences, including microaggressions, are governed by the denial of particularity and replaced by socially-constructed meanings of race, racial stereotypes, etc., which are often applied automatically and inflexibly to racially designated others (Leary, 2007).

The otherizing of people of color facilitates the invisibility of whiteness which creates a barrier to White people’s ability to recognize their power and privilege. Becoming closer in a closed system may demand a jarring transition. Changing this dynamic would cause White people to have to relinquish the psychic gain of believing in their fairness and lack of bias (Mazzula & Nadal, 2015; McIntosh, 1990).

Racial identity development. The racial identities of the people in the system are critical to their approaching the conversation of racial differences. While certain physical attributes, such as skin tone, hair texture, eye shape and body type are traditionally associated with distinct racial groups, and thus are a strong indication of individuals’ race, the way in which individuals internally relate is far more complex and continues to evolve as events and experiences with people from the same and other racial groups occur. The fact that individuals may be at different points in their awareness of, and stability in, racial identities has implications for the content of the interaction and the

perceptions that follow. This factor has particular resonance in therapy when clients and clinicians confront potential ruptures and repairs.

The racial identity development process is distinct for each racial/ethnic group. Several scholars have endeavored to create models and delineate this process. For example, Cross's Racial Identity Scale incorporated the nigrescence model of black racial identity development originally developed in 1971 (Vandiver, Cross, Worrell, & Fhagen-Smith, 2002). Additionally, Phinney developed a multigroup ethnic identity scale for broader use (Phinney, 1992).

As a thorough review of the identity development models of each racial/ethnic group is beyond the scope of this project, the Minority Identity Development (MID) will be used as a framework (Atkinson, Morten, & Sue, 1993). This model, originally published by Atkinson, Morten, and Sue in 1979 and since revised, is made up of five stages, each of which has corresponding attitudes toward self, group, other minorities, and the dominant group (Atkinson, Morten, & Sue, 1989). During the first stage, *conformity*, the attitude toward the self includes self-depreciation and shame, both of which may exist on a conscious or semi-conscious level. This attitude extends toward one's group and other minorities, and is consistent with the dominant-held perspective of the group. Groups are seen as more favorable the closer they resemble whiteness and other groups are depreciated.

The individual at this stage appreciates, admires, and respects the dominant group and unquestioningly adopts its values and practices (Atkinson et al., 1989). When individuals in this stage are in treatment, they may fail to recognize microaggressive statements by the therapist, or even agree with the sentiments of a biased therapist, because such negative statements are supportive of the internalized racism of the patient.

The self-depreciating impact of microaggressions may have a psychological effect on the patient irrespective of whether the offending communication is understood on a conscious level.

The second stage of the MID model, *dissonance*, is characterized by conflicts between depreciation and appreciation in attitudes toward the self which are mirrored by conflicts between shame and pride in one's racial/ethnic identity. As counter evidence to the stereotypes of the individual's group becomes more readily apparent and his/her own cultural values are seen as appealing, the individual begins to challenge the dominant view. Persons at this stage also confront a conflict between the dominant-held views about other minorities and the sense of shared experience as oppressed peoples among minority groups. White people are viewed with growing suspicion as people of color begin to see that the dominant group's values are not necessarily beneficial to people of color (Atkinson et al., 1989). Although patients at this stage of racial identity development may be better able to identify microaggressions from the therapist on a conscious level, they may have great difficulty in trying to address the conflict within the dyad, in addition to the inner conflict they may experience.

During *resistance and immersion*, the third stage of MID, persons of color now view themselves as explorers and discoverers of their history and culture. Their identity and physical characteristics, previously sources of shame, are subjects of pride and honor. At this stage, individuals experience a stronger sense of identification with, and commitment to, their group whose members and values are appreciated and accepted without question. Rejection, depreciation, and distrust of the dominant group occur at this stage (Atkinson et al., 1989). There is a conflict between empathy and culturocentrism toward other oppressed groups, however. Alliances may be formed on the basis of shared

experiences, but other groups are valued in proportion to their similarity to the individual's own culture. Cultural issues may be at the forefront of patients' experience in therapy, but notwithstanding a desire to be seen, heard and acknowledged, distrust may cause patients to be less open about some aspects of themselves with White therapists. In addition, as cultural identity is so salient for individuals at this stage, microaggressions may be noticed consciously and have a harmful impact on the therapeutic relationship.

The fourth stage of the model is *introspection*. At this stage, the individual's newfound self-appreciating attitude presents a dilemma: Does the unequivocal nature of group appreciation and allegiance also allow room for personal autonomy? At this stage, additional concerns arise as to whether there is an ethnocentric basis for judging members of other minority groups, and greater value is placed on groups experiencing similar oppression. The individual has conflicting feelings about dominant group deprecation and is navigating the usefulness of incorporating some cultural elements of the dominant group as well as more selectivity with distrust (Atkinson et al., 1989). At this stage, therapy patients might experience more ambivalence toward labeling their experiences in therapy as microaggressions as well as ambivalence toward the conversation and resolution of ruptures.

At the final stage, individuals are *self-appreciating* and have *self-worth* and *confidence* in themselves, as a member of their group, and as members of the broader cultural context. Attitude toward the group is more prideful, yet individualized and dynamic. Respect, understanding and support, coupled with acknowledgment of individual differences, form beliefs concerning members of other minority groups. Finally, there is a greater openness to constructive elements of the dominant group as individuals selectively trust those members of the dominant group who pursue social

justice beliefs and are seeking to eliminate their group's repressive behavior (Atkinson et al., 1989). This stage is optimal for repair of ruptures in therapy as there is room for trust and connection.

In the United States where white is considered "normal," people of color often recognize the implications of their physical and cultural differences early in life, while many White people fail to recognize the advantages they receive on the basis of their racial identity. These blind spots are a culmination of: a) the myth of colorblindness, b) the belief that equality has been achieved, c) isolation from other communities, d) personal disavowal of racism, e) lack of understanding of systematic racism, and f) guilt and shame surrounding one's attachment to White privilege (Altman, 2006). In addition, acceptance of a cultural identity with a transhistorical and transnational legacy of power and privilege utilized to disempower other groups is not only a major undertaking, it carries with it the potential challenge of relinquishing or having to share that power. One scholar (McIntosh, 1990), who accomplished that journey, described the process of realization of the advantages her whiteness gave her:

In proportion as my racial group was being confident, comfortable, and oblivious, other groups were likely being made unconfident, uncomfortable, and alienated.

Whiteness protected me from many kinds of hostility, distress, and violence, which I was being subtly trained to visit in turn upon people of color (p. 33).

She acknowledged how the intrapsychic conflict of White therapists might result in a harmful impact on the therapeutic relationship with patients of color.

Whiteness has always been defined as a juxtaposition to Blackness which is otherized (Altman, 2006; Helms, 1997). Thus, the paradoxical aspect of White racial identity—the lack of reflection about the meaning of being White—is put into

perspective. Historically, Anglo Saxon whiteness connoted “fit for self-government” (Altman, 2006), giving other groups not then considered white, e.g., Irish and Italian, insight as to the ways in which the category was defined and how they might maneuver themselves to achieve access to the fantasy of whiteness (Altman, 2006).

Many European immigrant groups to the United States gained access to the social location of whiteness when the group was able to distance itself in ways, sometimes subtle and sometimes violent, from Black people and other people of color (Guglielmo & Salerno, 2003; Roediger, 2006). The distinction between whiteness and “other” is also that one group possesses freedom while others are unfree. The fantasy of whiteness therefore grants omnipotence and mastery, as well as limitations from the full human experience of loss, pain, and risk (Altman, 2006). Thus, there are various intrapsychic and interpersonal processes by which whiteness remains protected and exclusive, if unexamined.

While much of the racial identity research concerns people of color with a focus on their experiences of racism in which they are often portrayed as victims, Helms (2014) endeavored to explore the process of White racial identity development. Her model incorporated two main processes: the abandonment of racism and the development of a non-racist White identity (Helms, 1997, 2014). During phase one, the White person first perceives the idea or actuality of people of color, but from constrained perspective due to limited interracial interaction. Attitudes are then often characterized by obliviousness and colorblindness, naïve curiosity, or trepidation. Affects include positive self-esteem and the belief that people of color are treated fairly by society. Transition status occurs when the White person accepts the reality of the pervasiveness of racism after encountering a sufficient number of incidents in which people of color are not treated equally.

At the disintegration status, individuals feel conflicted, but conscious of their own whiteness. Incongruence leads to discomfort which is reduced by information seeking, avoidance of people of color, or denial of racism. Affects then include guilt, helplessness, anxiety, and depression. At the next transition phase, there is a desire to be accepted by one's own racial group and adopt attitudes of White superiority. At the reintegration status, individuals acknowledge a White identity and view others as inferior and their own privilege as earned. Residual feelings of guilt are transformed into fears of people of color. Racism may be passively or actively expressed. This attitude persists until White individuals have a jarring experience or realization that causes them to question their previous definition of whiteness and privilege and serves as a transition to phase two (Helms, 1997). A White therapist in phase one may adopt a colorblind attitude or patronizing manner toward patients of color which can manifest in microaggressions.

During phase two, the White person enters "pseudo independent status" where the White "liberal" questions the notion of people of color's innate inferiority and acknowledges White people's responsibility for racism and their continued participation in it. Affect from the previous stage is submerged and feelings of sympathy for people of color emerge. This, along with intellectual curiosity toward people of color, facilitates redefining a White nonracist identity that incorporates a sense of responsibility to ameliorate the consequences of racism. Behavior may change in that more contact is sought with people of color; however, a White person at this stage often pursues an assimilationist agenda with people of color, expecting them to adopt the dominant culture's values. At this stage, the White person may still arouse suspicion among people of color, particularly if they are expected to explain racism to the White individual or if it

is perceived that the White individual is implying that it is the responsibility of people of color to change the conditions of the systematic racism impacting them.

The next transition phase, immersion/emersion, is characterized by self-reflection and consciousness raising as the White person may seek out positive aspects of whiteness, i.e., those not related to racism. Emotional as well as cognitive restructuring can happen at this stage. Successful resolution apparently requires emotional catharsis in which the person re-experiences previous emotions that were denied or distorted. The final stage, autonomy status is an ongoing process that involves internalizing, nurturing, and applying the new definition of Whiteness evolved in the earlier statuses. The White person no longer feels a need to denigrate, oppress or idealize people on the basis of group membership characteristics such as race because race no longer symbolizes a threat. Individuals at this status, akin to racial self-actualization, are seeking to abolish racial oppression, experience kinship with others regardless of race, and actively seek to learn about other cultures (Helms, 1997). A White therapist in the first part of this phase may fail to acknowledge the ways in which they blame the victim and cause ruptures in the therapeutic relationship. At the autonomy status, however, there is more room for openness and exploration of potential microaggressions.

Social cognition. Social cognition, defined by Smith and Semin (2007) as “the mental representations and processes that underlie social judgments and behavior—for example, the application of stereotypes to members of social groups” (p. 132), may provide some insight into the phenomenon of microaggressions. Although mental representations have traditionally been thought of as automatic, stable and independent of context, some research has demonstrated that representations are associated with social goals, are context-driven, and are impacted by bodily states (Smith & Semin, 2007;

Wennekers, 2013). In a study where individuals were primed with both social category stereotypes and matching or nonmatching contexts (e.g., Airport -> Arabs -> terrorists), researchers concluded that stereotypes are automatically processed based on congruent context (Casper, Rothermund, & Wentura, 2010).

Much of social cognition relies on categorization of individuals into groups based on perception of shared characteristics. Categorization occurs when stored information is activated, an exemplar is compared to the activated information, and the likelihood of category membership is activated (Barsalou, Huttenlocher, & Lamberts, 1998). One example of human categorization is the stereotype which functions to summarize information about a group based on previous learning and to inform interpretations of new information gained through future encounters (Smith & Semin, 2007).

Understanding stereotypes as a method of conserving cognitive resources, the position of Casper et al. (2010), does not excuse the perpetrator or mitigate the damage they cause.

Human categories are thought to have deep, hidden, and unchanging meaning (Bastian, Loughnan, & Koval, 2011). While categorization may serve as an important tool when we encounter new information, this process can become extreme and rigid when stereotypes are not sufficiently flexible to take individual differences and situational factors into account. For example, a therapist might mistakenly assume that a Black female patient is an unwed mother because some of her other Black female patients have children fathered by boyfriends.

Essentialist thinking, a form of category representation that makes social categories more apparent in social perception at the expense of erasing the individual, provides fertile ground for microaggressions. For example, when White people enthusiastically compliment Asian Americans on their excellent command of English, the

underlying “essentialist thought” is likely to be that Asians are foreigners who do not speak English because their families come from “exotic” places. Indeed, for a stereotype to be maintained, unusual individuals are discounted (Barsalou et al., 1998). Perhaps awareness of the process by which stereotypes are created and maintained could be beneficial in order to contemplate solutions that would avoid this frequent source of microaggression.

Much of the early research on microaggressions primarily focused on race. Findings indicated that racial microaggressions become automatic as a result of social conditioning and may be neurologically connected with the processing of emotions around prejudice (Sue et al., 2007). Thus, challenging microaggressions becomes a task of unlearning and establishing new associations on a neural level—a process made more difficult in view of the likelihood that the cognitive mechanisms surrounding microaggressions are ingrained and highly defended. For example, in an effort to maintain their self-image as decent moral human beings, oppressors often engage in defensive maneuvers to deny biases (Sue, 2010a; Sue et al., 2007; Sue et al., 2008), such as the claim to have Black friends. While this assertion may be perceived by the person who made it as irrefutable proof of the absence of racism, such remarks can be perceived by people of color—who encounter racism on a daily basis—to be deceptive and an attempt to conceal or justify prejudices (Sue et al., 2007). Interestingly, Sue noted that other researchers who contested his work on racial microaggressions used techniques that mimicked the cognitive defenses of a perpetrator of microaggressions in their critiques, such as rationalization, minimizing, trivializing, and blaming the victim (Sue et al., 2008). The stakes are the same for both individuals who admit committing a

microaggression or expressing prejudice and the individuals perceiving the microaggression—their self-image as decent, moral human being.

Implicit biases. Along with the cognitive and affective processes involved in stereotyping and categorization that often form the basis for unconsciously motivated microaggressions, implicit in-group bias, e.g., attitudes favoring the social category to which an individual belongs, can influence social behavior without any intention or awareness (Blair, 2001). In-group bias facilitates the belief that some behavior or characteristics of the external actors are the basis for negative attitudes toward them, rather than bias within the individual. For example, research studies of both race and gender have demonstrated that faster responses occurred when devalued categories were associated with negative words, thus confirming the presence of implicit stereotyping (Greenwald & Banaji, 1995; Greenwald, Poehlman, Uhlmann, & Banaji, 2009).

It is common for people to communicate with or act unfairly toward those belonging to different and/or devalued social groups without a conscious motive. For example, Dovidio and Gaertner found that some White people may use observable nonverbal behaviors, such as reduced eye contact or a less warm and natural tone of voice, during interactions with people of color when implicit biases are held (1986). Internal neurological processes also occur when implicit biases are activated, indicating that one aspect of racial bias may be automatic and based on familiarity and identification. Studies reviewed by Eberhardt in 2005 indicated that both White and Black people exhibit more positive evaluation bias (greater amygdala response habituation) to in-group faces than to out-group faces (as cited in Mazzula & Nadal, 2015). Because racial groups hold differential power and privilege, however, biases of group members would not have the same impacts.

Individuals with implicit in-group bias may be fully aware of the biased attitudes they hold but lack insight into the operation and sources of such attitudes (Wennekers, 2013). Thus, racists may be able to offer detailed explanations of their ideas about people of color without any knowledge of the source of their attitudes or how such attitudes manifest in interpersonal interactions. In terms of race, studies have found that some White people unconsciously associate being different with being deviant, pathological or abnormal when the cause of such belief, in actuality, is their own bias—a process known as projecting (Sue et al., 2007).

The denial of bias is sometimes just as harmful as its explicit presence. As people attempt to preserve their ideal of themselves as unbiased and fair, they are likely to endorse colorblind attitudes, e.g., that they treat all equally (Mazzula & Nadal, 2015). When such well-intentioned people commit microaggressions, they may react with defensiveness to preserve their image and that of their social group, and not be able to see the perspective of the victim. For example, therapists might think that they can check their attitudes at the door of the therapy room and not allow them to influence countertransference.

Along with implicit biases and perceived group differences, cultural differences exist that privilege some belief systems and style of interaction over others. For example, the (White) Western bias stresses individuality and objectivity, while other cultures emphasize collectivity and subjective experiences; White people's communication styles tend to be more objective, detached and unemotional, while Black people tend to be more expressive, passionate, interpersonal, animated, and confrontational (Sue et al., 2007). Those aspects of cultural identity associated with communication and relation to others are especially salient to the therapeutic relationship. For example, the Western bias of

individualism and assumption of individual autonomy can lead to victim blaming when a person from a collective culture asks for help and support.

Illustrations of cultural differences leading to misperceptions can be found in the literature, e.g., a Black man asking for information may be perceived as lazy rather than seeking help, a Black man seeking to acquire job skills may be perceived as wanting handouts (Sue et al., 2007). In addition, microaggressions may be expressed in the therapist's negative verbal or nonverbal reaction when patients of color relate experiences in the form of storytelling or describe their friend groups and family structure. Another method by which microaggression can occur is when therapists minimize areas of importance to the patient because these aspects are given less prominence in the therapist's culture.

Affect. Cognition, behavior, and emotion are intricately linked. In terms of affect, emotions such as anger, fear and disgust influence avoidance behaviors toward outgroups in addition to distance and lack of understanding perpetuated by prejudice (Bastian & Haslam, 2011; Wennekers, 2013). Avoidance behaviors, such as not wanting to shake hands or sit next to a person of color, themselves may be perceived as microaggressions, conveying the message to people of color that they are unclean or unsafe. In addition to readily observable behaviors, emotions motivating perpetrators are felt by victims as well through the process of projection. (For a more detailed explanation of projection see the discussion of object relations below.)

Leary (2007) posited that shame is the primary emotion evoked in microaggressions or stereotyping. Shame functions as a tool of behavioral regulation and control when victims assume false complicity in the authorship of the stereotype. For example, Asian Americans may feel pressure to adopt a White American-sounding name

or change cultural practices when confronted by exoticising microaggressions and stereotypes. In the context of therapy, therapists' denials of implicit bias or stated belief that they are incapable of committing microaggressions can lead to feelings of frustration, doubt, and mistrust in patients who perceive the microaggressions (Mazzula & Nadal, 2015).

Object relations theory. The school of psychoanalytic theory known as object relations holds that the ways in which we view and relate to others are shaped by the significant, symbolic and meaningful relationships between people and early love objects. This concept may extend to our relationships with others as representatives of racial categories (Altman, 2000). The processes involved in microaggressions are inherently interpersonal and object relational. Although a full exploration of race and object relations is beyond the scope of this study, an overview of their interaction offers a salient theoretical foundation for the present investigation.

Race is one of the categories by which we define ourselves, others, and our relation to others. Altman (2000) described these categories as constructed in the service of a bounded, masterful self, that is, a self that can identify the borders and characteristics of "me" and "not me." The contrast is helpful in that it can facilitate positive racial identity, group identification and self-preservation when there is a threat; however, it can also facilitate distance when intimacy is needed. From a psychodynamic point of view, abstract, unconscious thoughts and beliefs have a great deal of impact on the therapeutic relationship and process, even more so than any concrete and observable aspects of therapy.

Race makes us different enough to project fears and other affects upon the other, but similar enough to also have strong feelings for the other, like idealization or hatred

(Altman, 2006). The therapy room is a microcosm of society where transference and countertransference reactions inform the direction of the treatment. Cross racial therapeutic relationships therefore can stir up many different projections and identifications based on the experiences of both the patient and therapist in encountering the racial other. Patients may culturally “test” the therapist by making statements pertaining to race and giving the therapist the opportunity to reply or react to them. The therapist’s response will prove or disprove the patient’s expectation of how the therapist metabolizes race and engages with it, and thus inform the patient’s level of trust (Gaztambide, 2012).

Altman (2006) described a fear of some White people to engage in conversations about race with people of color because they might have to confront uncomfortable emotions regarding racism, e.g., fear and guilt. A lack of engagement on the part of White therapists may influence them to disavow unwanted feelings and project them onto the racialized other as a defense while they continue to be haunted by them. From the perspective of object relations theory—we develop a sense of ourselves through the eyes of the first objects with which we interact, our parents—people of color may then internalize or introject this self-image based on how other figures see them (Altman, 2006). Where power and authority are unbalanced, as in the therapeutic relationship, the potential for a patient of color to introject and identify with the projections of the White therapist is significant, and could be potentially paralyzing when the impact of the microaggression is multiplied by both the power differential in the room as well as addition to racial object relations dynamics in the larger society.

In a therapeutic relationship where patients’ ability to express a range of emotions is crucial, repression of feelings inhibits responses to a microaggression that would serve

the client's interests. Unspoken ideas, histories, and feelings about race are always in the room with the therapeutic dyad informing what is said or not said and how interactions unfold. An additional element in the therapeutic relationship that has special relevance to cross racial therapy is what Altman termed "the third space," i.e., the societal space (2000). To illustrate, Altman described his racial countertransference toward a Black male patient who had overdue fees, his potentially occupying the stereotype of the greedy Jew, and the patient's potential experience of internalized racism. Not surprisingly, this resulted in an impasse in therapy (Altman, 2000).

Interpersonal dynamics and impacts of microaggressions. Social cognitive and implicit in-group bias principles provide some explanation for why microaggressions occur, but the interpersonal dynamics during and after an instance of microaggression warrant discussion as well. The interpersonal psychological dynamics of microaggressions include: a) a clash of realities, e.g., individuals differ in their perspective on how salient social categories are and what they mean; b) the invisibility of unintentional bias and discrimination, leaving victims to question whether something occurred and whether they are justified in speaking up; c) perceived minimal harm, e.g., the offender trivializes the potential impact; and d) the catch-22 of responding, whereby the victim is torn between addressing the issue and being seen as overly sensitive, or letting it go and feeling resentment. To complicate the dilemma for the victim, the interaction is conducted in a context of power and privilege differentials (Sue, 2010a).

The processing of a microaggression is complex and involves several steps. First, one must make a determination as to whether an interpersonal interaction qualifies as a microaggression. It is likely that contrasting perspectives of the offender and the victim will result in different answers. Another factor in how a possible microaggression is

processed is the status of the recipient. People in positions of power are more likely to experience instances of microaggressions as singular and not recognize harm, whereas oppressed people tend to recognize a pattern in nonrandom events when their only common denominator is their identity category (Sue et al., 2007). Additional concerns may be present in a help-seeking relationship such as psychotherapy, including: a) there may be apprehension as to whether speaking up would jeopardize the patient's quality of care, b) the potential of the psychologist to further pathologize the patient, and c) the development of an impasse in treatment or premature termination because the patient does not feel he or she will be understood. With such clashing points of view on the issue, it is no wonder that communication and repair are difficult. Ruptures and repairs can also be valuable aspects in strengthening therapeutic relationships insofar as both patient and therapist engage in honest communication.

Too often, however, it seems as if the result of microaggressions is additional support for a range of already present personal and societal beliefs and behaviors surrounding identity. In order to avoid any disharmony that would reify stereotypes, persons experiencing microaggressions may engage in rationalization or self-deception, thereby challenging the reality of their experiences, rather than advocate for themselves (Sue et al., 2007). A further complication arises from what bell hooks characterized as White society's interest in pathologizing "anger" as "rage," because Black rage is perceived by them as alarming. She advocated that Black people instead own rage rather than acquiesce to the sense of victimization that promotes passivity and is encouraged by the dominant society (as cited in Altman, 2006).

Groups that experience chronic microaggressions are often marginalized and disempowered (Sue et al., 2007; Sue, 2010a). These populations endure the constant,

cumulative experiences inherent in living on the lower or outer limits of social desirability; consciousness; and the sociocultural, political, and economic spheres (Sue, 2010a). As marginality may contribute to social distance among groups and thus minimal opportunities for them to have contact and understanding, microaggressions may be even more likely to occur.

Researchers have demonstrated that unconscious, subtle acts of oppression by even well-intentioned individuals are more damaging than overt racism in that they affect overall wellbeing and contribute to inequities in healthcare and employment (Sue, 2010a; Sue et al., 2007; Wennekers, 2013). When microaggressions are commonplace within institutions, such as in the example discussed above of a health center in which only representations of Whites are visible, environments of social distance and silence are promoted. This situation can only compound the already existing healthy suspicion or distrust that people of color in need of services have toward mental health systems.

Dehumanization, perceived when basic aspects of personhood, identity and status are undermined or not socially valued (Bastian & Haslam, 2011), is another way in which people of color receive messages that they are of less worth than others. For example, when a Latina guest at a hotel is mistaken for a maid, she may perceive that because of her ethnicity and gender—identities salient to her—she is somehow less than others. She may think that she is not viewed by others as a person with the potential to fulfill a variety of roles beyond a stereotype. Researchers have identified specific cognitive and affective impacts that may result from dehumanization, such as a) aversive self-awareness, shame and guilt when the failure to recognize a person's equal status occurs; b) cognitive deconstructive states, sadness and anger in response to a denial of personhood; and c) psychological distancing (Bastian & Haslam, 2011; Sue, 2010b).

In a therapeutic relationship, the affective results of microaggressions may be mistaken by the therapist as symptoms of the patient's underlying mental illness and then treated unsuccessfully, frustrating the therapist. On the other hand, when the affective responses are so incongruous with the presenting problem that there could be no confusion, both patient and therapist may be lost as to where to go next unless the patient is confident enough to speak up. Thus, irrespective of the intentions of the perpetrator, it would appear that the consequences of microaggressions harm the individual victim and result in less contact and lack of communication across groups.

Racial microaggressions in therapy. The therapeutic relationship is designed to serve a healing purpose. Ideally, therapists draw on their expertise and training to help the client through hardship, mental illness or self-discovery. All individuals have been socialized within particular historical, social, cultural and political contexts, however, and these shape our views about ourselves, the therapeutic relationship, and psychological wellbeing (Mazzula & Nadal, 2015). In addition, therapy is a microcosm of race relations in a society that promotes Western ideas of normality and abnormality. Thus, neither therapist nor client enters the therapy room stripped of their authentic identities, biases, and values. Thus, it is unrealistic to believe that biases will not impact the treatment in subtle or overt ways.

Any content representing racist beliefs may manifest and harm the relationship as well as the help seeker. Therefore, therapists must explore their biases in the transference and countertransference process to guard against subtly conveying attitudes that a patient of color is less intelligent, capable, or worthy (Owen et al., 2014; Sue et al., 2007; Vasquez, 2007). It is the therapist's responsibility to ensure the avoidance or repair of destructive interactions.

Colorblindness. Cross racial therapy dyads may confront both institutional and racial power dynamics. The context of the institution of psychotherapy offers insight as to the difficulties the profession has experienced in providing effective services to people of color. Based on historical and continued injustices, many people of color have a healthy suspicion or distrust of mental health institutions—beliefs more difficult to overcome when the majority of therapists are White (Constantine, 2007; Sue et al., 2008). Racist attitudes or aversive racism can manifest unconsciously (Constantine, 2007), and even well-intentioned therapists can covertly communicate biased or prejudiced messages to clients. Despite recent efforts undertaken by the profession to make treatment more inclusive, e.g., requirements that counselors receive multicultural competence training, microaggressions still continue. Perhaps the training received is limited, counselors were not fully engaged in or invested, or the ideas were not practically applied in training.

Some counselors may adopt a colorblind attitude, e.g., minimizing or erasing the importance or existence of racial difference, or engage in blaming the victim by a failure to acknowledge the impact of other groups or circumstances on a client's difficulties. These problematic attitudes may be the result of the therapists' unwillingness to accept that they could hold any beliefs that would be detrimental to patients as that admission would be incongruent with the therapist's sense of self as an agent of change (Mazzula & Nadal, 2015). While this practice may, as with any other defense, ease some anxiety, it leaves the conflict unresolved. In addition, when therapists employ defenses, patient relationships are harmed. For example, colorblindness—functioning as a denial of White privilege—was shown to relate to lowered empathy (Constantine, 2007; Shelton & Delgado-Romero, 2011).

This has serious implications when treating patients of color, especially if cultural factors are critical to the presenting problem, as lowered empathy may prevent the therapist from seeing the level of the patient's distress and processing emotional material. Indeed, research has shown that treatment neglecting the context of racial and cultural factors partially explains poor engagement, missed appointments, mistrust, and premature termination among patients of color (Mazzula & Nadal, 2015; Owen et al., 2014; Sue et al., 2008). There have been attempts by the field to address issues that White therapists face when treating persons of other backgrounds. For example, the American Psychiatric Association's most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (2013) has been updated to include a cultural formulation interview guide. This protocol, designed in part to reduce the anxiety or apprehension clinicians might have surrounding the discussion of race, is a tool to assess a patient's cultural and historical context that may impact treatment (American Psychiatric Association, 2013). Perhaps a standardized instrument meant to make the process more formalized will help clinicians avoid mistakes and microaggressions but, as with multicultural competency training, negative practices continue to occur.

Denial and discomfort. Another type of microaggression is aimed to provide evidence of a lack of racism, such as self-righteous assertions that "I have a Black friend," or "I love Korean food." These offensive comments are often the result of the White therapist believing that such comments will help to build connection and rapport. The goal may be creditworthy as the therapeutic alliance, including the quality of interaction, collaboration and development of a bond or attachment, has been found to be the greatest predictor of therapy outcomes (Constantine, 2007; Vasquez, 2006). Therapists may also think that such statements will aid in reparative work for the clients

who have suffered from racism; however, as discussed below, a microaggression in the therapy setting might have the opposite effect. Clients may feel disheartened that racism does not elude them even when they are seeking help and healing. Retraumatization may be experienced by African American clients (Constantine, 2007).

Discussing race and ethnicity with clients, while remaining vigilant about client reactions, is not easy for therapists, but a therapist's reluctance to have these conversations will result in many missed opportunities for cultural attunement and repair. Patients may become less engaged, stay reluctantly, or drop out. The people of color who stay reluctantly might have felt forced to engage in a cost benefit analysis, weighing the integrity of their cultural identity with their desperate need for help. In addition, researchers have confirmed that a therapist's unwillingness to participate in such discussions may contribute to a negative treatment process and outcome (Owen et al., 2014).

Microaggressions by therapists of color. There has been a lack of consensus in the field about whether matching therapists with clients of the same race and ethnicity is beneficial for patients. The presumption was that stronger therapeutic alliances would result when patients were treated by therapists of the same race and ethnicity (Cabral & Smith, 2011). While patients might feel more comfortable and better able to relate to therapists who look like them, matching dyads might also be perceived favorably by therapists, particularly those of color, who feel strongly about working with people from their community. In a study of 36 Black therapists working in a variety of settings, researchers found that the therapists felt more solidarity, a greater sense of commitment, and made easier and faster therapeutic connections with their Black patients (Goode-Cross & Grim, 2016). Such feelings are likely to have a positive impact on the patient by

creating a warm and supportive bond. It should be noted, however, that there are potential pitfalls, as discussed below, for racially matched dyads. The exterior presentation does not in itself predict the success of the client/patient relationship.

Researchers have investigated the linkage between racially matched therapist and client dyads. In a meta-analysis of 52 studies examining patient preferences and responses to matching, there was a moderately strong preference (Cohen's $d = .62$) for a same-race therapist. Across 81 studies, there was a tendency of patients to perceive same-race therapists slightly more positively (Cohen's $d = .32$). Finally, across 53 studies, almost no benefit was found (Cohen's $d = .09$) to treatment outcomes of racial matching (Cabral & Smith, 2011). These findings indicate that a more positive therapist/client relationship does not necessarily translate into better treatment outcomes; however, it should be noted that treatment outcomes are not measured through identical means, but in a variety of ways across different therapy modalities.

Interestingly, there may be some added value for Black patients seeking a Black therapist, as research has shown that all of the effect sizes were higher among African Americans (Cabral & Smith, 2011). This may be explained by the inclusion of racial socialization messages in treatment to soothe the effects of racism, and the tendency of Black therapists to self-disclose more to normalize the experience of Black patients (Goode-Cross & Grim, 2016). For people of color who may not have significant knowledge about treatment, self-disclosure can demystify and destigmatize the process of therapy (Helms & Cook 1999).

Therapist and patient characteristics other than race and ethnicity can contribute to the success or ruptures in a relationship and microaggressions and impasses do occur when therapists of color are the same race or a different race from their patient, e.g., both

Native American, or an Indian therapist and a Black patient. In a study of 2,212 participants with both same and mixed dyads, 81% reported at least one perceived microaggression in therapy, mostly consisting of denial or a lack of awareness of cultural stereotypes (Hook et al., 2016). Although this did not hold for Black therapist/client dyads, for racially matched dyads of Latinxs and Asians, however, microaggressions were more impactful. These results may be attributed to: a) patients having greater expectations of therapists who looked like them (Hook et al., 2016); and b) transference, and/or associations that may not match the internal racial identity or experience of the therapist.

Paradoxically, aspects of a matched racial therapy dyad may contribute to the instance of a microaggression, for example, therapists of color might hold biases toward other people of color based on socialization in a White supremacist society. Black clinicians who participated in Goode-Cross and Grim's 2016 study acknowledged their lack of formal training in working with Black clients and possible boundary crossings. Additional causes primarily arose from issues of identification, e.g., denial of identification or overidentification; or differences in other intersectional dimensions of identity, e.g., socioeconomic status, age, particular ethnic identity, sexual orientation, religion, and/or gender, among others (Goode-Cross & Grim, 2016). For an example of missteps surrounding identification, the patient in a racially matched dyad may comment about something particular to their shared racial experience and seek validation from the therapist by asking, "You know what I mean?" The therapist might avoid the question or self-disclose in a way that crosses boundaries. Overidentification might involve therapists making assumptions about patients based on their own experience, or giving the patient special treatment like extending sessions without compensation. In addition, because of

their shared race, therapists may make incorrect assumptions that patients have similar identities and values on other dimensions, i.e., Latinos are Catholic, Black patients struggled economically, Asian patients were raised with stereotypical gender roles.

Another factor that might impact the relationship between a therapist and a client of the same race concerns their being at different stages of racial identity development. For example, a patient may be in the integrative awareness stage of Helms' model (values collective identity and empathy for other oppressed groups), while the therapist is in the conformity stage (devalues in-group and idealization of whiteness). If this is the case, expectations of the client may not be met by a therapist who fails to understand the salience of the patient's experiences of racism (Helms & Cook, 1999). By the same token, if the roles were reversed, the more integrated therapist might be increasingly frustrated when a conforming patient does not understand the nuances of race and ethnicity.

Colorism, in which lighter-skinned people of color (closer to appearing or passing for White) are privileged, is a pervasive issue across communities of color (Helms & Cook, 1999), and may bring up a host of feelings and associations about the way patients or therapists feel about themselves or others in their racial group. For example, darker-skinned patients may not react positively to lighter-skinned therapists' attempts to empathize, because patients may question the similarity of their experiences. Differences in skin tone may increase the distance between the dyad, and, if left unaddressed or denied, may be as harmful as other microaggressions.

Language is an additional dimension in which issues may arise between patients and clients of color. Patients may be more comfortable expressing themselves or reverting to their native language or dialect when discussing highly emotional and/or

painful matters (Helms & Cook, 1999). It is essential to follow the lead of the patient and not go beyond one's competence in the case of language switching (or code switching), otherwise this attempt to connect through the use of language might be perceived as mimicry. Language may also be associated with life stage and social class, where the same warnings apply. Imagine an older therapist treating an adolescent of color whose conversational style reflects slang and other "street" vernacular. Differences of age and social class may be more salient than the dimension of race in this case, and a therapist's adoption of the client's style, even if done in a well-meaning effort to connect, is not likely to be seen as authentic by the client and might not prove valuable for the relationship. Considering the potential pitfalls, researchers encourage an attitude of cultural humility, or an orientation of openness to the other, when aspects of cultural identity are important to the patient (Hook et al., 2016).

Therapeutic alliance. The therapeutic alliance was described by Vasquez (2007) as "the quality of involvement between therapist and client or patient, as reflected in their task teamwork and personal rapport" (p. 879). Vasquez also stressed the vital role of the clinician in the alliance: "The therapist's contribution...is an important element of that involvement" (p. 879). The therapeutic alliance provides a context for therapist and patient to work through difficult feelings and experiences while relating to each other and/or representations of the other. It is considered to be critical to facilitating therapeutic work as the quality, nature and strength of this alliance has been demonstrated to have a significant impact on outcomes (Sue et al., 2007; Vasquez, 2007). One study demonstrated that the quality of alliance accounted for 7% to 14% of the variance in treatment outcomes (Owen et al., 2014).

The therapeutic alliance is not a simple static relationship that either exists or does not. It is dynamic in nature, with an emphasis on the process components of relating to the other person and the subjective quality of that experience. The alliance may also be viewed, according to Bordin, as a contract or agreement between the two parties on the goals of therapy and the methods used to reach those goals, in addition to the relational bond (1979). This definition emphasized mutual participation in the earliest phases of creating the alliance as client involvement will act, to some extent, to counterbalance the power dynamic in the dyad, and set the tone for the remainder of the relationship.

Several factors contribute to the formation of a strong therapeutic alliance and also the potential ruptures of one, including the historical, social and environmental factors that influence how individuals enter the relationship. Sue et al. expressed the view that the perception of a positive relationship is the most important factor in the alliance (2007). It is apparent then that microaggressions have a grave impact on client perceptions and thus the therapeutic alliance. Insensitivity to race and ethnicity may influence the patient's negative perception despite a well-intentioned therapist's use of other therapeutic techniques to build rapport and express concern. Various studies have confirmed that the perception of racial microaggressions was negatively associated with the perceived quality of the alliance as well as overall satisfaction with services (Owen et al., 2014).

In addition, as the first, and arguably one of the most important tasks in therapy or counseling, the therapeutic alliance is a significant point of intervention to address the harm of racial microaggressions that occur outside of the therapy room. Consider the example of environmental microaggressions, as discussed above, in which people of color may perceive that they will not be welcome or understood when entering a room

where the dominant culture is represented exclusively in the form of employees, art, magazines, etc. (Sue et al., 2007). If a similar environment is present in the treatment center, the patient may have negative expectations and concerns with White therapists. This is especially likely for patients not accustomed to mental health services who may not be able to distinguish between the therapist and the institution.

People of color also bring histories, current social injustices, stigma and marginalization which, whether experienced on a conscious or unconscious level, may be expressed through a range of reactions, including shame, discomfort or mistrust, when the therapist represents the historical oppressor (Mazzula & Nadal, 2015; Sue et al., 2007). A further difficulty may arise from therapists' inability to distinguish between patient defenses and resistance, given the healthy cultural suspicion people of color bring to institutions and mental health interventions. A careful consideration of cultural context may aid clinicians in identifying the adaptive function of the resistance, especially in the case of White clinicians who have not recognized their privilege and its impact.

Another important consideration arises out of the events and context that motivated the client to seek help prior to intake. People of color seeking mental health help generally access the community/cultural resources they trust prior to entering therapy. They often enter treatment only after exhausting services in their communities that failed to provide the help they needed. Thus, they are likely to present in greater distress than other populations (Sue et al., 2007). As patients are often particularly vulnerable at this point and longing for support, therapists may commit microaggressions in attempts to join with the patient, such as overcompensation for the level of recognition of social injustices in the world, or in efforts to overidentify with patients. Conversely, therapists who consider it "fair" to treat patients of color like everyone else may adopt

colorblind attitudes. It should be noted, however, that cultural issues may not be the most salient aspect of help seeking for people of color (Mazzula & Nadal, 2015), reinforcing the responsibility of therapists to listen to each client with an open mind.

Researchers identified personal attributes of therapists and techniques that can contribute positively to the alliance, such as flexibility, honesty, respectfulness, trustworthiness, confidence, warmth, interest in the patient, and openness. Helpful techniques included exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience (Ackerman & Hilsenroth, 2003). Comas Diaz (2006) cautioned therapists to be aware of the variety of factors and attitudes people of color and immigrants might bring to therapy and thus to engage with clients in a careful manner. Thus, general therapeutic techniques and a warm presence, while essential elements for the foundation of an alliance, are not sufficient in and of themselves.

Differences in the quality of the therapeutic alliance partially explain some of the disproportionate rates of utilization and dropout between White patients and patients of color (Goldstein, 2008; Sue et al., 2007; Vasquez, 2007). People of color underutilize services and often terminate prematurely. Fifty percent of the time people of color enter treatment they terminate after one session, in contrast to 30% of Whites who terminate after one session (Sue et al., 2007). This situation may be changing as more recent studies on attitudes toward help seeking have shown that people of color do not self-report less willingness to seek mental health treatment as was thought previously (Mazzula & Nadal, 2015).

If African Americans are increasingly open to the idea of seeking mental health treatment, what is the explanation for the comparative lack of positive outcomes?

Microaggressions may be a determining factor deterring people from continuing the therapeutic process. The good news is that a strong therapeutic alliance can be a mediator between microaggression and therapy outcomes and will allow the relationship to get through rupture in a meaningful way (Owen et al., 2014). Therapists are in the profession to effectuate positive outcomes. This should be motivation enough to not only form strong alliances, but to repair alliances that are broken.

Rupture and repair. The causes of ruptures are complex and multiple. Therapists should be aware of their participation as well as the patient's collusion in the process (Gaztambide, 2012). Ruptures were defined as a breakdown or tension in the collaborative relationship of patient and therapist, and might be caused gradually by minor transactions or be manifest in dramatic negative processes (Safran, Muran, & Eubanks-Carter, 2011). Safran and Muran (2000) described two markers indicating rupture: patient withdrawal, e.g., the patient appears increasingly distant (although patient attitudes of distance and frustration in therapy may also be related to life circumstances outside of therapy), and confrontation, e.g., clear negative transference or explicit hostility and anger is expressed toward the therapist. If the therapist is not conscious of the process unfolding or exhibits a lack of sensitivity, outcomes may worsen as the patient's trust and level of comfort in the relationship declines.

Ruptures can seem very subtle or ambiguous (Owen et al., 2014). As the process unfolds in therapy, it can be a difficult task to repair the relationship given the complex intrapersonal and interpersonal dynamics occurring in the dyad. For the benefit of the relationship and treatment, the therapist has to intervene to resolve the tension as well as correct the cultural misattunement if the rupture is caused by a racial microaggression. Ruptures may also result from the absence of empathy, or what Comas Diaz (2006)

referred to as missed empathic opportunities. These types of ruptures might occur when therapists adopt colorblind attitudes or avoid acknowledging the patient's distress related to racism.

The divergent life experiences of patients of color and White therapists often result in contrasting degrees of sensitivity to ruptures in therapy caused by microaggressions, and make it less likely that ruptures will be addressed. For example, the nation's history of discrimination and racism, in addition to people of colors' personal experiences, have caused them to become particularly sensitive to these issues and prone to shame. On the other hand, White therapists who may be knowledgeable about the historical context but lack personal experiences of being the victim of racism, may not have this sensitivity and thus may convey negative messages through nonverbal behavior (Vasquez, 2007). One example of this is colorblindness. Patients experience blame, nonverbal anxiety and lower empathic understanding coming from their therapist and have less faith in the therapist's credibility and honesty, while therapists who adopt a colorblind attitude avoid guilt about their privilege (Sue et al., 2007).

Inappropriate interventions or dismissive or negating messages about cultural heritage may recapitulate cultural injustices occurring outside of the therapy room and create an impasse in the therapeutic process (Owen et al., 2014). Therapy presents an opportunity for those injustices and negative relationships with the oppressor to be experienced differently, but that process demands both people to be attuned and willing. When that doesn't happen and offending behavior is unaddressed, impasse in the therapeutic process often results (Owen et al., 2014), and patients become increasingly distressed with subsequent incidents.

Reactions to microaggression ruptures in therapy vary and serve different functions, including self-protection and suppression of shame. Patients often feel invalidated and disrespected as the rupture detracts from the goals of therapy and the reason they sought help (Owen et al., 2014). Ruptures also lead to patients feeling negatively or uncertain about therapy in general (Gaztambide, 2012). This is unfortunate because people of color have developed a healthy cultural suspicion towards mental health professionals and institutions, as discussed above, and may enter treatment being guarded and vigilant. The promise of therapy is that they will be liberated from the pain that brought them to treatment despite misgivings, but the reality is that microaggression ruptures are likely to lead to increased feelings of oppression and alienation (Sue et al., 2007). Such experiences further marginalize people of color from the mental health field. Another common reaction is for patients of color to place psychological burdens on themselves, rather than confront the therapist, by modifying their behavior in an attempt to manage the responses of the therapist. They often edit their responses and defer to the clinician's authority to avoid further microaggressions (Gaztambide, 2012; Vasquez, 2007).

In the fortunate event ruptures can be repaired, the relationship will be strengthened, allowing therapist and patient to refocus on the goals of treatment. Researchers have described the successful processing of a rupture or impasse as a corrective emotional experience that can be transformative for both parties (Gaztambide, 2012). For the patient, the therapist's efforts at repair provide validation and change the power dynamic so that the relationship becomes more equalized and less dominated by the therapist's authority and expertise (Gaztambide, 2012). The repair of a racial microaggression may even have an impact beyond the dyad and contribute to healing the

patient's experience of injustice in the larger social cultural context. Thus, the repair process can have multiple benefits for patients in counteracting: a) feelings of blame, b) lack of an internal locus of control, c) invalidation, and d) uncertainty about the truth of their experience. The repair allows room for both parties to hold their truths, but also see and appreciate the other's truth on a foundation of honesty, self-reflection, and vulnerability.

Perhaps the greatest benefit repair has on patients is that its value was confirmed by researchers (Safran et al., 2011) in a meta-analysis in which "promising evidence [supported] that rupture–repair episodes were positively related to outcome" (Gaztambide, 2012, p. 186) This study also stressed the need for therapists to be trained and supervised in the process of rupture resolution as these efforts "had a statistically significant contribution to patient improvement" (Gaztambide, 2012, p. 186). Inclusion of rupture resolution in professional curricula may allow therapists to become more open to admit and process their mistakes, and patients more empowered to resolve the rupture in the relationship, and, with the therapist, work through the material that the microaggression elicited.

Racial microaggressions study findings. Although microaggressions in the everyday lives of people of color have been studied extensively, very little research has been done on microaggressions in therapy. The few studies investigating microaggressions in therapy have focused on particular ethnic groups, rather than the larger population of people of color. For example, through the use of focus groups, Constantine (2007) examined African American college students' perceptions of White therapists with regard to perceived racial microaggressions, multicultural competence, the counseling working alliance, and overall satisfaction. The common themes and examples

of microaggressions the undergraduate students experienced were then analyzed in order to develop a scale which then formed the basis of a study of a second group of students at different counseling centers. Constantine found that greater perceived microaggressions predicted weaker alliances, lower ratings of general and multicultural competence, and lower satisfaction. In addition, the perceived microaggressions were found to have shaped the clients' perceptions of therapist competence, demonstrated by lower ratings (2007).

Owen et al. (2014) conducted two studies in college counseling centers using the Racial Microaggressions in Counseling scale. In one study ($n=120$), the majority of clients (53%) experienced a microaggression, over three quarters (76%) of those who had experienced a microaggression never discussed this in therapy, to the detriment of the therapeutic relationship. The study participants who had discussed the microaggression with their therapist, however, had similar alliance scores as the group who had not experienced microaggressions after controlling for current psychological wellbeing, number of sessions, and therapist race, as measured on the Working Alliance Inventory-Short Form (Owen et al., 2014). These results attested to the power of repair.

One limitation of the study may be due to the validity of the scale, as the results indicated that racial/ethnic minority group members and Whites did not differ in the degree to which they perceived "racial microaggressions." Although all patients can perceive their therapist to be not attuned to or sensitive to their culture, microaggressions have the specific component of perceiving insult or insensitivity due to marginalization and status. Thus, researchers concluded that the scale must measure another construct, racial insensitivity, to account for the number of study participants who reported racial

microaggressions in therapy but were not members of an ethnic/racial minority group. (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, E., 2011).

In the 2011 study using the same scales ($n=232$), perceived microaggressions were negatively associated with wellbeing, which was mediated by the perception of the alliance. There was also no difference in race of therapist. An additional limitation to this study resulted from the demographic composition of the sample. Participants had been recruited from a university with high numbers of Asian Americans (41% of the student body) and Hispanic/Latino(a) Americans (16% of the student body), but a disproportionately small number of African American students (3% of the student body). Although all study participants were people of color, only 1.7% of the sample was African American.

In a qualitative analysis study, Miranda (2013) explored experiences of racial microaggressions in therapy with a sample of 11 second generation Asian American and Latin American women. Five constructs emerged from the study including types of microaggressions, influence of clients' reactions, navigating the experience, the role of the therapist, and practice recommendations. Themes identified with Asian American women included: a) alien in one's own land, b) pathologizing cultural values and means of communication, c) ascription of intelligence, d) colorblindness, and e) invisibility. Themes identified with Latina Americans included: a) passing for racial majority, b) ascription of intelligence, c) colorblindness, and d) assumption of superiority (Miranda, 2013).

Participants expressed feeling frustrated, misunderstood and upset. Most participants did not address the incident directly, acknowledging that they felt unsafe challenging the therapist. These participants mentioned engaging in alternate coping

behaviors, such as alterations in behavior and/or speech, and rationalizing the microaggression by recharacterizing it as a misinterpretation. Of the three clients who challenged the therapist, two were met with responses of defensiveness and dismissal and one received a meaningful response from her therapist. The patient who successfully challenged the therapist used counter-storytelling as a coping skill. This supported a positive self-schema, rather than internalizing microaggressions, and enabled the rupture to be repaired, thereby strengthening the relationship (Miranda, 2013).

In his study of the effect of microaggressions and race in therapy with a sample composed of multiracial individuals, Foster (2014) investigated: a) which, if any, microaggressions were expressed by the therapist, b) how microaggressions in therapy would be contextualized by multiracial individuals, and c) the facts that contributed to more positive experiences of discussing race in therapy. Multiracial microaggressions in the study were categorized as: a) avoiding/minimizing race in therapy, b) denial of multiracial reality, c) stereotypical assumptions based on race, d) second-class status, and e) treatment of multiracial people.

Microaggressions were found to negatively impact the therapy experience in that clients often expressed feeling worse, struggling with the dilemma of whether or not to confront microaggressions, becoming more guarded, holding the view that therapy was not helpful, and terminated therapy prematurely (Foster, 2014). Participants expressed frustration over therapists' avoidance of the topic of their multiracial backgrounds through abruptly changing the subject and ignoring disclosures about race. Participants attributed therapist unresponsiveness to discomfort, lack of knowledge, and/or inability to relate.

Therapist communication that race was off limits as a topic for therapy, however subtle, was in stark contrast with other issues that had been explored with care and concern when therapists typically asked follow-up questions and displayed empathy. Many participants mentioned their therapist's nonverbal manifestations of discomfort when the topic of race came up, e.g., suddenly shifting their body posture, becoming flushed, and even breathing differently (Foster, 2014). Participants then often concluded that therapy did not seem like the place to talk about issues of race, e.g., racial identity, racial discrimination, and particularly their multiracial identities (Foster, 2014). Other indications reported by participants included the superficial way race was addressed during initial appointments as well as what one participant described as the "framing" of therapy in the larger culture. In terms of recommendations, participants mentioned approaches that were not indicated, e.g., "textbook" responses, as these would strike clients as contrary to their desire for authenticity in the therapist personally as well as in the relationship; and poor pacing, e.g., or moving too fast and putting pressure on the conversation about race (Foster, 2014).

Best practices. Preventing microaggressions seems like an enormous task given their nature as often automatic and unconscious manifestations of firmly-held attitudes about social categories. Some strategies to minimize their occurrence have been suggested by research on stereotypes and social cognition. For example, stereotype suppression may be counterproductive as it often results in increased stereotyping, but attentional control diverts the focus away from social categories and thus decreases opportunities to stereotype (Blair, 2001; Greenwald & Banaji, 1995). In practice, individuals who might purposefully attempt to aim their attention away from social category cues might be concerned that the opportunity for increased social distance has

been diminished or that such avoidance, however well intentioned, may be perceived as a lack of appreciation or embrace of other people's identities. One approach with great support is consciousness raising, which encourages individuals to increase their awareness of potential cues that might elicit discrimination (American Psychological Association, 2003; Greenwald & Banaji, 1995; Mazzula & Nadal, 2015; Miranda, 2013; Owen et al., 2014; Sue et al., 2007; Sue et al., 2008; Vasquez, 2007). When utilizing this stance, individuals communicating or acting in a manner not congruent with microaggression is facilitated. Applying the concept of consciousness in practice requires skill development in certain areas, one of which was identified by sociolinguist researchers as existential competence, a skill that incorporates one's self-image, the way in which one views other people, and the willingness to engage in social interactions with others (Horakova, 2007). Implicit in existential competence is the ability to suspend pre-existing beliefs about others and those about one's in-group (Horakova, 2007). Integrating the practice of consciousness raising into training as an element of developing multicultural competence may be indicated as maintaining a rigid, negative view of other groups is likely to result in a lowered willingness to learn about and interact with them.

Horakova stated that the best way to be critical about one's own attitudes is to actively experience others' feelings and emotions, which requires an ability to decenter (Horakova, 2007). When this approach has a stable foundation, it can be put into practice. The difficulty arises when an individual who has had a lifetime experiencing social privileges in the real world is expected to learn the emotional experience of a disadvantaged group in one or a few short exercises.

Horakova suggested five goals that existential competence training should seek to achieve: "1) To imagine yourself from the outside 2) To understand the world we live in

3) To be acquainted with other realities 4) To see difference positively 5) To favour positive attitudes, values and behaviour” (2007, p. 22). Her goals—which in her view could be best achieved through role play—would enable persons guilty of committing microaggressions to learn more explicitly what disadvantaged groups feel and, as a result, associate their well-intentioned, yet problematic, behavior with negative emotions, and allow them to be replaced with highly valued positive attitudes. This strategy, recognizing both an interpersonal and environmental understanding that multiple realities exist and all are equally valid, might be part of the repair process in therapy after rupture.

Microaggressions occur automatically and unconsciously because the attitudes behind them are so ingrained. Therapeutic methods involving role-play or other experiential interpersonal processes can encourage an active, critical, and positive view of culture. For example, role plays may also be indicated when therapists undergoing treatment with a culturally competent therapist recognize their tendency to commit microaggressions. Horakova acknowledged an additional goal—that therapists become active interpreters and analysts of culture (2007).

In addition to consciousness raising, increasing knowledge about different cultures is critical for therapists treating diverse clients (American Psychological Association, 2003; Sue et al., 2007; Vasquez, 2007). Scholars have put forth many other approaches, some of which had been suggested by participants in their research. One category involved professional training. For example, incorporating material about microaggressions and culture into courses throughout graduate school, as well as the use of experiential learning techniques, were proposed (Owen et al., 2014). De las Fuentes (2007) and Hardy and Laszloffy (1995) advocated for the cultural genogram, a tool that

maps patient cultural identity within the family context and throughout the lifetime, to be incorporated into training and practice.

Both stereotype avoidance and consciousness raising exclude interpersonal communication. These techniques might then be less appropriate approaches for use in therapeutic relationships as their use would create barriers to patients who might want to bring up aspects of their identity or social category. Perhaps one of the answers to this dilemma is to have an open and honest dialogue between groups about race, gender, sexual orientation, religion, and more—an opportunity that might be lost when a microaggression occurs. Other strategies involve suggestions for therapist interactions with patients, such as being direct and curious about exploring race, ethnicity, and engaging in other cultural identity conversations (Foster, 2014; Miranda, 2013).

A therapist's use of the patient's language is a technique that demonstrates attentiveness and a willingness to learn about them (Vasquez, 2007); however, as discussed above, this intervention must be applied carefully, otherwise it may be perceived by the client as mimicry or evidence of a lack of authenticity. Therapists facilitating opportunities for patients to give feedback or their actively checking in with patients has been suggested by both patients and researchers. This method in which patients are encouraged to express a range of emotions without fear of rejection might also promote a more balanced power dynamic in the dyad (Gaztambide, 2012; Owen et al., 2014; Vasquez, 2007).

One strategy with particular relevance to psychodynamically-oriented clinicians is making use of countertransference in therapy, or letting the reactions of the therapist inform the conceptualization and treatment of the case (Gaztambide, 2012; Owen et al., 2014). Cultural mindfulness/attunement, the practice of monitoring the therapist's

closeness, distance, emotional reactions, misunderstanding, and engagement through verbal and nonverbal awareness, is another approach described in the research that may be effective (Gaztambide, 2012; Miranda, 2013). When doing multicultural work, however, therapists are cautioned that there are intraracial differences within ethnic groups so that assumptions should be avoided (Goldstein, 2008).

Although many of the above suggestions may be incorporated into training and supervision, researchers have encouraged clinicians to pay attention to personal aspects that also influence professional identity and practice, and commit to combat racism (Sue et al., 2007). Sue encouraged White clinicians to develop a nonracist White identity (as cited in Vasquez, 2007), and to have more emotional and meaningful encounters and personal relationships with people of color (Sue et al., 2007), in order to facilitate the realizations necessary for identity to evolve. There are many fears and barriers that White therapists may have to overcome in order to accomplish this personal growth. Paradoxically, people who consider themselves politically liberal often have the greatest challenge in relinquishing implicit bias because the idea that they may be biased and need to change is so incongruent with their sense of self (Owen et al., 2014).

People who are successful at evolving a White antiracist identity have found that new identity not readily accepted by others. A qualitative study by Smith and Redington demonstrated that adopting a White antiracist identity resulted in interpersonal conflicts (Mazzula & Nadal, 2015). Such a dramatic shift from the norm based on context may have negative implications for White therapists in terms of support from White colleagues in training settings, institutions, or in supervision.

Social justice in clinical work. Marginalized people face chronic exposure to social injustices in daily life on a personal and systematic level. The myths of White

superiority and rugged individualism juxtaposed with the myth of the mediocrity of persons of color contribute to a post-colonial stress disorder that is inescapable for this population (Greene, 2005). Despite the overwhelming presence of racism and discrimination, however, some forms of justice can be achieved. The traits of resilience and psychological independence will help to counteract internalized distortions of the self based on racism and are part of the healing process. This process can be guided in a therapeutic relationship committed to social justice (Greene, 2005).

Social justice action is often misconstrued by people whose knowledge of this is limited to news reports, e.g., riots, rallies, petitions, boycotts, and protests. Advocating for social justice, however, does not require being on the frontlines in order to accomplish change. Incorporating social justice into clinical work is intersectional and complicated, however, Sue and Sue (2008) offered an explanation of social justice principles and how they might be applied in the profession:

[Social justice counseling is] an active philosophy and approach aimed at producing conditions that allow for equal access and opportunity, reducing or eliminating disparities in education, health care, employment and other areas that lower the quality of life for affected populations, encouraging mental health professionals to consider micro, meso, and macro levels in the assessment, diagnosis and treatment of client and client systems, and broadening the role of helping professionals to include not only counselor/therapist but advocate, consultant, psychoeducator, change agent, community worker, etc. (p. 74).

In order to be effective in this model of therapy grounded in social justice, clinicians must also recognize and honor the sources of the conditions to be improved. Thus, the therapist must consider how issues other than race, such as ethnicity,

immigration status, class, gender, sexual orientation, ability, age, etc., interact with race and also with the systems with which the patient is involved. The role of the therapist becomes far more comprehensive when the patient's overall wellbeing is integrated into treatment. This requires a more active approach than the comparatively ambiguous and passive one traditionally expressed in the field that clinicians are to "be aware" and "consider" issues that may be critical to the patient's wellbeing but were not presented at intake.

Any assumption that competence in basic relational approaches translates to cultural competence is flawed (Gaztambide, 2012). For example, cultural competence within a feminist framework would encompass a clinician understanding that mental health problems may develop as a result of negative systemic discrimination and socialized experiences. With such understanding, the therapist would then be able to guide patients towards empowerment, collaboration, and shared power as they gain insight to aspects of themselves and their socialization (Mazzula & Nadal, 2015).

Therapist and patient have an opportunity to meet, see each other in nuanced ways, and repair.

Framing clinical work in a paradigm of social justice may have seemed radical at an earlier point of the profession's history, as described above. Today, however, even the American Psychological Association's ethics code (American Psychological Association, 2010) reflects the salience of the social justice perspective in the mental health profession. Principle D states:

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures and services being conducted by psychologists.

Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise do not lead to or condone unjust practices. (p. 4)

The above quote, which has particular relevance for avoiding rupture or repairing the microaggressions that many people of color have experienced, makes it clear that such behaviors are not only personally harmful to patients, but violate professional standards as well. Those in the mental health field need to hold one another accountable on all matters that concern the wellbeing of patients, whether or not there are difficulties involved.

Chapter III: Methods

The participants included 12 adult people of color who had an experience of a rupture in therapy due to a perceived racial microaggression according to the definition of microaggression as discussed above (see Chapter II). For the purpose of this study, a person of color was defined as any non-white person and/or a member of a racial minority group in the United States including, but not limited to: Black, Latinx, Asian, Native American, and multiracial individuals. In order to capture a wide range of experiences with mental health professionals, the term “therapist” or “clinician” included, but was not limited to: psychiatrists, psychologists, social workers, school counselors, mental health counselors, and graduate students training in any of these fields. There were no restrictions on the duration of treatment, or on the length of time since treatment ended as long as participants were able to recall the details of the event.

Participants

Participants were recruited through a network sample utilizing email, social media, and word of mouth distribution of the study advertisement. A total of 20 individuals expressed interest in participation in the study. Of the 20 prospective participants, 12 individuals scheduled appointments and were interviewed successfully, resulting in a 60% response rate. Participants included ten females and two males ranging in age from 22 to 39. Six were African American and six were Asian Americans. Of the Asian Americans, one had an ethnic Chinese background, four had an ethnic Indian background, and one had an ethnic Pakistani background. (For more comprehensive demographic information, see Appendix A.) Participants were interviewed in their homes; in private spaces of public areas, such as university campuses, that offered a comfortable degree of privacy; and through video conferencing technologies.

There were no adverse events or experiences reported by participants during interviews.

Recruitment

Participants were recruited through a network sample. The researcher posted advertisements for the study on various listservs, social media outlets, and through email communication to current students and alumni of the institution the researcher was attending. Interested parties contacted the researcher and answered a few screening questions to verify that they fit the study's criteria, i.e., a person of color with experience of a microaggression in therapy. Then, an interview was scheduled.

Measures

Every participant read and completed a consent form explaining the purpose and procedures for participation, the risks and benefits of the study, confidentiality, limits to confidentiality, and provided contact information for all individuals affiliated with the study (see Appendix C). The consent form also explained that the study was completely voluntary and participants had the right to decline participation at any time during the interview process. The addendum to the consent form requested permission to record the interview (see Appendix C).

The demographic questionnaire was meant to collect identifying information about the participants and their therapy experience (see Appendix F). Participants were sent the questionnaire through email before their scheduled in-person or video conference interview. They were instructed to return the completed document to the password-encrypted email address of the researcher. Each participant was assigned a code and all documents were identified by that code.

The semi-structured interview protocol (see Appendix G) was meant to guide the inquiry about the participant's therapy experience. The interview consisted of closed and open-ended questions that examined: a) presenting problem and initial attitude toward therapy, b) the therapeutic relationship, c) the participant's feelings and reactions to the rupture due to the microaggression, d) suggestions for therapists working with patients of color, and e) changes in the therapeutic alliance and/or attitudes toward therapy.

Procedures

Upon approval by the Institutional Review Board, individuals who expressed interest in the study and who contacted the principal investigator regarding participation were presented with brief information about the purpose and nature of the study. They were asked preliminary eligibility questions about their identification as a person of color and their experience of a rupture in therapy related to a racial microaggression. If prospective participants did not meet criteria for the study, they were thanked for their interest and debriefed on the rationale for their exclusion. Prospective participants who met criteria were scheduled for an in-person or video conferencing interview, depending on their proximity to the researcher. The investigator was prepared to provide referral information to any participants who experienced psychological distress at this point or during the subsequent interview. No adverse events or experiences were reported by participants at any time.

Interviews took place in settings that were private, comfortable, and accessible for participants including their homes, campuses, and clinic rooms. The investigator explained informed consent and provided the participant with the consent form to read and sign (see Appendix C). The researcher also informed participants that they would be audio recorded unless they objected, and provided them with a consent form to sign (see

Appendix C). Each participant consented to the recording. The investigator also clarified any questions or concerns about the study. Prior to the interview, all participants had returned the completed demographic questionnaire to the researcher as a password-encrypted document through email. Interviews lasted 24 minutes to two hours with an average of 53 minutes. Interviewees were given the opportunity to add information or ask questions outside of the semi-structured interview at its conclusion. Later, interviews were transcribed and stored as password-protected documents with a corresponding code for each participant. All study data will be kept for at least three years after completion of the research, after which all documents with identifying information will be shredded, audio and video tapes will be erased, and computer files will be erased by the researcher.

Data Analysis

The investigator analyzed the qualitative data resulting from this study using a grounded theory informed approach (Corbin & Strauss, 2014). There was no a priori hypothesis based on established theories, so the aim of the study was to explore common and divergent themes in the narratives of people of color who had experienced microaggressions in therapy and generate a new theory.

Grounded theory data analysis consists of three sequential phases: open coding, axial coding, and selective coding (Corbin & Strauss, 2014). Open coding consisted of the line-by-line reading of transcripts as well as consideration of narratives as a whole to identify macro level and micro level codes. These codes were compared across transcripts and informed the development of categories. Next, axial coding was performed, comparing codes and collapsing these codes into categories so that meaningful patterns and hypothesized causal mechanisms began to emerge. This phase of the analysis allowed the researcher to begin developing ideas about influences on, and

consequences of, the main phenomenon, thus providing directionality to the analysis.

Finally, the process of selective coding was performed, further collapsing or refining the major categories discovered in the previous two phases into central themes that constituted the grounded theory, i.e., the theory that emerged from the narrative of the data (Corbin & Strauss, 2014).

Chapter IV: Results I

The results of the current study were divided into two thematic chapters, separated in accordance with the timing of the microaggression. Chapter IV: Results I describes participants' experiences before the microaggression and explores participants' qualitative responses to questions about general attitudes about therapy and initial alliance with their therapists through common themes. Chapter V: Results II examines the moment of the perceived racial microaggression and its aftermath, as well as offering suggestions for professionals in the field of mental health.

Attitudes Toward Therapy

Participants' general attitudes toward therapy were assessed in order to contextualize their particular experiences in treatment. Their responses to the question "How would you describe your attitude toward therapy in general?" were interpreted as the baseline from which additional experiences might align or deviate. Responses to this item comprised eight major categories including: barriers to accessing therapy, positive therapy experiences, the effort or work therapy requires, evolving attitudes towards therapy, lack of stigma toward therapy, personal experience as a therapist, ambivalence about therapy, and efficacy of treatment.

Barriers to accessing therapy. Barriers to accessing psychotherapy which impacted their attitude about treatment were identified by participants as including financial difficulty, insurance coverage, and finding a good fit. Two participants (16.67%) cited difficulty accessing therapy as a barrier, with Participant 1, a Black woman, having her positive attitude toward therapy complicated by both concrete and intangible concerns: "I'm always very optimistic...about receiving therapy....I'm just reluctant and weary of being able to find therapists that are able to meet my needs based

off my identity that I can afford, too.” In her case, more than one factor influenced access to therapy: financial cost and the need to feel understood or connected based on identity.

Additional participants also cited more than one factor.

Positive therapy experiences. The majority of participants (nine, or 75%) described their general experience of therapy as positive, although some would later describe microaggressive ruptures in treatment. Participant 2, a Black woman, credited perseverance as crucial to attaining a positive therapeutic alliance and thus deriving the benefits of treatment:

I think...psychotherapy...saved my life....It's just like finding a great mechanic or hairdresser. You have to go through a few in order to find the one person you have good rapport with [because] it's not like you're working by yourself, you're working with another person.

In her case, she presented in considerable distress and psychotherapy was successful at meeting her needs. Other participants' responses reflected receiving increased insight about themselves or their circumstances, as well as the symptom reduction expressed by Participant 2 above.

Therapy requires effort or work. Participants recognized psychotherapy as a dynamic and interpersonal process that was more effective when they were active. Two participants (16.67%) made explicit reference to the efforts required to engage in psychotherapy effectively. Participant 3, a Black woman, saw the positive attitudes she had about therapy influence other choices, such as changes in her relationships with others outside of therapy:

I'm a big fan of therapy. I'm in therapy now....I feel like...it helps me...have like a better understanding of myself and a lot of my interactions with people...through

some of the work that I've done in therapy. It's...opened my eyes to...the dynamics of other close relationships I have in my life and...I'm able to...spot certain things, or just be more mindful ...[of] things, and I'm really...interested in having all of my relationships be healthy.

Additionally, achieving positive results in the quality of her relationships was a contributing factor to Participant 2's decision to continue seeking therapy. Other participants also recognized their subjectivity in the therapeutic relationship and their responsibility to be active partners in efforts to change.

Evolving attitudes toward therapy. Some participants described their attitudes toward therapy as changing over time. Two participants (16.67%) tied their changed attitudes about therapy to specific events, such as entering different therapeutic relationships, aging, or altered life circumstances. Participants also mentioned certain variables, such as the therapist and the reason for entering therapy, as impacting their attitudes.

Lack of stigma toward therapy. A few participants mentioned that their positive perception of therapy contrasted with the stigma their community and the larger society often associated with therapy. Three participants (25%) reported their perspective that psychotherapy was destigmatized. Participant 4, an Indian female graduate student, stated, "I think that therapy in general is really important and can help anyone regardless of [whether] you have severe psychopathology or are just trying to be a better person." This corresponded with the consensus among participants that psychotherapy was an adaptable process that could meet the needs of many individuals on a wide spectrum of mental health, and ran counter to the somewhat common idea that psychotherapy is

reserved for people who have a severe mental illness or difficulty outside of the norm of the average person's experience.

Personal experience as a therapist. Many participants were also graduate students in pursuit of degrees in mental health and related fields. Some participants gained their insight into the value of psychotherapy and its potential effectiveness from the vantage point of being both clinician and patient. Three participants (25%) related their experience as therapists in training to their attitudes about therapy. Having the experience of both the clinician and the patient, some participants expressed a unique value for the process of psychotherapy and its potential effectiveness. For example, Participant 5, a Pakistani woman, answered, "I don't think everybody uses therapy in the same way...But for me therapy has been...helpful for the most part, so I believe in therapy and I'm studying to be a therapist."

Ambivalence about therapy. Two participants (16.67%) expressed their initial hesitancy about psychotherapy for the first time, primarily due to previous perceptions about mental illness and therapy. For instance, Participant 6, a South Asian woman, explained:

I perceived...my...depression to be my own weakness, and so I didn't admit to myself that I was depressed. Instead it took me almost four years...to admit to myself that I was depressed....A supervisor...helped me see [by his saying], "Maybe you are depressed, maybe therapy will help, maybe medication might help."...Due to this encouragement, I finally started going.

Participant 6's comment highlighted the research findings that many people of color attend therapy after an extended period of utilizing other supports or coping methods (Sue et al., 2007). She, along with other participants, attributed her perceptions of mental

illness to cultural and familial beliefs. A trusted stakeholder in her life provided an alternative perspective which enabled her to seek help.

Efficacy of therapy. Many individuals commented on the efficacy of therapy as a factor contributing to their current attitudes; however, four participants (33.3%) qualified this as dependent on several variables. Participant 7, a Jamaican and African-American female doctoral student, elaborated:

I would say that my attitude towards therapy in general is very positive. I feel as though...therapy isn't necessarily for everyone, but for the majority of people, it can be a very useful experience depending on the interaction with the therapist, the...strategies...the therapist uses, as well as the tactic or the goals the person holds for therapy.

Her statement is consistent with the literature stressing the centrality of the therapeutic alliance along with the interpersonal interactions between the therapist and the patient in the provision of effective treatment, in addition to techniques employed and patient motivation.

Timing of the Therapy

In response to the question concerning when they began psychotherapy treatment, the majority of participants (ten, or 83.33%) reported multiple experiences with psychotherapy, while only two participants (16.67%) had a singular experience. Two participants (16.67%) started therapy as children, one participant (8.33%) as an adolescent, six participants (50%) during college, three participants (25%) after college, and six participants (50%) were in psychotherapy during the time of the interviews. In some cases, multiple experiences of psychotherapy were not motivated by benign factors.

For example, Participant 1, a Black woman, explained her difficulty in finding a good fit and her consequent frustration:

[I've] been doing...trial and error....I just moved for my PhD program to a new institution, but [in] my previous institution [where] I was...for seven years,...I just kept trying, but there...wasn't ever any...success....I tried for six-seven years on and off...and...it was just bad experience after bad experience, unfortunately.

Participants named barriers, such as insurance coverage and financial problems that impacted the timing of their encounters with psychotherapy. Four participants (33.33%) mentioned delays in receiving treatment or lapses in treatment periods due to unstable insurance and/or finances.

Two responses pertained to individual emotional and social circumstances hindering their accessing psychotherapy. Participant 2, a Black woman, related how onerous accessing services was because of the intake procedure during which she had to reconcile the formal structure of the intake interview with managing the strong emotions evoked by retelling her trauma history and processing the reactions of the clinicians:

This process was very difficult for me because...you're reliving this trauma,...you're still in trauma, you're still in crisis....I'm trying to validate my experience for...intake doctors, and so I had to keep telling these people what was wrong with me to justify how I felt...to justify...my emotions, and every time I recounted my story, I just saw the look of horror or pity or shock. There was a visceral reaction to what I was telling them and they're like, "Yeah, yeah, yeah, you need therapy," and they [saw] me right away.

Participant 1, a Black woman, explained that she was hesitant to engage in therapy despite a need to address longstanding mental health concerns because of the

stigma attached to it by her family and the social context, i.e., the “healthy cultural suspicion” with which many people of color view the mental health profession:

I started...in therapy...when I started [college]. I wasn't able to receive therapy...before [because] my family didn't believe in it....Like, “Don't trust those white folks. Don't talk about our business.”...My mom wasn't gonna pay for [my] therapy, even though I knew in high school that I was depressed.

Setting

Participants received psychotherapy in a variety of clinical and school settings across their experiences in therapy. The majority of participants (seven, or 58.33%) received services in college counseling centers, five (41.67%) were treated in private practice (41.67%), and two (16.67%) experienced in-home therapy. Settings that were utilized by only one participant each included a mosque (8.33%), a high school (8.33%), a university career services center (8.33%), a hospital (8.33%), and a clinic (8.33%).

Duration of Therapy

The participants were asked about the duration of each therapeutic relationship rather than the amount of time spent in therapy altogether. Most participants (seven, or 58.33%) reported relationships of more than five sessions but lasting less than six months, five participants (41.67%) reported having therapeutic relationships that lasted more than one year but less than five years; three participants (25%) reported therapeutic relationships lasting more than six months but less than one year, and three participants (25%) reported therapeutic relationships lasting more than one session with a maximum of five sessions.

Participant 1, a Black woman, described a “trial and error” process that led to early terminations with a series of clinicians and left her with less optimism about psychotherapy as a means for addressing her mental health:

[That] summer...I went to two sessions with this...lady, but it ended after...she told me that racism wasn't a thing, and so I was...“Alright, I'm done.”...There were never any people of color...that I was matched with. They were always White ladies, and this lady told me that my stress would be alleviated from school if I just went back home. Then I tried the state's...counseling....I only met with this lady one time, and I was done....I just [didn't] like some of the comments that she made, and she just didn't seem...culturally astute [enough] for me to go into more detail of...what I'm experiencing, based off of the things that she said. And then on my school side...Once again, just the same...experience. And they even asked on my school side,...”Do you have any preferences for the therapist you want to be matched with?” I [said], “Yeah, a Black woman, someone of a similar identity as myself.” And they [said], “Well, we....don't have any Black people.”...I mean I've been doing this for several years now, and, I'm just going to have to probably figure out...alternative routes to therapy [to speak] with a professional that looks like me.

Repeated microaggressive experiences when treated by White therapists made it increasingly important for her to be in treatment with someone who shared her identities as a Black woman. She expressed her frustration with her apparent inability to obtain a cultural match in response to other questions in the present study. Although without identifying the cause as specifically as Participant 1, other participants described not receiving the hoped-for connection and understanding with therapists.

In contrast with Participant 1 above, Participant 2 was able to have a racially matched dyad, and a therapeutic relationship of long duration (over five years). An examination of the two responses at opposite ends of the duration and quality of relationship spectrums sheds light on the factors impacting the therapeutic connection and the probability of attrition. Participant 2's experience was unique among the subjects of the present study, not only in duration of treatment, but in intensity (several 90 minute sessions a week during especially different periods). It is evident from Participant 2's description that the cultural/racial match made a critical contribution to the success of the pairing:

I was with her...I think...six full years. And the only reason we ended [and] we both knew this was going to happen, [was that] I moved [away. We tried phone sessions, but] we did not work well over the phone...because half of what she does is...look...at nonverbal cues,...at my body language,...what I do when I say certain things, or when I don't say things....So like her gender and her race, her ethnicity was a part of her politics....That helped me as a person, a student. She could empathize with me and understand what I was going through culturally. That was very important to me. That is not discussed really when you're dealing with these disciplines....Race,...gender...and not separately, but together. As a Black woman...we need therapy, but...we neglect to have it, and... the fact that she was a Black woman helped me immensely. She saved my life, and initially because I was in such a state, I was seeing her three times a week at 90 plus minute blocks.

The deeper connection with the therapist in this case was facilitated by an affiliation based on identity which allowed the patient to perceive a level of understanding on the part of the clinician in addition to effective techniques utilized in the relationship.

Type of Therapy

Participants engaged in psychotherapy from various modalities and orientations; however, the present study concerns the periods of therapy during which the microaggressions occurred. Three participants (25%) reported experiencing a microaggression in psychodynamically-oriented psychotherapy. Three participants (25%) stated that they experienced microaggressions in therapy they described as “open ended.” Participant 1 described her frustrating experience with this style of therapy and how it left the issues that concerned her the most out of the discussion. In addition, the White therapists’ responses exhibited avoidance of the topic of race and a lack of validating of the client’s identity:

In the last [session] I went to a few weeks ago, she said that she wanted me to do more of...a very self-reflective...method, and so she would [ask] not probing questions, but, like, “Why are you stressed?,” and I would [respond], “I’m a PhD student. I just moved to a new state....I’m balancing different roles. I work two different research assistantships.”...Then she would respond with,...“Do you think...you put too much pressure on yourself?”...I had issues with the questions....It’s this White girl asking me [whether] I put too much pressure on myself, not understanding the place that I am occupying as the only Black woman...in my [PhD] program. So, I...just feel like...yes, I do, and then she would respond,...“Oh well, you know you have to not put so much emphasis on that.”...You can’t tell me that I can’t be intense about my experience. or my

education, or my expectations...when I am the only woman of color in my program....It does stress me out, it does spike my anxiety, but I can't just not be a Black woman in a PhD [program]. How I am navigating these spaces...contributes to my stress and anxiety....I didn't really like the questioning aspect of it because it never centralizes my identity. So asking me blanket statements does not help me in therapy sessions because it's not coming from a place of understanding myself and my identity in relation to...my experiences in education.

Two participants (16.67%) perceived microaggressions in cognitive-behavioral therapy. Two participants (16.67%) reported perceiving a microaggression in therapy that they described as integrative. Participant 8, a Black man, described his integrative treatment as a very straightforward approach with the client directing the content of the sessions:

It was very stereotypical, like the coach, and taking notes, and recording, and talking, and then...feedback every maybe 3 or 4 sessions...It was really...me...asking questions....It was never [the therapist asking], "So what are you thinking about today?"...I always went to therapy with a purpose, so I always had...questions....I'm more concerned about... human behavior.... I'm really interested in...why or what compels people to think a certain way or do certain things....Most of the time...I would try as best as I can to step outside of myself and say, "I find myself doing this or thinking this. What's that connected to?" And [the therapist] would give me... methods... like behavioral modification almost. [The therapist would connect] things to certain stuff, and [pull] things out of me that...I had suppressed, and just [explain] certain things to me.

One participant (8.33%) experienced a microaggression in an interpersonal group. One participant (8.33%) stated that she perceived a microaggression in the context of psychiatry sessions. Participant 3 (8.33%), a Black woman, experienced a microaggression in what she called a “structured inquiry” style of therapy:

It was...more structured...He just had...certain questions....With the person I meet [with] now...it's less, structured. It's like, “What do you wanna talk about? Okay, boom.” But with him, it [was] just like, “Okay we're gonna talk about this. Can you tell me about this, this and that?,” and he would ask really specific questions. So it felt more like I was being like interviewed.

Presenting Problem

When participants were asked to identify the presenting problem that led them to seek psychotherapy, some participants cited specific moments or problems; however, many people named a constellation of problems. When participants were asked in a follow-up inquiry whether their presenting problem was related to their racial or ethnic identity, all but one participant (91.67%) answered in the affirmative.

Depression. The majority of participants (eight, or 66.67%) reported experiencing depression that led them to seek psychotherapy. Participant 1 explained how her symptoms of depression were related to racism, but the lack of diversity at her college made it difficult to find sources of support, making her depression more severe:

When I...first...wanted to seek therapy,...I experienced a lot of racism....I was...really angry, and I felt isolated and depressed. It was a predominantly White institution, and I'd never been around so many White people before, and so I felt like...this alien....They'd ask...stupid questions like, “I can't believe you don't wash your hair every day,” or...“What sport do you play,” and things like

that....I was really angry and I was becoming...depressed. It was affecting me...wanting to go to class, [asking myself] “Do I really wanna be here?...Maybe I should have accepted going to an HBCU instead of being here?”...So that’s what led me initially to want to seek out...counseling services....I wanted...a space, [because] I do believe in therapy. I really do....The pain and...the issues that occupied my head all the time....I know I need to speak to someone and talk to someone...so I can improve...my mental health, but I wasn’t really finding anybody to talk to about that.

Participant 6, a South Asian woman, explained how the stigma around mental illness in her culture made it difficult for her to manage her depression:

All of my experiences are connected to my racial or ethnic identity. I can’t necessarily remove them....As a young adult...my mom recognized some depression in me....I still couldn’t admit it....It’s something that we don’t necessarily talk about....I think that that...stigma that was associated with...being Hindu American or Indian American more so than it was...a stigma in my family...specifically with my mother. With my father,... when he found my...antidepressants, he was like, “Why are you taking these?”...And I was like [because] I’m depressed. So I think...that stigma...existed....I [was] feeling like I was really under a lot of pressure to succeed academically and to...make something of myself and [my depression] was definitely connected to...cultural type pressures...in an indirect way.

Participant 3, a Black woman, described that her perception of discrimination in the workplace impacted her mood and the lack of validation she received from her therapist:

I think...there were a lot of...racial issues happening at that organization, and I felt like as a Black woman...from a low-income background [that] there was sort of this assumption, like, just give her the harder work, just give her the tougher clients. Oh, this person's threatening her? So what?...Let her work with them....I felt like a lot of that was at play, and...whenever I would mention that to my therapist,...he would be dismissive, "Why would you say that?"...It would never be,..."Oh, please elaborate."...He was just...dismissive.

Interpersonal relationships. Six participants (50%) identified problems in relationships, either within families or romantic partnerships, as their motivation to enter therapy. Participant 4, an Indian woman, described the pressure she received from her family to marry as a result of cultural norms:

My brother was getting married...and he's younger than me which was...weird, I guess, and they'd been putting pressure on me for a long time. They actually didn't want me to go to grad school....They worried it would impact my ability to find someone because I'd be...stuck for such a long time, but...the bargain that we had was that I would go to school in [the] area...which would allow me to meet more people, and I would...try to find someone to marry....That pressure was a lot of what I was dealing with at that time.

When she continued, she reflected on the pressure to marry with more ambiguity:

Marriage is very, very important, very sacred....There's a sense that your life is really sad, or incomplete, until you get married, or you have a partner, and you have...kids....My parents know...a girl who's...35. She...was hugely, hugely successful, but there's a sense that, oh, her poor parents, she's not married. Or poor her, she must be so lonely...despite her success.

Trauma. Almost half of the participants (five, or 41.67%) described instances of physical, verbal and sexual abuse, as well as chronic community violence related to their racial and ethnic identity. Participant 2, a Black woman, described chronic trauma and family dysfunction throughout her life, including financial issues, incarceration, and the stigma against mental illness, i.e., therapy is for “crazy people,” that prevented her from seeking help until the pain became unbearable:

I started seeing a doctor, and that’s when the repressed memories came out....I realized that...I couldn’t deal any more with the effects of being sexually abused as a child, and it was somebody in the family....My mom [told me] to see a shrink, and the way that my mother said it was not in a positive way. It was, like, “You’re crazy, and something’s wrong with you, you need to see a doctor.”...I had to stop running. I couldn’t outrun the problems anymore. I couldn’t suppress it....It took me...25 years. It was literally rock bottom. I had to deal with this, and that’s when I embraced therapy ’cause I had no other options left, other than death. To me...this seemed like a weakness that I couldn’t afford. To admit that I needed therapy meant that there was something wrong with me. And I didn’t want anything to be wrong with me. I felt like a mug... that fell and was shattered to pieces, and, as a child using the only skills I had, used glue and tried to put the pieces back. But once you break something, it never goes back to its original [state]. Everything came back! It was like a thunderbolt! It was crazy ’cause I don’t even remember the rest of the conversation I had with him....But it was just like...how dare he [abuse me]? He’s the reason why...there was cognitive dissonance. He’s the reason why I was so...outraged!...It was really hard. I was later diagnosed with complex PTSD with dissociative [features].

Anxiety. The same percentage of participants (five, or 41.67%) who had cited trauma identified anxiety as a primary reason to seek therapy. Participant 7, a Black woman, related the anxiety she experienced as a young adult to learning more about her racial identity in college:

I went into college being very colorblind...really focusing on...institutional issues, and I know that as I learned more, I became more...anxious, perhaps....I felt very overwhelmed, just learning about my own...racial history, especially with all of the identities that I held and...what that meant in...this society,...and it was really hard to process....I had a lot of internalized racism that I had to work out and it was hard to do that work with some of the therapists that I was seeing.

Adjustment. One third of participants (four, or 33.33%) reported adjustment issues leading them to seek therapy. For instance, Participant 5, a Pakistani woman, shared her adjustment difficulties as the only woman in her graduate program with her background. Additionally, she felt a sense of obligation to educate her classmates about her group so they could offer culturally competent services to this population:

I identify as Muslim, and I come from a South Asian family and...I work with women who also identify as Muslim and who are South Asian and Arab, and...a lot of different sort of racial groups....From what I know about those women and girls,...there isn't a space to talk about certain topics, and when those certain topics are brought up,...there's...a lot of shame [around] stuff related to...sex, and...body autonomy, and...self-esteem, and things like that. There's...a lot of...objectification that has to...impact [them] from...multiple angles, being South Asian, being Muslim,...either making the decision to observe or not observe hijab or...the head scarf, and...what that means.... I came into this

program thinking...I would like to be trained to...listen to these people's stories and...help them work through some of these really difficult decision making processes the way that...I struggled when I was...an undergrad....What I've found is that [the] experience that I bring into the classroom as a woman of color, as a South Asian woman, as a religiously identifying woman...seems like it's...too new, or...too uncomfortable, or...it comes out of left field...for my classmates, and they...don't know how to respond. And...that's...my perception of it,...but it makes for very uncomfortable classroom settings....It puts me in a very difficult position in my program because...I can't [treat] all the Muslim South Asian girls in the world, and so it's very important to me that my classmates and the field of counseling psychology [are] equip[ped] to handle these stories, and [do] it in a...culturally sensitive way, and I really struggled....It affects me personally, but it also makes me feel pretty hopeless sometimes about the field.

Other themes. Additional categories with lower frequencies included grief (two, or 16.67%), suicide attempt in the context of depression (one, or 8.33%), substance abuse (one, or 8.33%), anger (one, or 8.33%), body image issues (one, or 8.33%), intimate partner violence (one, or 8.33%), and career counseling (one, or 8.33%).

Race of Therapist and Choice

Participants discussed 18 total instances of therapy during which they perceived racial microaggressions. Of these instances, 15 involved White therapists (83.33%), one mixed-race Jamaican (5.56%), one Afro Latina (5.56%), and one East Asian therapist (5.56%). The demographic composition of the participants' clinicians is reflective of the underrepresentation of people of color in mental health fields (APA, 2015), as discussed

below. (As racial microaggressions are the focus of the present study, the data presented represent the race of therapists with whom they perceived this experience although participants reported engaging in therapy relationships with mental health professionals of various racial/ethnic backgrounds across periods of therapy.)

When asked about the race of the therapist discussed in the present study, some participants also offered other aspects of their therapist's identity. Seven participants (58.33%) mentioned gender, and one individual (8.33%) mentioned sexual orientation. The salience of these identities may indicate that the specific intersectionality of race, gender, and sexual orientation was meaningful to the patients and may have impacted their therapeutic relationship. Exploration of intersectionality is outside of the scope of this project.

When asked whether they were able to choose the race of their therapists across their experiences in therapy, the majority of participants (nine, or 75%) said no. Some elaborated on the circumstances. Three participants (25%) mentioned having limited options related to racial preference of their therapist. For instance, Participant 1, a Black woman, reported: "I tried several times [to find a Black therapist or any therapist of color], but...they just didn't exist....They would frame it as if we're just like these mythical magical beings roaming around." Two participants (16.67%) stated that they were unaware they could express their preference. Participant 7, a Black woman, elaborated:

While I was busy getting over the stigma of therapy....It's just thinking...can I go to therapy? Oh, I can go to therapy, and didn't realize...how many choices I had....I can choose a therapist, I could look into what types of therapy my therapist [offers], where I wanna go to therapy....I finally have insurance to see a

therapist....I went to school so...now [I'm aware] I can say...I prefer a Black woman. I didn't really know how to...advocate for myself [before]...They did ask if I prefer to see a male or a female....I knew that I felt more comfortable with females, so I [said], "I would like to see a female," but they didn't ask me if I had any other preferences when I was looking for a therapist. Then when I didn't have insurance with the school, I asked for a referral, and then...I spoke about different issues. She's the one that...said that she felt like I would be better fit with someone else, and I didn't even realize that I could choose...different people. I just thought okay, my insurance is covering it. I didn't know how to shop around for therapists until I got older.

Two participants (16.67%) stated that they were able to choose the race of their therapist. Participant 8, a Black man, shared that he decided to request a Black woman therapist because he thought she could offer a perspective that would help him understand prior negative relationships with Black women and have healthier relationships with Black women in the future:

At the end of it all, my abandonment issues...come from a Black woman. I was physically abused by Black women. I'm a heterosexual Black man who marries and dates exclusively Black women. My issues are with Black women. So [in] my twisted logic...I don't want a guy that's gonna...sit there and...bro code me up. I actually want to...have some feedback and insight from a Black woman because I believe that...if I'm blessed enough, I will enter into a relationship with a Black woman, and I wanna...change certain things whether...consciously or...subconsciously....that I do in engaging Black women, or views that I have of

Black women that I may not be aware of, that affect...my day-to-day interactions with them.

Initial Therapeutic Alliance

When participants were asked about the initial quality of their therapeutic relationship with the therapist who committed the perceived microaggression, they provided a range of responses with both positive and negative valence. Some participants described their relationship with their therapist at the start of treatment with a range of descriptors.

Positive therapeutic alliance. Nine participants (75%) characterized their initial relationship with their therapist as positive in nature which they ascribed to qualities of the therapist or use of an approach that helped them. For example, Participant 2, a Black woman, who'd experienced trauma and had to overcome her family and culture's stigma surrounding mental health treatment, considered her therapist "very positive": "He validated my experiences. I felt that I wasn't going 'crazy' and that therapy would be a good decision. I was in a space that I didn't feel like living would be possible. He pulled me from that precipice." For Participant 3, a Black woman, the initial experience was a positive one due to the therapist's style of interaction, which put the participant at ease, and his willingness to self-disclose:

[My reaction upon getting the contact information was], "Oh I work in that building. This is super convenient....Great. So I'll keep seeing you."...In the beginning,...I would say it was fine....I think he did a good job of making me feel comfortable initially....If I said something funny, he'd laugh or...maybe share...little things, little personal details about his life.

Participant 9, a Black woman, ascribed her positive initial impression of her therapist to her flexibility and openness when the participant brought up the importance of her identity:

[Before entering treatment] I made a decision to [start with an] interview, or trial, and she was okay with me coming. The first session was like a consult... 'cause I told her I don't wanna enter into this, and it not really work out. So she gave me a second session at half price, or it was half the time, or something...to feel it out a little bit more....Because of [my prior negative experiences] she was fine with me asking her about how she worked with...Black people and Black women.

Distant relationship with therapists. Half of participants (six, or 50%) described their initial therapeutic relationship as distant. They described how their thoughts on psychotherapy, feelings about the therapist, and goals for therapy influenced this impression. For instance, Participant 10, a South Asian man, described his lack of patience with his therapist due to her not allowing him to set the agenda or pace of treatment:

It was kind of distant....I think we were both there for different things. I think she...I don't wanna say be a social worker, but she really wanted to...get all the information, [such as] "at...day one you were born, what happened next, kind of thing." It's like I just want my pills, lady....Things would just come up, and I would [think] this is just repetitive and [ask] why am I here.

Similarly, Participant 5, a South Asian woman, described an initial impression of how her therapist's approach conveyed a lack of warmth. Although frustration with their therapist was conveyed very strongly by both this participant and the participant quoted above,

Participant 5 attributed the distance in the relationship to the therapist's inability to perceive the level of the client's distress for the first year of treatment:

[The relationship] didn't feel warm....I felt like we were trying to...jump to solutions, before...understanding my experience...The depth of my distress was not acknowledged. Later on, she acknowledged it, because she said something like I had spent an entire session talking about one thing...like grad school and then...at the last 10 minutes, "Oh, and then there's this family thing going on." And she was like, "Oh, there's so much there." And I'm like, "Yeah, that's my whole freaking life! Like how do you not just get [it]?...It wasn't until...a year [into treatment] that she really sort of understood...the depth of my distress, and I'm like..."If you understood that in the beginning, first three sessions...maybe I wouldn't be trying to avoid you."

Participant 1, a Black woman, allowed that the distance between the therapist and herself might have had its origins in her cultural and familial taboo about revealing vulnerability to those from the dominant culture:

I wasn't too comfortable [initially], because I'd been socialized through my family [that] you don't talk about Black people business with White people, especially White women....You keep that to yourself....Also, in my family, we were raised to be this strong Black woman and...therapy is...a weakness. And so I was also struggling with the logical side of me [that is saying], "No, we know therapy is good 'cause we need to help our mental health." Then, at the same time, my body...or my mind is feeling uneasy about speaking to this White woman, because I'm [thinking]: "Are we letting them know now that we're not as strong as we're perceived?"...I guess it was...some...cognitive dissonance of

trying to figure out...how I'm gonna navigate...therapy with these...warring...interests, and thoughts in my mind about how I was told not to speak about these things in public.

Conflicted relationships with therapists. Five participants (41.67%) reported feeling in conflict with their therapists at the beginning of the therapeutic relationship. For example, Participant 6, a South Asian woman, described it as resulting from her therapist's unwillingness to respect the participant's cultural values:

She seemed nice and willing to listen...but that was at the beginning of treatment....It became clear to me that we would have some...conflict...when she started saying that I was codependent on my parents....My perception was the reason she was saying that was because I was living at home. I cared a lot about what was happening to my parents and [her view was that] I was becoming codependent on them,...”Why am I not independent? Why am I not living away from home? Why am I putting their needs ahead of mine?”...I felt [there] was definitely a cultural clash [between] what she perceived to be normal for a 25 year old and what I perceived to be normal for a 25 year old.

Other participants began to feel a sense of conflict with their therapist from the very first encounter. For Participant 9, a Black woman, the conflict arose from her White therapist's lack of cultural competence in avoiding discussions of race and invalidating the Participant's experience. Rather than acquiesce, however, the participant confronted the therapist for trying to take advantage of the power dynamic in the therapeutic relationship:

I am talking about the things that led up to my break....I just need a letter that I can't go back to work....I was reading her body language, and she was getting

uptight, she was upset! I mean I'm talking about this White woman...across the room from me [who] is not having it, and...she started [asking], "Have I tried yoga? Could it have been part of my diet?"...Am I exaggerating a bit?...She was trying to pace it....She didn't say all these things rapid fire. But I had to...take a moment, because I was already on edge and...I told her all the way off. I was like, "You just got your master's...a year ago. I got mine eight years ago. I have a master's in counseling." I said...."Did you ever take any multicultural competence courses? Because it wasn't offered when I was looking at that program. [If you had] you could have at least figured out to never say any of those statements." I [then] said, "Did you have any cultural training here at the hospital?...I know you didn't, because they never offered that to you....Everything you just told me, you're blaming me, not the [institution, not the] system, not [your utilization of] your position of power to blame a patient who literally just came in.....This is your first crack at building a relationship with me, and somehow [you've decided that] I put myself in this position [of there being] something wrong with me, not [that] there's something wrong with you."

Therapist was condescending. Three participants (25%) reported that they sensed that their therapist was condescending during the initial phase of their treatment. As with Participant 9 quoted above, Participant 1, a Black woman, took offense at her perception of the therapist's taking advantage of the power dynamic, but also referenced an environment of infantilization or dehumanization of patients that the participant expressed as commonplace among therapists at the counseling center where she sought therapy:

They treat everyone like children. Worse than children. We don't have our own minds. We don't know what's best for us....Let's just listen to them. Everyone's a number. It's a very terrible [method] of serving clients. You're not doing good therapy. You're not doing good work.

Invalidating. Three participants (25%) shared that they perceived messages of invalidation from their therapists at the beginning of their relationship. Participant 1, a Black woman, described the therapist's use of the 2008 presidential election results to negate the presence of racism in society, and the participant's educational attainment to negate the presence of racism as a force in the participant's life. This invalidation of the participant's experience led to an internal sense of self-doubt and confusion:

At first I wasn't really...suspicious or weary that maybe this person won't understand my experiences, because I...just figured that I probably will be speaking with a White person....Then I started talking more about my experiences...being the only Black person in my class, and then...she made the comment of how...Obama had been elected....“Well you know, we have a Black president.”...She [made the statement] “Race isn't as salient as it [was] anymore, and since you're...at the university, it shows how you...overcame the obstacles in your life.”...She was just invalidating...how I was feeling as a Black person, the only Black person in my classes. She was...well, Obama exists, and...you're here.” So you know I'm a token, [an] example of what all Black people should aspire to. So therefore, it couldn't be that bad 'cause I'm in this important position.....She still just continued to invalidate...my experiences. [When] I was talking about...feeling stressed out and all my professors are White,...it's all White spaces,...she made the comment,...“You know...everything isn't about

race.”...I’m [thinking] what else can it be? So...it made me feel like I was being...paranoid, neurotic. I was...trying to talk about race, then I...started...doubting myself like...maybe it’s not about this....It just started being more confusing then...not helpful at all....Then I stopped going to her.

Uncomfortable. Two individuals (16.67%) highlighted feeling uncomfortable in their initial therapeutic relationships. Participant 7, a Black woman, attributed her therapist’s discomfort with the topic of race as a contributing factor to the issues she had with the relationship:

I...remember talking to her...about my race and specifically how I’ve been feeling very overwhelmed [while] navigating larger society, especially being from a lower-income family and being a Black woman....I remember her talking about her race....“I know it’s awkward talking to....a White woman about this, and I know...you’re Black.”...It was just...so out of place....Then she [changed the subject], “This is why we really need to focus on...your anxiety.”...Saying that I need to work on myself...not necessarily embracing the fact that there’s a lot of structures in the world that cause it to be difficult for Black women to navigate the barriers....She didn’t know what to do because she felt...uncomfortable dealing with the topic....It just felt...really awkward after that....It felt like I didn’t have the space to talk about things and she was...dismissing my struggles as real. Instead of [asking], “What do you mean by that?” or...inquiring more, it’s just,...“That’s why we really need to focus on—managing anxiety and coping and stuff.” And to me that was a microaggression because...she’s...saying, “Well, something’s wrong with you,”...and that was difficult for me.

Suspicious. One participant (8.33%) described bringing a sense of suspicion to a therapy relationship as a result of previous experiences of feeling invalidated, Participant 1, a Black woman, related how past efforts at therapy gave her a negative outlook on the process, especially with White female therapists, but that her mental state was so precarious that she was motivated to make another attempt despite strong misgivings:

I felt very vulnerable, but then I...just felt desperate....I was [so] desperate...for... mental health that I was willing to still talk to these White women, even though I was running this high risk that I was probably... gonna be invalidated, which is gonna be even more traumatic than maybe not speaking to them at all. But I was...just really depressed....Not to a point where I thought I would hurt myself or my daughter, but ...just in a bad place and...I need[ed] to speak to someone.

Intimidating. One participant (8.33%), Participant 7, a Black woman, reported discomfort with her feeling unable to advocate for herself with people who did not share her culture compounded by the unequal power dynamic that made her interactions with the therapist difficult:

I definitely did feel...intimidated at times....I felt like I couldn't really speak up....I also at the time struggled with authority figures and things like that, so I don't know if that had to do with that, but...there were times where I felt like they wouldn't understand something or take something wrong...because they were White women....There were even times where they would react to me in a certain way...like...commenting on my hair, or on my body, that I thought...was inappropriate. But I didn't point it out with them ever. Well, I'm not gonna say never but...it was hard for me to get to a point where I felt comfortable with that.

Context of the Microaggression

When asked to recall the context in treatment during which the microaggression occurred, participants related: a) the phase of treatment in which it took place, b) the context of the conversation, and c) whether it was a singular incident or multiple instances of microaggressions. Seven participants (58.33%) described the experience of a perceived microaggression in the middle of treatment, five participants (41.67%) shared that they encountered microaggressions during the first few sessions, and it occurred during or intake for two participants (16.57%). Three participants (25%) reported experiencing microaggressions during their final sessions with mental health providers, often with the microaggression prompting their termination. Five participants (41.67%) reported multiple instances of microaggressions during treatment periods. Participant 10, a South Asian man, described the pattern of microaggressions in his relationship with a White therapist who personalized the participant's descriptions of racial inequities he'd witnessed:

I was just mentioning how...you don't see people of my color in positions of power at the graduate school. They're not professors, they're not...major staff members. They're custodians, or...the guys working in the cafeteria....It was just...a bummer...that...me and...10 other people in my cohort are people of color....I just remember her...not getting it, but...just nodding her head...robotically. And her statements, I don't quite remember what her statement was, I might have blocked it out, but it was something, it was just...talking about herself almost in an apologetic way for the White race when it wasn't necessary, like, "Oh, I don't see color." I'm...okay, that's cool....That's not the point,

but...it was just...a weird thing to say in general as a person, but also a weird thing to say in that relationship.

One participant (8.33%) had the unique experience of a microaggression that occurred at the beginning and end of sessions when his therapist's other patients would infringe upon his time. Participant 8, a Black man, explained:

There would be times where I felt like...my session would...be cut short, or...the White chick in front of me...would run into my therapy session, and I would be, "Yo, what's that about?" But...when I'm...on a roll and I'm [trying to] purge, and get some stuff out [the therapist would say], "Oh, we're out of time."...That would piss me the f--- off.

In terms of the context of conversation, five participants (41.67%) described microaggressions as occurring during discussions about identity and/or culture when the therapist made an assumption that offended participants. Participant 4, a South Asian woman, described such an occurrence with a therapist whom she perceived to have violated her professional responsibility to focus on her patient and rather devoted the majority of the session to her uninformed views of the patient's culture. This left the patient with a feeling of defensiveness about her culture and a need to educate the therapist:

Generally, I felt the microaggressions were...tying things too much to my race, or...cultural identity, and trying to understand my culture, rather than trying to understand me....I particularly remember...one session where I was talking about how I had hung out with my friends, and this one guy that I was really interested in....My friends [had] kind of set it up, so I had thought that there may have been interest on his part too, but he didn't really seem interested....I

was...disappointed by that, and this therapist [interjected], "Was it possible that he's gay, because I imagine that in your culture that would be really hard." And then the rest of the session was about how my religion sees homosexuality which is actually, by my interpretation, very positive or very accepting and very pluralistic....I felt...a need to...explain and teach her about that, and we didn't talk about my feelings or my rejection or anything.

Two additional participants (16.67%) described feeling a sense of pressure to explain or educate their clinician about their culture. Participant 3, a Black woman, related the difficulty in trying to get her therapist to understand that she might face discriminatory treatment in the workplace:

I was talking about some of the issues I was experiencing at work, especially...seeing the way...White female coworkers were handled...after dealing with something maybe a little traumatic versus...how I was treated, and to me it was just *glaring*....This is...painfully obvious....You guys are making all of these accommodations for these White girls, and I had valid issues going on. I had brought that up, and his response just seemed like he didn't believe me....He was...asking questions like..., "Well why do you think that?"... "Well *what* happened?"... "Do you know *exactly* what they went through?"... And it was...really dismissive. It was...like he wasn't even listening to what I was saying. It was just him trying to get me to understand that it must have also been hard for someone, or harder for someone else....I can't remember....specific quotes 'cause it was so long ago, but I...always remembered...how that made me feel....But then I realized that there was something wrong....This was towards the end of the therapy, because I stopped going [when] I felt...I couldn't...be

open anymore....I [thought] let me just keep that to myself then....He's just not gonna get it, and then that made me feel...why am I in therapy...if I can't just be myself?

Participant 5, a South Asian woman, described how out of place she felt in her psychotherapy group when the other members treated her as if she was there just to answer their questions, rather than as their equal with the shared goal of being help:

I'm tired of explaining my experience and I just...want to be in a setting where the person...gets it or...is able to...work with me to understand my experience, and then provide feedback, instead of the group being like...an interrogation....I didn't like that.

Chapter V: Results II

Introduction

This chapter of the results discusses the participants' experiences with the microaggressions they identified in therapy, including: a) the content and process of the microaggressions, b) the negative experiences they represented, and c) the outcome of the treatment process. Participants differed in their responses to the microaggression. The chapter explores the reasons why some participants decided to remain in therapy after the microaggression occurred and others left, and why some participants chose to discuss the microaggression with their therapist, while others did not. Participants offered their reflections on how their therapists could have handled the situation differently, and the impact of the microaggression experience on the participants' attitudes toward therapy and future help-seeking behavior. Finally, participants suggested methods by which therapists working with clients of color could improve those relationships so that microaggressions are less likely to occur or more easily repaired after the incident.

Content and Process of the Microaggression

Participants were asked what the therapist said or did that they perceived as a microaggression along with follow-up questions about their reaction, emotions, and feelings toward the therapist.

Content. Microaggression content fell within three general categories, including therapist: a) dismissiveness about race, b) racial assumption or stereotype, and c) unfair treatment. Six participants (50%) reported that their perceived microaggression was related to the therapist dismissing the topic of race or their experiences related to racial identity. For example, Participant 1, a Black woman, described her experience with a White female therapist whose consistently inappropriate and unprofessional remarks

resulted in the participant's self-advocacy, which then resulted in the therapist disclaiming any racial intent and offering as proof her associations with Black coworkers. These interactions resulted in the participant terminating treatment and losing confidence in therapy:

[When the therapist stated] "I have several Black friends,"...that was...one of my first, and not last, and probably more encounters to come in the future of,...White people saying [things like this], I guess to validate how they're not racist because they know Black people. So...after that experience, between her making comments about my body, and then comments about my pregnancy, and how I shouldn't have any more kids...and then that comment about "Oh, my Black friend is one of the advisors," I was...done for that session and...seeking any counseling.

In another instance, Participant 7, a Black woman, described her therapist's reaction when the participant broached the topic of racial identities. Although the therapist responded to the participant's initial attempt by acknowledging the racial difference in the room and how that might impact her capacity to understand the patient's experience, the participant perceived her discomfort when the therapist dismissed the area of racial identity as less significant than the symptomatic presentation:

Learning new things...about my struggle as a Black person, [thoughts] of how that [interacts] with all of the stuff in my head [were] kind of spiraling....I was feeling very anxious talking to her about it, and so I think in order to slowly decide to try to create that space to comfortably engage, she said to me,..."I know I'm White and this is awkward to talk about to a White person," or something [like], "I'm a white woman."...I thought she was...*going* somewhere with it, but

then she like went to that direction of...this is why we need to focus on anxiety, and I was just...wow...exactly what I needed to hear.

Six participants (50%) described a racial assumption or stereotype made by their mental health provider. Participant 1, a Black woman, elaborated on her therapist's assumption that the reason the participant became pregnant and gave birth to her daughter could only be attributed to carelessness or ineffective birth control. That the participant could have wanted the child was not even considered by the therapist:

I told her about my daughter and she [asks], "Do you have any more kids?" And I [answered], "No. I just had a daughter...six months ago, so no, I don't....have any more kids." And then she's like, "Oh,...do you think you'll have any more kids?" And I was like, "I don't know. Not right now probably." She's like, "Because I know you," [and implies] that basically I'm causing stress to myself because I'm not being responsible, and so she's like, "Well, you know you should consider other birth control options so you don't have any more unplanned pregnancies."

Participant 5, a South Asian woman, expressed her anger about her therapist's prioritizing her own cultural curiosity about the origins of the participant's parents' marriage over the participant's treatment needs:

The actual microaggression that occurred [was her assumption that my parents] had an arranged marriage....Whether...that's true or not is irrelevant....It was more like, "Oh, because [I'm South Asian, their marriage] might have been set up or arranged." [I'm thinking] maybe, maybe not, you're never gonna know, because I'm never gonna tell you....I just really struggle with it....I have another South Asian friend in my program who...I feel...would respond...differently. She would [say], "Oh, you know enough about my culture that...you've brought this

into the room, and now we can discuss it,” or whatever. But for *me*...I was insulted because I’m [thinking], “No....You don’t get to make that assumption about my family, and I’m not gonna fight you on this because...right now my family issues are totally irrelevant to what we’re talking about...I don’t wanna correct you...because...what’s that gonna do for me?” But I was *pissed!*

Participant 2, a Black woman, reported how her therapist who shared a similar ethnic background responded to her concerns about high levels of crime in her neighborhood with his personal beliefs, e.g., suggesting that she should move, which she perceived as boundary crossing and insulting, tinged with race and class bias, and violative of his responsibility as a mental health professional:

He was just making flippant comments like, “Yeah,...so much shooting....Oh my God, yeah, you shouldn’t live there anymore.”....It didn’t seem like a therapist, but somebody’s uncle giving me bad advice....Probably because I’m a Jamaican,...it was just like the boundaries had disappeared or flattened, and he wasn’t doing his work as a professional. I just remember how raggedy it was, it was very terrible.

Additionally, one participant (8.33%), Participant 8, a Black man, described the nonverbal environmental microaggression, as discussed above, of his therapist allowing White patients access to his time so that his sessions began late and ended early.

Reactions. Reactions to microaggressions varied widely, some of which were captured in follow-up questions. Five participants (41.67%) questioned the competence of the therapist, five (41.67%) engaged in internal reflection, two (16.67%) responded with passive aggressiveness, two (16.67%) directly confronted the therapist, two

(16.67%) responded with non-verbal reactions, e.g., facial expressions, one (8.33%) changed the subject, and one (8.33%) became defensive

Participant 4, a South Asian woman, explained that educating her therapist when she interpreted a negative view of the participant's cultural group's values regarding LGBTQ individuals left the participant feeling the need to defend the culture rather than focus on her own concerns during the session "Defensively...I was like,... 'Yes, that is hard in my culture, but...I mean that it shouldn't be, or whatever.'...I wanted to present my culture in this positive light...[by] taking the entire [session] to explain myself rather than coming back to me."

Participant 1, a Black woman, was among many participants who questioned the competence of her therapist, particularly when the therapist was perceived to appear baffled by the participant's high standards for educational attainment. This value, along with the participant's economic responsibilities to support her family which entailed working two jobs as well, led to the presenting problem of stress. Her therapist suggested that lowering her standards for herself might reduce stress—a view the participant perceived of as lacking cultural humility:

It almost was...like a waste of an hour and a half....I was only giving her very superficial responses because she was asking very superficial questions [such as], "So, if you didn't strive for As all the time, then you wouldn't be so stressed out?" I was like, "I strive for As because if I'm not getting As in these courses, as a Black woman...my credibility, which is already degraded...becomes...further depleted, as far as my validity in these spaces and degree attainment."...It did feel uncomfortable telling her that....I just can't stop striving to get good grades in school, and so I talked about working two different...assistantships, and she was

like, “Well, do you think it’s possible...to lighten your load?,” and I was like, “Yeah, if I don’t want my family to eat.”...So...she seemed...just not culturally astute or privy to discuss anything in detail.

Negative emotional experiences. Participants described a wide range of negative emotional experiences related to the perceived racial microaggression and the consequent feelings toward their therapists. Half of the participants (six, or 50%) described feeling anger. Other emotions or experiences included shock (five participants, or 41.67%); frustration (four participants, or 33.33%); disappointment (three participants, or 25%); pressure to educate the therapist (three participants, or 25%); disempowerment (two participants, or 16.67%); annoyance (two participants, or 16.67%); disconnection (one participant, or 8.33%); dread (one participant, or 8.33%); anxiety (one participant, or 8.33%); invalidation (one participant, or 8.33%); disgust (one participant, or 8.33%); defeat (one participant, or 8.33%); exhaustion (one participant, or 8.33%); sadness (one participant, or 8.33%); and feeling cheated (one participant, or 8.33%).

Participant 9, a Black woman, described her view of seeking therapy as a setting in which she could find safety from the racism and sexism she experienced at work, but found that her therapist, rather than engaging with her concerns or even being willing to listen to them, instead defended the environments where the participant experienced racism and sexism. This left the participant with no refuge at all and angry:

I just felt like I was caged. Like she and I [are] here and...I am under this monster of an institution, the hospital, and the school....They should treat me with some respect, [but] I felt like there’s no place here that’s safe for me. Even the one place that said that I’m supposed to be safe....And then I also felt...*so angry* that even in another place, which was outside of my department...outside the

university,...the racist and sexist structure still got supported! I [thought] this is *deep*, and [the therapist] is defending [these systems], and I was like, “Wow! I do not need this to be healthy.”...Oh, I wanted her to lose her job!...She’s...completely ill equipped....She was spilling all this stuff out....You’re supposed to be quiet. It’s usually quiet. I ain’t even gettin’ it out good. [The therapist didn’t] have any basic attending skills whatsoever....If you didn’t like the details, just attend to the emotions. I’m upset, I’m angry, I’m agitated....Even if [she] were to say,...“Oh, that’s a lot, let’s just sit here and just breathe.”...You know what I mean?

Participant 2, a Black woman, expressed her shock at her therapist’s mocking reaction when she described the trauma she experienced. His behavior eroded her trust in him. Although she did not challenge his statements or attitude at the time, she described what she termed as her “interior monologue” that reflected a range of emotions during and subsequent to the microaggressive event:

If it happened to someone else, I would laugh. It’s happening to me, and I’m laughing but also like, *No* that’s not funny. What is he *doing*? That’s inappropriate. Shock [was my reaction] initially, and then after [he] continued [with the] the session, it’s just like disappointment, anger, sadness because...this is *my life* you’re talking about. Why are you making a mockery or being flippant about somebody’s life? I just told you these traumatic things happened to me and...I don’t feel good about it....You’re...a joke as a professional....You put trust in this person to help you, or fix you, and then they’re laughing at your pain, so it makes you feel small....I just didn’t have any confidence [in him].

A few participants described their therapists as seeming to prioritize satisfying their own curiosity about the participant's culture over individualizing cultural information to serve the treatment of the patient, with the result of participants feeling pressured to educate their providers about their culture. Participant 11, a South Asian woman, described this process: "We kept having these conversations, and...I just answered his questions. Waste of my time. Is this a class about South Asian anthropology? I don't know where this is going. I was frustrated with him."

Although Participant 12, an Asian woman, reported a similar experience in that her therapist seemed more interested in learning about her culture (Chinese) than about her individual experience, this led to the participant questioning whether she and the therapist had shared goals for the participant's treatment rather than, as was true for Participant 11 above, feeling a pressure to address the therapist's concerns while ignoring her own:

I'm not sure what the word for it would be, but I guess I was a little disconnected from her whenever she brought it up...because [it made me] more aware that she was like a person who studied people like me, rather than a person who...understands people in general....It just created a barrier between us.

Participant 1, a Black woman, was one of two participants who described feeling disempowered. As her therapy was conducted in her university counseling setting, she felt constrained from speaking honestly as she feared expressing her true feelings without first censoring them might be misinterpreted as her being a danger to the school, resulting in severe repercussions:

I...felt ...this power imbalance....Can I curse this lady out? If I curse her out, will she tell other people, and then is there some kind of disciplinary thing?...I was

unsure what I could actually really say, [what] I really felt, because...I knew that [if] I...came off intimidating or threatening, then maybe she would file a report or something, and then I...would be kicked out of school.

Participant 3, a Black woman, described her difficulty in balancing the convenience of her provider's office, which was only one floor below her workplace, with the overwhelmingly negative feelings she experienced as a result of the therapist's continued microaggressions:

I'm seeking therapy to deal with [a problem], and I can't really get to the root of it...and that made me even more frustrated....It was like I just was *dreading* going....So many feelings...led me to [think that] maybe I shouldn't go 'cause...I'm feeling this dread....I should not be going anymore. [It] was a super convenient situation to just go downstairs and see a therapist [but then I'd think], "Ugh, how can I get out of this, how can I get out of this session? What excuse am I gonna come up with? Maybe I'll just come late, so I don't have to stay the whole session." It was like that....He made it so that it couldn't be addressed directly because he was so dismissive.

Participant 8, a Black male, felt treated unfairly by the microaggression, discussed above, of his therapist's not adhering to their time boundary:

Like I was getting *cheated*....[The therapist's previous patient] gets to...,go on a roll....I don't know what's going on behind that door, I can't hear or whatever,...but...sometimes she would come out, and she's crying and stuff like that, and so I'm [thinking that] maybe this was like a really intense type of thing. But then there are some times she'd come out, and they'd be laughing like they [had been] joking or something....At first, I [thought] this isn't cool....I'm...here

because I feel...this sense of impending danger....I'm here because I'm trying to...prevent something from happening,...so *I need* [the agreed upon time].

Outcome

Duration of therapy after the microaggression. Participants were asked whether they remained in therapy after the microaggression experience, and, then in a follow-up question, were asked to describe the reason for that decision. The participants who reported instances of microaggressions occurring in more than one therapeutic relationship made separate determinations as to whether or not to continue with the particular therapist. Of the 12 participants who reported a total of 18 microaggressions, the majority of participants (seven, or 55.56%) decided to terminate, while five participants (44.44%) remained in the therapeutic relationship.

Of the individuals who chose to terminate, eight participants (75%) cited a poor therapeutic relationship as a reason for their departure. Two participants (16.67%) described their therapeutic relationship as so lacking in open communication and so uncomfortable that they gave their therapists fictitious reasons for terminating. For example, Participant 4, a South Asian woman, described that although she “felt like I couldn’t connect with her and that therapy wasn’t gonna be effective,” she told the therapist that finances were responsible for her decision. The lack of connection may have contributed to her difficulty communicating honestly.

Participant 7, a Black woman, similarly alluded to a dissatisfactory therapeutic alliance which led to her having a pessimistic view about continuing with the relationship. As with the participant above, Participant 7’s communication issues during the duration of treatment resulted in the participant’s unwillingness to explain the true reason for termination:

I did stay [only] a couple sessions after [the microaggression] because I felt like...the therapeutic alliance was kind of distant....I didn't want to talk about things that were bothering me, and I just kind of shut down in therapy....When she challenged me, I just felt...attacked, but I [also] felt like she didn't understand me. I felt very misunderstood going forward, and so I ended therapy, I told her [it was] because I didn't have insurance anymore, but I lied to her.

Although communication issues were present throughout the therapeutic relationship for Participants 4 and 7 above, and encompassed a variety of subjects, for other participants an impasse resulted from differences that emerged during the course of treatment. For example, Participant 6, a South Asian woman, mentioned her therapist's unwillingness to accept the participant's perception of her attachment with her family and persisted in trying to persuade the participant to adopt the therapist's view:

I think what led to the decision to leave was [based on my doubt] that she would be able to be useful because I felt like she...just...cut off any [discussion about whether] I was codependent on my parents....I wasn't willing to compromise on her conception of codependency, [so] it didn't seem...worth it to continue with that particular therapist.

Participant 3, a Black woman, described how, in the aftermath of a cultural misunderstanding, she felt she could no longer engage in honest discussion with her therapist. This prompted her decision that there was no use in continuing to pay for a service from which she was deriving no tangible benefit. Unlike Participant 4 and 7 who gave false excuses for termination, Participant 3 felt that any further conversation with her therapist would be futile, and never returned to the therapist's office:

I had this feeling...like I had to censor myself, or I couldn't really express myself freely, and I felt like...if I'm paying all of this money, it's just kind of a waste. I'm not getting the most out of it. So...I decided to just stop going, and I didn't even really have a conversation with him....I didn't say,...”By the way, this is why...I'm feeling this way about talking to you, and I don't want to see you again,” ’cause I just didn't feel like it would even make sense to do it....Would he really even get it?

For others, their therapists' perceived hostility related to culture was the impetus for the patients' decision to terminate prematurely. For example, Participant 1, a Black woman, described engaging in therapy as a means to process her experiences with racism and a refuge from the toxic environment that surrounded her; however, because of her therapist's inability to listen to her or offer helpful feedback, she experienced only reinforcement of the negative influences in her life:

At the end, I just really wanted someone to like listen, and they...just weren't listening. I'm not asking for...your footnotes or interpretation when I am talking about my experiences....These therapy sessions became...another [source] of...hostility and...and it contributed to...racial battle fatigue....I was trying to get some help for my racial battle fatigue and this is exacerbating it.

Similarly, the lack of seriousness with which her therapist treated her and his dismissing messages resulted in Participant 2, a Black woman, perceiving that the therapeutic relationship was not worth continuing:

There was no hope. There was no recovery....The classist and dismissive statements made by this doctor...didn't inspire me to stay. I felt like it wasn't helping. There wasn't enough empathy. His remarks about where I lived...made

me feel as though I brought these challenges on to myself. He was free, but it wasn't worth my dignity.

Additional reasons for leaving therapy included scheduling conflicts (two participants, or 25%) and financial difficulty (one participant, or 8.33%).

Half of the participants (six, or 50%) reported remaining in therapy after the experience of a perceived microaggression because they believed they needed to be in treatment. For example, Participant 3, a Black woman, made a calculation that the benefits she derived from continuing the therapeutic relationship, specifically in terms of the insight she gained about herself during a period of distress at work, outweighed the negative feelings she continued to have in light of the therapist's microaggression:

I...just knew that I needed help, and so I tried to keep that in mind. There were still other elements of the therapy that [were] helpful. Like...I had...an understanding of...the dynamics between [my] mother and I probably playing a huge role in...making...my career [decision], and [influencing] my relationships with certain types of clients that...reminded me of her. I started getting an understanding of that, so that was kind of helpful. It wasn't like he was just...completely useless. So I think that's probably why I was in therapy that long, but it was still kind of inconsistent 'cause, again, I would have these feelings of not looking forward to it.

Participant 2, a Black woman, reported that achieving relief for her extreme level of distress was more important to her at that time than reacting to or addressing the microaggression: "I stayed because I was suicidal and I needed help. I wanted to live, but I just didn't want to suffer anymore."

Three participants (25%) reported remaining in therapy because of positive aspects of the therapeutic alliance. Participant 8, a Black man, described the ease of communication with his therapist, in addition to shared attributes, that influenced him to remain in treatment:

I feel comfortable talking to her....We're relatively close in age so...culturally...I can reference certain things and...she kinda gets it....I think she had...some similar experiences....There's this empathy that she has,...this understanding of certain challenges,...certain things.

Two participants (16.167%) reported that the convenience of the location or limited ability to access other services was part of their rationale for remaining in therapy.

Discussion of the Microaggression With the Therapist

For each instance of a perceived microaggression, participants were asked whether they discussed the microaggression with the therapist. If answered in the affirmative, follow-up questions concerning who initiated the conversation, the quality of the conversation, and whether it helped or harmed the relationship were asked. If the answer indicated that the microaggression had not been addressed, participants were asked a follow-up question regarding what stopped them from confronting the therapist. The majority of participants (eight, or 66.67%) did not discuss the perceived microaggression with the therapist, but four participants (33.33%) had explicit conversations with their therapists after the rupture. Various reasons were given for participants' decisions not to discuss the microaggression with their therapist, including internal and external conflicts.

Anticipated poor outcome. Five participants (41.67%) reported that their anticipation of a poor outcome was a barrier to having a conversation about the

microaggression. Some reported that their expectation that the therapist would not understand them would only increase their frustration. For example, Participant 3, a Black woman, explained that her therapist's demonstrated failure to understand her during treatment caused her to believe that trying to address the microaggression would meet with the same result:

If he couldn't even understand where I was coming from when I was talking about [presenting] issues, then how was he gonna understand [the more complex process discussion]? Like, "Oh hey,...I feel uncomfortable now, because I can't just say what I really wanna say 'cause you're not gonna really...acknowledge it."

Similarly, Participant 2, a Black woman, explained how her sociocultural location compared to that of her therapist impacted her perception that he would not get past his prejudices:

I didn't bother, because I didn't think he would understand or care. He was an old, old Jamaican doctor, with light skin. I feel based on his age and where he was from, he was classist, and was judging me based on the color of my skin. Those old-school upper-class Jamaicans from back then were all about class and color. I've dealt with those types before. I'm sure he expected me to have these issues living [where I did] and being from a lower income family.

Other participants experienced guilt about initiating the discussion, and assumed some ownership or responsibility for the impact the conversation might have on the therapist's feelings and/or perception of their competence. Avoidance was the more tolerable option. For example, Participant 11, a South Asian woman, succinctly stated, "I didn't want him to feel like he didn't get me. I felt bad. I didn't want him to feel bad."

Participant 4, a South Asian woman, wanted to avoid the possibility of upsetting the therapist, analogizing how concerned she is as a therapist in training not to upset clients:

I felt really guilty about that....I felt like my obligation as a therapist was to tell her so she could do better....I just had a sense that she would just try to defend herself...in an empathetic way, I'm sure, but not really get what I meant and...I always have trouble...communicating feedback or criticism or [even] constructive...things to people. I don't like to upset them, and I didn't want to deal with her potentially being upset. It was easier to leave.

Not worth it. Five participants (41.67%) reported not having an explicit conversation about the rupture because it was not worth the time or effort. Some participants thought engaging in the potential confrontation would entail the unwanted burden of having to educate the therapist. For example, Participant 2, a Black woman, exclaimed: "It was my last session, and I wasn't invested in educating this tragic ---hole. That's his problem, not mine." Similarly, Participant 6, a South Asian woman, expressed that she did not want to have to explain herself and added that the unsatisfactory quality of the therapeutic alliance was a mediating factor:

I just didn't want to have to explain myself. So that's probably why I didn't continue....I didn't think it would be a productive conversation to have....If I had been more invested in the relationship with that therapist, like in a long-term sort of thing, then maybe I would have addressed it, but in that sort of situation it wasn't really worth my time or energy to do so.

Participant 1, a Black woman, added yet another layer to this dilemma. She described how priorities with greater salience at the time took precedence over confronting therapists about their microaggression:

At [the] time [of the first microaggression], I was just still really just new to adjusting to college life. I was a first-generation college student, and then I became pregnant, so I just had...so many, many things that [were] occupying my mind that I just wasn't particularly in the mood...to address that in that moment.

During the second example of a rupture in therapy related to racial microaggressions, this participant explained her thought process in not confronting her therapist:

My research interest is critical Whiteness and so I talk about Whiteness, White identity, and fragility, and the emotionality of Whiteness. [I'm in therapy], I'm not in class, I'm not researching....I'm supposed to be getting help, not...schooling someone else, and providing...this free education opportunity for this White therapist to check their White privilege....That's what's taxing and just further draining me.

Power dynamic. Two participants (16.67%) identified the power dynamic in the room as a contributing factor to their failure to address the racial microaggression. For example, Participant 1, a Black woman, explained that in the earlier instances of microaggressions she had not gotten far enough as a psychology student to know whether therapy was an appropriate venue for the expression of anger or to feel confident with self-advocacy in light of the power differential, but as she furthered her education, she had confidence to stand up for herself:

I brought up the power dynamics [in response to the question] because then I wanted to react [because I was] very angry about how she's invalidating my experiences. But I wasn't sure at that time of...how these sessions work. So that also prevented me, but in later sessions, [as] I advanced through my various degrees....I started...asking them more questions than they were asking me.

Participant 12, an Asian woman, recognized that her difficulty questioning an authority figure in other areas of her life operated in the therapy room as well:

[I didn't respond because of] the power dynamic....She was the one who had finished the...training, and for me to question her would have felt like...questioning an authority. Although...in our relationship, she wasn't really an authority, but it felt like [she was]. I have issues with authority, so I didn't want to...question her, and be like, "Yo, why are you doing this?" So...that's what stopped me, I guess.

Other responses. In addition to the reasons listed above, three participants (25%) mentioned not feeling comfortable having a conversation addressing the microaggression, and one participant (8.33%) reported being unsure of what to say.

Although only four participants (25%) engaged in an explicit discussion with their therapists following instances of perceived racial microaggressions, those who did reported the conversation as having a significant impact on the patient's experience and the therapeutic alliance. Of the six instances during which the microaggression was discussed, four of the conversations (66.67%) were initiated by the patient and two (33.33%) were initiated by the therapist.

Positive conversation with therapist about microaggression. Three participants (25%) reported a positive conversation about the microaggression. For Participant 8, a Black man, boundaries were clarified, the therapist agreed to a change in her behavior in the future, and proposed a solution to remedy the microaggressions that had taken place on prior occasions:

She [said], "I understand,...and...I don't want you to feel like I'm more concerned about [my previous patient] than I am you. [It's] just certain situations

come up where...if a person is...crying,...I'm not just gonna...stop them....That would...be insensitive....But if you have an idea of how much time I've...cut into [your sessions], I can credit that to you or whatever, and I can [assure you] that...I will be more mindful...of the time in the hour."...It was very calm,...very cool. [There] wasn't some...big thing [made] about it,...and we went on ahead and had the session that day.

In another case, an explicit apology during the termination phase of treatment about assumptions the therapist made and their impact facilitated a positive conversation between the therapist and Participant 9, a Black woman:

She did apologize [for] saying [the perceived microaggression] to me, because she was like, "I can see that...that was hurtful to you, and that after you've gone through all of this with your family, with them not really believing in you, and not trusting you,...then for me to say something like that when you're about to leave....probably sounded like one of your family members, and I don't want that."...She was really excellent.

The therapist above drew on the concept of transference to gain an understanding of how her invalidating microaggression might have been similar to the hurtful experiences the participant had experienced in other relationships.

Negative conversation with therapist about microaggression. Three participants (25%) reported negative conversations with their therapists. Participant 1, a Black woman, explained that her therapist's attempt to show understanding with her comment that she has Black friends caused the participant to consider termination; however, the participant realized that a decision to terminate might have a negative

impact on her mental health. Given the level of her distress, she continued with the therapeutic relationship, albeit with misgivings:

It...felt...patronizing, [as if] I know more about...your experiences as a Black person because I have these mythical Black friends.”...Because, once again, when you ask about your experience, and then not understand...the intersectionality of identities...then I feel embarrassed, and it makes me not want to talk about these things anymore. So it makes me not wanna come, which...is terrible when you’re suffering from mental illness because obviously your mental illness is gonna get worse because of circumstances like this.

Participant 9, a Black woman, described a mutually angry conversation that contained both verbal and nonverbal hostility between herself and her therapist in which the participant confronted the therapist with her lack of preparation for treating clients of color:

Oh, she was angry! First she had a notebook, and at some point, she put the notebook down. She had her legs crossed, and she was relaxed at first. Then she...uncrossed her legs, then she was leaning in, and then she...turned her body away from me, and at this point, I’m leaning into her....I’m getting loud....We Black people, we kinda get loud. So I’m getting louder, not to a point where I’m yelling....I was absolutely clear and told her that I was angry [because her conduct] was unprofessional....She was...angry, but...she was [also] offended, she was surprised....I want[ed] her to be surprised actually....“So you thought I didn’t know about therapy?” I said. “I know,” I said, “And I even know about your program.”...Then she tried to be defensive, [but] I said, “I know you don’t have any multicultural classes at that program...because my supervisor [for] my

master's program...went to [your university], and she had the same issues with clients of color." I said, "That program attracts women like you. I've worked with...social workers and counselors [who attended your program and] Ya'll ain't got none of this!" And...each time, she was just surprised. I'm like, "So, what did you think? That I'm just some stupid colored idiot? That I don't know anything?"....I guess I was mean, I don't know, I don't care.

While the patient was tracking the therapist's nonverbal behavior, she was simultaneously making an effort to disprove potential prejudices and misconceptions about herself as a Black woman. There seemed to be an effort to shift or level the power dynamic in the room. While the participant quoted above later reported that she felt confident in her ability to advocate for herself, she recognized the anger and defensiveness in the dynamic between the dyad during the session.

Impact of discussion on relationship. Four participants (33.33%) reported that their conversations with the therapist about the racial microaggression helped the alliance, and reported feeling a sense of relief due to the therapist's engagement and openness to the participants expressing their feelings irrespective of the ultimate outcome with reference to repair. Two participants (16.67%) indicated that the discussion hurt the conversation. These individuals reported disappointment in the lack of resolution or perceived a therapist reaction of defensiveness.

Therapeutic relationship post-microaggression. While this question was not applicable for the four participants (33.33%) who left therapy immediately after the occurrence of a microaggression, the remaining eight participants (66.67%) described the microaggression's impact on the therapeutic relationship. Three participants (25%) described their therapeutic relationship as positive after the occurrence of a

microaggression. Of the three, two of these participants (16.67%) had discussed the microaggression with the therapist in a productive manner resulting in some repair.

Participant 8, a Black man, described growth in the strength of the relationship with his therapist:

It was cool....I still feel like I'm getting something from it, and I'm not just spinning my wheels. I think that...more attention is being placed on the conversations that we have, and some of the things that I'm dealing with.

On the other hand, two participants (16.67%) had mixed feelings. Participant 5, a South Asian woman, described her ambivalence about remaining in therapy because although the microaggression experience had altered her trust in the therapist, she was still being helped effectively in other areas:

There were times when...I felt like I had a strong alliance with [the therapist], but after that...moment, I definitely felt like, Why am I here?...A part of me [thought], "This is not good, and I don't trust you." But then, because there was so much other stuff going on, and she was kind of helpful related to that other stuff, not probably helpful all the time, but enough that I [thought] I'm getting somewhere....It was just like, okay.

The majority of participants described the relationship with their therapists after a microaggression with some negative valence. For example, two participants (16.67%) described relationships with their therapists after the microaggression as marked by skepticism. For example, Participant 3, a Black woman, recalled, "For him everything was...normal, I guess....After each time, I was just kind of...giving him the side eye, like,..."Should I say this?...What's the point?" Participant 4, a South Asian woman,

found that her focus during the sessions involved scrupulously scrutinizing her therapist's reactions rather than reflecting on the content of the therapy:

I felt like I was still evaluating her, waiting to see if she actually got it or not. I was...very consciously seeing how she interpreted and responded to what I was saying and rather than like actually taking...in [what she was saying, I was] judging her for it.

Participant 7, a Black woman, was the only participant (8.33%) who described feeling unsafe after the moment of the microaggression. She felt inhibited from speaking freely, apprehensive, implicitly if not explicitly, of a disapproving therapist:

I felt very uncomfortable. I felt...misunderstood. I was afraid that...she would say that I was doing something wrong again....Not that she said that outright, but that's...how I was interpreting her statement,...like, "This is why you need to work on this....You're thinking about this wrong."...I think that's probably why...sometimes...therapists have a lot more power than they realize, and...I felt her judgment on me in that moment....I...felt like...it wasn't a nonjudgmental space anymore, and it wasn't safe for me.

Additional singular responses included feelings of distance (8.33%), intensity (8.33%), a lack of trust (8.33%) and feeling that the relationship was inauthentic (8.33%). Participant 4, a South Asian woman, explained how the mutuality of the lack of authenticity served both interests—the participant avoided confrontation, and the therapist got to indulge her curiosity:

I don't think she could tell [how I really felt]. I always presented a...positive face...I mean, I think she may have even asked me, or said...at some point, "Sorry for asking so many questions, but I find this fascinating." I was like, "Oh, no, it's

fine. I like talking about this,” which was...a lie. It was probably not fair to her, but...that’s what felt easy in the moment....It made me angry because I felt like if she knew [I was being inauthentic], then she should stop [me]. I felt like she had a sense that [my presentation] was inappropriate, but she didn’t [intervene]. She didn’t put understanding me above her need for...what she finds fascinating.

Alternative Response: What Could the Therapist Have Done Differently?

Participants’ responses varied widely when they were asked what their therapists might have done differently at three stages in the relationship: a) the start of treatment, b) during the moment of the microaggression, and c) after the occurrence of the microaggression.

Don’t make assumptions. A large portion of participants (five, or 41.67%) stated that they would have changed their therapists making assumptions that manifested as racial microaggressions. For example, Participant 5, a South Asian woman, hoped that her therapist would have adopted a more professional, humble, and collaborative approach when discussing marriage practices in the participant’s culture rather than making an assumption that influenced the patient to feel excluded from the conversation, and lacking the desire to further discuss the content area:

She could have been a little more tentative maybe [asking], “Have your parents had an arranged marriage?” or “Do you think that’s impacting [their relationship]?”...instead of just [assuming], “This is why this is happening, right?” And it’s like no, maybe....I’m not gonna tell you now...[She should have been] more tentative...on...some of...those cultural stereotypes.

For Participant 12, an Asian woman, her therapist’s efforts at hypothesis generation by universalizing the experiences of members of a group represented in her

practice acted to strip the participant of her individuality and created a “racial distance” by emphasizing the participant’s “otherness”:

I guess she should have not have brought up that she has a ton of other Chinese clients that are having the same issue. I feel like that’s some kind of breach in...ethic[s] to describe her other clients [to me] and to generalize a person. She could have kept that to herself, and continued asking me questions to see if it made sense with her hypothesis ’cause then I wouldn’t have felt so...distant from her,...distant racially.

Listen. Four participants (33.33%) viewed their therapists’ interpretations as intrusive or premature and wanted their therapists to actively listen more. For instance, Participant 2, a Black woman, found her therapist’s comments about her community and her trauma offensive as well as unprofessional: “He could have listened without the stupid insensitive commentary. I do not want to hear snide asides. I know how this situation looks.... *I lived it!* Just do your job and have some freaking decency!” In another case, Participant 1, a Black woman, described her therapist’s interrupting her while she related her experiences of racism on campus with the therapist’s alternative conceptions of how events should be perceived:

I really wanted just someone to listen,...not give me an interpretation of how I should be thinking, feeling, or experiencing or reacting, but just to listen.

So...here you are, White lady, just listen to me talk....I was not religious, but [the analogy is] going to a confession if you’re Catholic....You’re just talking to the priest,...letting them hear everything....I wasn’t able to...talk about..., “Oh, I had this experience with a professor,” without [the therapist] interjecting with, “Well,

maybe it wasn't that." I didn't ask you that! I just wanted a space or...to be listened to...because it helped me to...really process all of these thoughts.

Similarly, Participant 3, a Black woman, expressed the frustration she felt when relating experiences she had with racism in the workplace. Rather than ask probing questions that would have allowed the participant to gain insight into the events and her reactions to them, the therapist asked invalidating ones:

Instead of asking me why I have those thoughts, just let me speak,...“Tell me more,” not “Why do you think that?” or “Why would anyone think that?”...And then [after exploring the issue, and I] had the awareness, of course, to just [say something like], “Hey, you mentioned this, and you didn't get a chance to elaborate on it, can you talk about it?”...That would've been ideal.

Apologize. Four participants (33.33%) also stated that they had hoped that their therapists would have offered an explicit apology as that would have demonstrated understanding and personal responsibility. For example, Participant 6, a South Asian woman, reported her therapist's tendency towards judgmentalism regarding the participant's family relationships despite their being consistent with cultural norms. The participant expressed the view that if the therapist showed respect and adopted a learning stance, the participant would not have terminated:

I think the word codependent is very loaded, and so...that triggered the response in me that I didn't want to continue....Codependent [is] so value laden, [and] it...shut down further conversation. Afterwards, had she apologized, like, “Oh, I didn't mean that,” [or] “I don't know...something,” [to] show that she understood...that there [were] cultural differences, and to understand that...not

everybody thinks of relationships with families the same way that I do, or something like that....I think that that would have been helpful.

Check in. Three participants (25%) reported wishing that their therapist would have checked in with them during the course of a session, especially when a rupture occurred. For example, Participant 9, a Black woman, explained that her therapist's failure to engage during the session by, for example, offering process comments left the participant not feeling as though she was being taken care of by the therapist in the moment. This gave the participant the message that the therapist was indifferent to the therapeutic alliance and not focused on the goals of treatment:

I think as the tension was building, she could have just checked in with me. She could have just said,...“going with what I mentioned, blah, blah, blah.” I don't know if she talked about yoga first or overreacting. She could have said,...“How did that make you feel when I say that?” or *something*, or,...“I noticed that you got a little angry,” or “After what I said that, now that I'm thinking about it, that probably sounds like I'm trying to blame you,” or something to...just attend to whatever emotion, or just to check in with me,...and let me say more, and then just stick with that....That really would have been enough, that it would have showed me that 1: she was paying attention to me, 2: she was paying attention to herself, 3: she could have been paying attention to the ultimate goal here:...for me to get the right letter, so I can have a medical leave of absence.

Increase self-disclosure. Two participants (16.67%) desired more self-disclosure from their mental health providers, particularly regarding White privilege and acknowledgment of the racial difference. Participant 1, a Black woman, discussed how self-disclosure on the part of her therapist, showing that she understood the societal

context of racial disparities, would have facilitated the participant's speaking about her concerns. Without that conversation, the participant felt limited in how open she could be about expressing the racial difference in the relationship and experiences related to race throughout her life and within her family system with her White therapist:

I guess what my romanticized version would be like,...“I understand...my White privilege and we live in,”...and not even bringing in racism, but...centering like,...“This is my White identity, and I'm gonna try my best to...understand where you're coming from as a woman of color,” and I never got that. That probably would make me feel a lot more comfortable to talk about...themes, [such as how] I could never afford a counselor, or about how I was taught...that...Black people...don't go to counseling because we don't trust White people....She was...*appalled* by this [statement]. But...I didn't feel comfortable going into more context of why I was socialized, that...it's not like some hocus pocus...just Black people being paranoid.

In contrast, another participant, Participant 5, a South Asian woman, related how her therapist's self-disclosure about White privilege changed their relationship from the participant having concerns that the therapist was a good fit for her to viewing the therapist as competent and trustworthy:

We were talking about privilege, and she disclosed a little bit, and I was [thinking] I trust you again, and I believe that you...are a competent therapist for me...because previously I had not. I really...doubted her,...and I feel bad because...she's been practicing for so long, and I still [have doubts] if [she is] competent to work with me, because I have a lot of stuff, and...I don't know if

[she knows] how to deal with my stuff without making me feel...cold or dismissed.

Notice nonverbal cues. Two individuals (16.67%) reported they wanted their therapists to notice nonverbal cues during the moment of the microaggression. For example, Participant 5, a South Asian woman, commented that her therapist's lack of responsiveness when the participant reacted to the therapist's microaggression led the participant to doubt whether the therapist was observant enough to offer effective treatment. Participant 5 has doubts about whether it was realistic to expect the therapist to know that her facial expression at the time was caused by the therapist's statement, or by other unrelated issues concerning the participant:

If I *looked* shocked at the comment, it would have been nice for her to [say], "Hey, you looked shocked, what just happened?"...But maybe I didn't look shocked, maybe I...was...so distressed about other things that...she couldn't tell that it affected me, or something....Then it's...okay....There's nothing I think she could have done 'cause...how is she gonna know that...I was upset about it?...If my therapist doesn't recognize that something even happened in that moment, then I'm never gonna be able to put words to what happened...If my therapist is not able to enter my worldview and understand...why [the microaggression is] a big deal, and we need to work on even naming it,...I'm just gonna continue to feel like I'm not allowed to feel whatever I'm feeling....That's just gonna make it worse for me, I think.

Provide validation. Two participants (16.67%) shared their comments about their therapists providing validation. Participant 1, a Black woman, took issue with White therapists' tendencies to interpret "validation" as offering support to an individual by

attributing a record of achievement to personal strengths, rather than acknowledge the larger societal context. The therapist's response also indicates the ways in which cross racial dyads may inhibit open and honest communication:

I honestly wanna go to a therapy session, and [say], "White people are really getting on my nerves, and...this is what's going on."...But, obviously, if I keep having White therapists, I can't say things like that. So I'm already having an abridged version of my therapy session because I have to be culturally aware of the person that I am speaking to, because if I say something...that's off, then it's gonna end up to be like [a] debate....If I'm coming in wanting to be supported and validated, that's not what I'm receiving. But also...during the moment of...the aggression...she made like really small like comments like, "Oh, so I assume...you're probably a first-generation college student." I mean true, but why...is that?...That was like another...small microaggression, and [she would say] things like,..."Oh, you're just so strong to have endured all of this and still be in your program." My oppression is not something to be admired. There's nothing great about college advisors telling me to drop out of my school. There's nothing great about struggling to pay for school and [realizing] that you can't pay for childcare [so you bring] your child to class all the time to get your degrees. That's not admirable, and I will never tell another Black girl who's going through it [that] this is admirable....I'm working this way to ensure that...Black women and other women of color...don't have to endure these types of obstacles, and so when White people are like, Oh, you're so strong and so magical, and so great." No!...you're not helping....Say[ing] comments like that,...I find that a microaggression.

Other responses. Other responses included focusing on individual factors of the patient (two participants, or 16.67%), being explicit about the process unfolding in the room (two participants, or 16.67%), and respect (one participant, or 8.33%).

Impact of the Microaggression Experience on Attitude Toward Therapy

When asked whether their experience of perceiving a racial microaggression in therapy impacted their attitudes toward therapy and therapists, the majority of participants (seven, or 58.33%) responded affirmatively and then offered explanations of this experience. The remaining five participants (41.67%) stated that the experience did not impact their original attitude toward therapy whether positive or negative.

Therapy as a tool. Six participants (50%) viewed therapy as a tool, i.e., a useful and important aspect of their lives that served a certain function. For example, Participant 5, a South Asian woman, regarded therapy as a form of self-care:

I want everybody to be in therapy...because I think it's great, and I think that everyone deserves a space to...give to themselves, especially women...Whether you know it or not,...an hour to yourself is...the greatest thing you can give to yourself.

Participant 8, a Black man, expanded upon the tool metaphor to incorporate the individuals who comprised the therapeutic relationship: the therapist who offers knowledge and insight, and the client who is able to put into practice what has been learned in treatment, i.e., the hands with which the tool is utilized:

Therapy...as a whole, as an instrument,...is...separate...from how a particular individual who is trained, or skilled, or educated...uses that instrument. Like a knife is a knife...but I could use the knife and slice things up, and...you can use

the knife, and [feel], “Oh, this knife sucks because...it’s dull.”...No, it’s not, I just used it....It’s the user, it’s not the instrument. The knife is the knife.

Therapists as people. Five participants (41.67%) recalled that the microaggression experience allowed them to see therapists as more than just performing a role, or as an occupant in a privileged position in a power dynamic. For example, Participant 12, an Asian woman, described the process by which the microaggression allowed her to see how therapists’ own experiences and life circumstances informed their practice:

I guess it made me realize that therapists are fallible, and...they’re human with their own...backgrounds, and...their own individual factors of...race and gender, and that...some therapists do overcome their own biases, but I’m not sure if all of them do, because of differences in training and what not.

Race and gender preference. Three participants (33.33%) stated that the microaggression experience influenced their race and gender preferences for subsequent therapists. For example, Participants 1 and 3, both Black women, commented on their preference to be treated by women of color. Participant 1 continues to have a positive attitude about therapy, but, as a result of multiple ruptured relationships with White therapists, she has concluded that she is in a better position to receive support and understanding from a therapist of color:

[The microaggression] has made me reluctant to believe that a White woman can actually listen to...my experiences...and be able to provide...support...because of their identity....I still wanna go to therapy. I still wanna have someone to speak with, but I know that it’s important that they are at least a person of color.

Unlike Participant 1, Participant 3 has had the experience of a Black woman therapist and found comfort and understanding when discussing negative racial experiences with her:

I want[ed] to see someone who's Black and a woman....I've had... a session with her talking about race, and...an incident that happened with someone calling me the N word...this White guy. Her response to it was...very nice. It was...nice to speak to an older woman about that, and she totally understood where I was coming from because that's not even language that I use.

Importance of fit. Four participants (33.33%) stated that their experience gave them insight into the importance of fit. Many factors, some professional, e.g., approach, and others personal, e.g., style and personality, contribute to fit between a therapist and a patient. For example, Participant 8, a Black man, used a metaphor to describe the process of finding a therapist who was right for him:

Therapists are just like shoes, you know, not everyone is gonna fit snug. There may be some stretching that has to take place, or sometimes the quality of the leather is bad,...and you need to keep trying on shoes until you find a brand and a quality that you're comfortable with. So I don't go into...every engagement or encounter with a therapist just because [of] credentials or...years of experience.

We may not vibe....It just may not be there.

Skeptical. After the experience of a microaggression, three participants (25%) reported skeptical attitudes toward therapy and therapists. For example, Participant 7, a Black woman, explained how complex her process is when discussions concern race with White therapists, feeling the need to constantly monitor their reactions so that she can determine whether it is safe to proceed:

I am very weary of White therapists in general...because I'm not sure...how comfortable I feel...talking about racial issues until I talk about [them] and I...gauge their reaction....I just know that I'm...more hyper vigilant, like,...I'm gonna say this thing, are you gonna say something?...I...analyze the reactions they form....Is this a safe space? Like, *oh, you raised your eyebrows to that*, do you not understand?

Therapy can be harmful. Two participants (16.67%) stated that they learned that therapy, meant to be healing, can also be harmful. For instance, Participant 9, a Black woman, explained how difficult it is for marginalized women, a vulnerable population to begin with, to make themselves even more vulnerable in order for therapy to be successful. That leaves them open to hurt, especially with White therapists when aspects of White privilege may further unbalance the power dynamic:

[For] Black women and queer women, and ambitious women, and outspoken women, and loud women, [therapy] can be a very dangerous place because...as Black women, we're vulnerable all the time, and then we...go into a room maybe, and be vulnerable and not be hurt. But in order for therapy to work, you gotta...be vulnerable [with] these people who...in every other place in the world [are] in a position of power, White. So it's in the air

Other comments. Two participants offered comments regarding training (16.67%), and one participant each (8.33%) offered comments regarding stigma, and developing higher expectations of therapy and therapists.

Future Help-Seeking Behavior

When participants were asked how likely they were to seek therapy in the future, five participants (41.67%) replied that this was their intention. For example, Participant 7, a Black woman, praised the transformational nature of psychotherapy:

I'm very likely to seek therapy. I have gone through a lot as a person, and I'm maturing and becoming better as a person, and therapy has really been a very positive experience for me....I've done a lot in work with different therapists.

Four participants (33.33%) reported that they would seek therapy again because they would need it to maintain their mental health. Some precipitating events mentioned for seeking therapy again included past conflicts being unresolved in some way, transitional moments arising, and aspects of identity that are particularly salient. For instance, both Participant 6, a South Asian woman, and Participant 9, a Black woman, enumerated sources of personal and/or environmental stress in their lives that therapy would help them get through. For Participant 6, current events and academic pressures make it "pretty likely" that she will seek therapy again:

I think I need it, especially....right now [because of] what's happening with the new presidential administration [and] anti-immigrant sentiment....Sexual violence [is] in the news, and it [is] so prominent, and people [are] just being so callous,...all of those things together, plus I'm supposed to be writing my dissertation, and I'm supposed to be...ready to propose it, and I'm having a really hard time with all of that....Yes, I need therapy, but I don't know when that would happen and how, because I don't know if it's gonna take another turn of events...to...push me to go,...or if...I can get myself together.

Participant 9, a Black woman, is considering returning to therapy to help her manage all the complex family and academic responsibilities she has to contend with, and added that it was better to start treatment before things get to the boiling point:

I'm sure I will [seek therapy in the future] because...I have... a foster kid who we'll be adopting soon. Either...helping her deal with...missing her birth family, and...blending some of the birth family with our family....My parents are aging....I'm a PhD student at [an institution], and it is a monster of a place...with...the same sort of...dominant structures....I'm trying to do a lot, so I'm sure I would [seek therapy] when things get tough...before they get to the breaking point....The lesson [is] do it before I get...so far gone, [stretched too] thin....So I probably will, and I think...I should.

Of the three remaining participants who did not state an affirmative intention to seek therapy again, one participant each (8.33%), gave the response of, respectively, “probably,” “it’s complicated” and “not very likely.” All referred to barriers or complications to access as their reasons for ambivalence about seeking help in the future. Concerns included: a) the difficulty of building rapport and trusting someone with sensitive material, b) finding a therapist of a similar racial background, and c) the specific requirement that the therapist have the ability to work effectively with racial identity.

Suggestions for Therapists

Transparency. When participants were asked to provide suggestions for therapists in handling microaggression situations similar to the ones they experienced, four (33.33%) mentioned transparency, or a desire for their therapist to be open and honest. Participant 9, a Black woman, suggested that therapists use self-disclosure to validate patients. In her opinion, therapists disclosing their countertransference feelings

related to racial identity and noticing when they have acted on their countertransference might have a significant impact on the therapeutic relationship:

I think that...one of the most honest things that they could do... is to say...“Well, you said that,” or “You feel that way about that person,” [and then add], “I feel a little guilty ’cause maybe...for a second there, I thought that way about you or other people, and that makes me think about how I am as a person or as a therapist.”...I think they just need to come out and say...that [the] “perspective you have of that person, that sounds like me sometimes, and I wish it wasn’t,” or “I don’t want to be that way with you now.”...I feel like they gotta own it, to...have it and own it, that they have done some of the same things, or felt that way, about the client.

Collaboration. A significant group of participants (four, or 33.33%) suggested that therapists encourage collaboration with patients, following the patient’s lead. For example, Participant 4, a South Asian woman, explained, “I’m sure there are times when all of us will be curious about something....Really just go with...where the client is affectively and stay there.” She emphasized the importance of following clients’ emotions in the session, rather than therapists pursuing inquiries about what interests them and overlooking clients’ needs. In another instance, Participant 12, an Asian woman, described how important it was in sensitive matters of race, for therapists to check that clients do not perceive them to be overstepping their role. In her view, the work between therapist and patient is a collaborative process capable of adaptation and change with the input of both parties through hypothesis testing:

I guess if [therapists] feel that something has to do with [clients’] race, they should ask [clients] if they agree with [the] hypothesis, or if they...see some

worth in pursuing this hypothesis, and whether [each client] is willing to look at it from that angle going forward, rather than [therapists unilaterally] deciding to do that.

Training. Three participants (25%) made suggestions related to professional training with respect to both the nature of the training requirement and its content. Participants agreed that content should include material on recognizing types of microaggressions. In terms of the nature of training requirements, Participant 9, a Black woman, explained how helpful it would be for diversity training to be framed as promoting skill enhancement rather than as a punishment:

I think they need to...invest, or demand their programs or employers...take their butts to...diversity trainings....It shouldn't always be a punitive thing....That's what happened in my department....They didn't admit that the woman was discriminatory towards me, but they said she could no longer...supervise professionals including me,...then they forced the whole department to restructure [so] that I report to someone else....Then they forced the department to...lay out their expectations,...and then they forced everyone into training. But it shouldn't be punitive. Like...you're making us do this extra stuff. It should just be [thought of as] we want to have excellent credentials, and this is something we have to do because it's gonna help us do our job, or just not be horrible people.

Safety. Two participants (16.67%) mentioned suggestions related to maintaining safety within the therapeutic alliance. For example, Participant 7, a Black woman, explained her view on the importance of therapists taking a proactive approach toward client input as a session unfolds:

I think it's important to...consider the strength of the therapeutic alliance and make sure that the client is comfortable, like checking in on issues, [for example saying], "Oh, I felt like there was some tension after we discussed this....How do you feel?" Checking in with the client...to...give them that space to...advocate for themselves [and] tell the therapist that they felt uncomfortable with the way that they handled something. I think...leaving more room for feedback is really important.

Open-mindedness. Two participants (16.67%) mentioned a desire for therapists to be more open minded, specifically that they go beyond their foundational training to explore individual client's cultural experiences. Participant 8, a Black man, cautioned therapists not to paint members of distinct racial, ethnic or cultural groups with too broad a brush:

If you're a non-Black [therapist], or Hispanic, or Asian, or Native American, whoever, and...you're dealing with someone of a different cultural background, everything is not what you have read in a textbook. It just isn't....Not every racial or ethnic group is...monolithic....Understand that...everyone is different. We're all unique individuals, and try very hard to not pigeonhole or categorize somebody, based off of what you read in a textbook, or your one or two experiences...during your internship, or something like that.

Apologize. One participant (8.33%) highlighted the importance of actively apologizing for microaggression moments. Participant 2, a Black woman, explained her view that therapeutic relationships are governed by the same rules of conduct as any other situation. Thus, therapists have a responsibility to make amends to patients they may have harmed:

Apologies and transparency [go] a long way in building trust with patients. If [therapists] are able to go back to their notes, and see where the session...left [off], it would behoove them to bring [the incident] up [in the] next session, or call and apologize. It's just the right thing to do, therapist or not.

Power/privilege. Another participant suggested that therapists make the power/privilege dynamics in the room explicit so that patients are empowered to advocate for themselves. Participant 7, a Black woman, advised:

I would just leave the conversations open to the client to discuss what they feel comfortable with, whether it's...coming from a place of curiosity, acknowledging the privilege [and] the power that the therapist has in the room. I think also it should be...noted that [clients have] the ability to advocate for themselves and change therapists. [Let them] you know...if they're uncomfortable, that there are other options out there.

Representation. One participant (8.33%) commented on the importance that people of color be represented in the mental health field, as patients of color often are seeking a safer space. Participant 1, a Black woman, explained:

A lot of counseling services at the university level need to start...realizing...how it's not preferential treatment [to have] things like a people of color support group....We need these spaces to be able to talk about [our] experiences, because...it seems like...being a person of color in higher education [is] like [a] fishbowl experience....Also...intentionality....I don't know the statistics of how many people of color are in counseling psych or in counseling programs, but if there's...a pipeline issue, then counseling services at the university level [need] to

start being strategic in their recruitment of students of color to increase the pipeline so we can increase representation of counselors of color...as well.

Other themes. Other suggestions for therapists included developing more self-awareness (three participants, or 25%), displaying respect (one participant, or 8.33%), being attentive (one participant, or 8.33%), and doing more research to understand the experiences of other cultural groups (one participant, or 8.33%).

Suggestions for Therapists in Training

Participants were also asked for suggestions for therapists in training to address racial microaggression issues. Participants might have had a different lens with therapists in training as their audience when compared to established mental health professionals; however, many of their comments resonated with identical or similar themes. In fact, three participants (25%) stated that they would provide the same advice as they gave practicing clinicians in their previous response.

Training. Half of the participants (six, or 50%) mentioned that specific aspects of training be augmented so that therapists might offer more effective services to a diverse population once they start their practice. Participant 6, a South Asian woman and graduate student in the field of mental health, recommended that clinicians in training adopt a stance of curiosity and openness to learning about other cultural groups without being voyeuristic. Rather than focus on educational institutions to provide all the resources needed to work with a variety of cultural groups, she emphasized the need for clinicians to take the initiative to learn on their own:

[I would suggest training in role playing....In...the master's program at my [former] university, the [students in] counseling type programs...had to do projects where they...immersed themselves into a different religion or culture and

had to write a report about that. I'm not...so sure of how I feel about that because it seems a little surveillancey, but I think [it provided] in some way a better understanding....If that means...asking questions, watching documentaries,...using the internet as a resource, like doing homework about the people that you're gonna be working with, then I think that's important.

Expand conception of cultural competence. Three participants (25%) commented on the need for clinicians to expand their concept of cultural competence beyond what is taught in formal training. Participant 5, a South Asian woman, hoped that therapists in training would make the effort to get to know people of various cultures outside of the restrictive environment of the therapy room to gain a more comprehensive picture of their lived experiences:

I am...tired of my classmates and other people in this field who...assume [they] are just...so culturally competent...because [they] have two...African American clients on [their] list of...100....First of all, that is a very specific setting,...and...I just don't believe that you can be culturally competent by [only] seeing different types of people. I think that you have to live amongst different types of people, and hear a lot of their stories, and hear more of what their everyday lives are like...before you can [say], "Oh yeah, I know how to deal with culture in the therapy room because...we talk about it so much."

Similarly, Participant 4, a South Asian woman, cautioned that cultural competence is a necessary skill, but that clinicians should not lose sight of the fact that they are treating individuals:

I feel [that] we're lucky...at [the school I attend] where I do think we get this message that I think should be continued to be hammered home that cultural

competence is just another skill. We have to understand our clients as individuals....It doesn't mean...actually knowing 100 different cultures, it's just having a mindset of being able to understand how...very much people can differ and...having an appreciation.

Effort. Two participants (16.67%) mentioned that developing cultural competence requires effort. Participant 5, a South Asian woman, alerted therapists in training that becoming culturally competent requires more of a commitment than taking a few courses. This skill, as with others in the field, involves a lot of work and outreach:

Being culturally competent takes *work*...just like...supervision is *work*, and dealing with your own biases is *work*, and coursework is *work*, and research is *work*. Being multiculturally competent is *work*. You have to go out, and you have to meet people, and you have to be uncomfortable, and you have to be committed to it. It's not just something that appears because you took two courses....It's not magic, and these people's lives are not just like things that can be thrown away, or...be put on an application because...you need two people on your application....That is ugly and dismissive of people's lives, and it's dehumanizing. So I would like therapists to know that it takes work and it's gonna be hard and, you...if you can't do that work, then don't freaking be a therapist because you're really hurting people in session by doing...halfass work related to culture.

In addition, she noted that having only a superficial knowledge of other cultures can be harmful and dismissive to patients who can benefit from effective, culturally informed therapy.

Self-reflection. Two participants (16.67%) suggested that therapists in training engage in a self-reflective process related to their own identities and goals for doing the work. For example, Participant 1, a Black woman, explained her suggestions for White therapists in training to work with people of color:

If the therapists in training are White people,...they would need...to understand their positionality and that [because of] their White identity, their experience is seen as...the norm, and that's how it's always been in research. [When] white's the norm, [people of color are] always in...deviations to the norm, or... this is the bell curve and that's the deviation. So like White therapists, men, women, whatever, they need to have counseling on their whiteness and how that will impact them and their ability to actually help [clients who] are of different races from them.

Participant 9, a Black woman, asked that therapists in training not work outside of their competence, and reflect on where those boundaries lie. In addition, she suggested that White therapists be open about race with patients of color, acknowledge their own limitations, and make efforts, such as consulting scholarly material and updating their knowledge with further training, so that they can be a support for this population:

They have to be honest about how they navigated their clientele, and...not use us to hurt us again, but take that as an opportunity to say, "Well, I have some weaknesses." So either intentionally say, "I can't deal with Black/women of color clients right now, until after...I read [the relevant literature]," or "I'm going to accept they're coming in, and then I need to tell them I've never had a Black woman client," or "Sometimes things come up in here, it's gonna be uncomfortable for me, and this is what I have decided to do. I'll tell you about

that, and I'll try and go read other books or do other training so I can support you."...That's what they have to, that's what they should do but they won't. I don't. I don't think they will.

Other themes. Other themes mentioned for this item included the importance of representation of people of color in mental health professions (two participants, or 16.67%), establishing safety (one participant, or 8.33%), ethical responsibility (one participant, or 8.33%), and recognizing nonverbal cues (one participant, or 8.33%).

Other Comments

Participants were asked whether they had any other questions, comments, or thoughts to express that were relevant to the discussion. Four participants (33.33%) provided commentary related to cultural competence, some of whom took issue with defining everyone by group membership and minimizing the status of the individual. For example, Participant 12, an Asian woman, expressed: "While therapists can be aware of multicultural issues, they [also] have to be aware that they're not the only issue or the most salient issue for the person." Additional participants also mentioned their discomfort when others imposed an over-emphasis on their identity, which they viewed as inappropriate or misguided. Some participants described a possibly related feeling that their therapists did not view them as complex individuals. Participant 5, a South Asian woman and graduate student in the mental health field, reflected on her view of how cultural humility, or accepting one's own limitations, is an element of cultural competence:

I've been thinking about, [as a] therapist in training,...what it means to be culturally competent because...I...have limitations,...and...I feel like I have to be

the one to figure out my limitations instead of...other people [saying], “Oh hey, work on this...because culture’s a thing.”

Three participants (25%) mentioned aspects of training for mental health professionals. For example, Participant 9, a Black woman, stressed the importance of representation, hiring practices, and the quality of multicultural and diversity training in graduate programs and mental health institutions. She urged programs to not consider their work done when students get their degrees, but to continue to educate them while they are working in the field:

[Patients] not being able to have a choice of...therapist [is] hard. So that would go back to...that clinic, [or] the hospital in a metropolitan area where they probably looked over qualified therapists [and] didn’t hire them for a number of reasons. Then, if they do happen to hire one or two [therapists of color, they get] overburdened....Once you’re a client, you’re coming into the structure that’s already set up, so you have to deal with that. I wish that,...if you have...a private practice, or...a group of therapists, [you] should...think strategically about who [you’re] bringing together to offer...services. I think programs...need to...deal with this issue....They shouldn’t be ranked highly if they don’t have trainings,...not only...training to get the degree, but [they should offer] continuous education for their [graduates]. It should be an ongoing thing....Like [suppose] you took a race class back in ‘67, [and] here you are. A lot of things have changed with race. What we’re doing is a little different now.

Additional comments by two participants (16.67%) were related to the importance of the present study as it furthers work in the field of multicultural psychology and provides an opportunity to shed light on the patient perspective. One participant reiterated

her message about the value of self-advocacy to marginalized people seeking mental health services, as this skill would help them to equalize, to some extent, the power imbalance existing in the therapeutic relationship. This imbalance may often be greater when racial differences exist as well. Participant 9, a Black woman, described that verbally complaining will not result in getting grievances addressed by large organizations, and that educating people as to how they might seek recourse for harm through self-advocacy is a skill that must be taught:

People like me, or you, or...clients who decided to stand up for themselves...need to know how to structure an adequate...complaint...if you really want someone to have to listen to you....We need to be able to [explain] the ways that HR, or the American Psychological Association [receives] the complaint, [and instruct clients that] you have to file it in this way....That's how you complain, 'cause we can cuss folks out, which is fine, and it can be appropriate sometimes, but when you're dealing with these...monster places, and associations, and people's reputations,...we...have to teach people how to advocate for themselves....You're hurt, you're trying to...deal with saying "rape" for the first time, or your parent died....You probably aren't in a place where you can speak up,...but for those people who have the energy to speak up in that moment, [they need to] know how to do it effectively.

Chapter VI: Discussion

Salient themes emerged in this qualitative research study related to the impact of perceived racial microaggressions on patients of color in therapy. The key findings can inform future research and clinical practice, particularly with this population. Central themes included: a) the significance of the subjectivity, including the social location, of both patient and therapist; b) the hypervisibility and invisibility of people of color longing to be seen and heard authentically; c) therapist dismissal, and deficits in the training of clinicians to discuss race in the treatment process; d) patient hesitance to verbalize reactions; e) underrepresentation of clinicians of color in the mental health field; f) suggestions for therapists from the patient point of view, and g) potential conceptualization of rupture as micro-trauma and repair as posttraumatic growth. Limitations of the study are explored as well as implications for future research, clinical training, and practice.

Central Themes

Subjectivity and social location of the therapist and the patient. When participants were asked to think about the race of their therapists in response to relevant research questions, they often offered additional information that impacted their interaction, such as the intersections of race and gender, socioeconomic status, levels of education, religion, and other factors of identities held by themselves and their providers. Thus, a central theme of the findings was: a) the continuous presence of intersubjectivity, or a mutually constructed truth between the two people in the dyad based on their unique contributions (Gaztambide, 2012); and b) the impossible situation of separating one's subjective identity from the symptoms to be addressed in treatment.

Many participants described a desire to work with a therapist of color, and some particularly hoped for a therapist of their own race or cultural background who they anticipated could understand their experiences and manners of expression on a more intimate level. Some expressed disappointment at the difficulty finding and accessing a therapist of color due to barriers including financial concerns, insurance coverage, and a lack of providers within their institutions.

The literature does not support the view that racial match always accounts for better therapeutic outcomes (Cabral & Smith, 2011), and the results of the present study are consistent with those findings. During the few instances in which the participants were treated by a therapist of color, racial microaggressions still occurred. These microaggressions, which had their origins at the intersection of race with other identities, such as gender and social class, took the form of environmental racial microaggressions and assumptions about race and class. When environmental microaggressions occur, the microaggression is not expressed verbally, but perceived as a result of the nonverbal actions of the clinician and the context in which it took place. Although racial and ethnic similarity may allow some patients to feel some confidence that the other may share subjective experience and understanding, and thus allow the patient to feel more comfortable to disclose material and express themselves more authentically, therapists of color also need to be aware that ruptures with patients of color can happen. Thus, therapists of color are advised to allow cultural humility to inform their work with this population.

The majority of participants were treated by White women clinicians in a variety of treatment settings. In nearly every case, the racial difference seemed salient to the patients of color. Participants described White clinicians as appearing to have varying

levels of racial identity development, or, at a minimum, varying levels of willingness to address their own racial identity in the dyad. Some participants also described the evolution in their own racial identity development and increases in their knowledge about racial microaggressions over time. This is congruent with models of White identity development, White privilege, and minority identity development in the literature which outline a spectrum of awareness and behaviors related to racial identity (Helms, 1997; Sue as cited in Vasquez, 2007).

Participants explicitly and implicitly described ways in which their racial identity development impacted their interactions in the dyad, including: a) censorship or disclosure, b) impact of the microaggression, and c) perceived likelihood of repairing the rupture. For instance, some participants viewed their therapist as unaware, i.e., unable to develop an understanding of their subjective experience, leading participants to believe that the therapist was unwilling to work through the rupture. This resulted in the microaggression left unaddressed.

An important element of subjectivity pertaining to race is physical appearance. Physical markers of race, such as skin color, facial features, and hair texture often give clues to one's racial identity, and may prime an individual's implicit biases to manifest (Blair, 2001; Greenwald et al., 2009), resulting in the projection of stereotypes on the other. In some cases, participants mentioned feeling uneasy when a White therapist commented about their appearance. For example, one therapist expressed curiosity about a Black woman's natural hair. Another therapist commented about a participant's weight during her pregnancy, a conversation that also included the therapist's gratuitous assumption that the pregnancy was not planned.

The other salient identities in the therapeutic dyad were the roles of the therapist and the patient. For some participants, identifying as a patient by occupying the role in the therapeutic situation had significance prior to their first experience in therapy as a result of familial and cultural narratives about mental illness and the mental health field. The stigma surrounding mental illness and seeking treatment, influential even for those participants who were graduate students within the field, emerged as a theme in several interviews. Many participants referred to the power dynamic and described noticing or struggling with its presence in the room, particularly with reference to its operation before, during, and after the microaggression.

Some participants described their being unaware of, or not feeling empowered to, make active choices about therapist selection and/or therapeutic approach. Participants also sometimes struggled in the course of treatment with what to disclose, how to disclose it, and how to advocate for themselves. Some outlying exceptions to this dynamic resulted in a hostile termination, in some cases growth, and in others a continued impasse. Some patients tended to see their therapists as knowledgeable and expert until the microaggression moment when the therapists' transgression and fallibility were revealed. It is possible that therapists, who were committed to a view of the participant as sick, lacking insight and dysregulated, weren't attentive to the rupture, and thus in no position to begin repair. Again, these roles of therapist and patient cannot be separated from racial identity and other markers of subjectivity.

Through various means, the roles occupied by the therapist and patient, including their racial identities and other intersecting identities, are maintained by the implicit and explicit interactions in the dyad. One conceptualization, supported by the literature on psychodynamic object relations and race (Altman, 2000; Altman, 2006), is that the

experience of a microaggression, whether unconscious or conscious, functions to maintain the client as an Other and prohibits the intimacy and trust required for a healthy and productive therapeutic relationship. It seemed that repair and growth occurred when patient and/or therapist made elements of this process more conscious by disclosing feelings, reactions, thoughts, and parts of their human experience in the room, including acknowledging making mistakes.

Hypervisibility, invisibility, and longing to be seen. The treatment of race in the therapeutic dyad varied from patient to patient and also across sessions in the same therapeutic relationship. Along with microaggressions based on racial assumptions and stereotypes, participants reported the overemphasis, i.e., hypervisibility, or dismissal, i.e., invisibility, of their race. Sue et al. (2007) described the conflict individuals face when they feel a pressure to counteract a negative stereotype and be a representative of an undervalued racial group. A fundamental finding of this study is the necessity for clinicians to examine who their inquiry or intervention regarding the race or ethnicity of the patient serves. Is it to the benefit of the patient and the building of the therapeutic relationship, or does it satisfy a curiosity of the clinician not relevant to the needs of the patient? By the same token, clinicians must also ask themselves whether their lack of sufficient attention to race and ethnicity is protective of the patient or themselves? If it is the latter, an exploration of the sources of resistance, which may include anxiety, guilt, bias and insecurity, among others, is indicated.

In the case of hypervisibility, some participants, particularly Asian participants, reported perceiving their therapist's inquiries about their culture as motivated for the purpose of their own learning and not to serve the treatment or the relationship. This is congruent with the common prejudice of Asian people as alien, which is often the source

of microaggressions (Sue et al., 2008). Being subjected to this line of inquiry, described by one participant as anthropological, often elicits feelings of inferiority in a power dynamic. These participants tended to withdraw, felt pressure to educate the therapist, or change the subject. They also expressed disappointment that clinicians could not be forthright about their gaps in knowledge and other limitations related to cultural issues. As one of the essential components of the therapeutic alliance is agreement on the goals of treatment (Constantine, 2007; Vasquez, 2006), the foundation of the therapeutic alliance is compromised when therapists pursue goals that are not goals of the patient, in this case, furthering their knowledge of race and ethnicity.

Other patients described their race being hypervisible to clinicians in more discrete moments, as compared to a more persistent study and fixation on racial identity. For example, Black women participants mentioned therapists commenting on their hairstyles, body type, and names. This explicit focus on characteristics or features related to race made those features, and perhaps otherness, more salient in the room. When participants perceived “otherness” underlying the comments, they often appeared to take greater issue with the style of the clinician’s approach than the content of the comments.

On the other hand, race was more often made invisible by the clinician. Experiences of erasure ranged from avoidance, to dismissal, to explicit rejection of patient experiences of racism. Along with verbalizations, some participants also noticed therapists engaging in nonverbal behaviors congruent with attitudes of dismissal. In many cases, participants’ presenting problem was related to their race, and invalidating experiences they perceived in therapy were often viewed as frustrating repetitions of their interactions outside of the therapy room. (See below for a discussion of the concept of

repeated trauma.) It is concerning to the patient, clinician and the profession when therapists have a blind spot to their patient's distress.

As the majority of clinicians discussed in the present study were White, it is helpful to analyze the behaviors described above in the context of White racial identity development. For example, a White therapist in an earlier phase of the development of a non-racist white identity might adopt a colorblind or patronizing stance as a coping mechanism to assuage anxiety about race, thus creating distance in the therapeutic relationship. They might also transform feelings of guilt into fear of people of color which may manifest in microaggressions (Helms, 1997). This highlights the importance of clinicians developing self-awareness as a key component of culturally informed practice, perhaps especially in a cross cultural dyad (Constantine, 2007; Gaztambide, 2012; Mazzula & Nadal, 2015; Miranda, 2013; Owen et al., 2014; Sue et al., 2007).

Participants expressed a desire to be seen authentically. While racial and ethnic identities were crucial, the salience of those identities to their current distress and needs in therapy also needed to be understood. In cases where the microaggression was not discussed, participants expressed a longing for the therapist to have recognized the level of discomfort the participants were experiencing through their facial expressions or other nonverbal behaviors, and thereby intuit how they were impacted by the process.

Some participants expressed frustration with clinicians outside of their race not understanding the whole picture leading to distrust, and a belief that only a clinician of the same race would be able to see them the way they would need to be seen to make progress in a therapeutic treatment. This may reflect deficiencies in cultural competency training. If so, there is potential for remediation and a paradigm shift. (See below for a discussion of how cultural humility might be promoted in clinical practice.)

Therapist dismissiveness and emphasis on deficits. Patients who are new to therapy often enter treatment without knowing what to expect and follow the cues of the therapist. Although the dialogue in psychotherapy consists largely of the contents and processes in the patient's life, clinicians wield significant power to guide the discourse of therapy, and their responses and interpersonal reactions impact what is said and what is kept silent. Participants described three primary causes for the rupture resulting from the microaggression: a) the therapist's seeming unwillingness to engage in the conversation about race, b) the therapist dismissing the concerns of the patient outright, or c) the therapist attempt to handle the rupture in an unskillful manner. Often, this further frustrated patients, or influenced them to give up on their hopes or efforts for resolution and withdraw.

Dismissiveness may signal that a topic or pattern of interaction is unwanted or inappropriate. Clinicians may have been experiencing a wide range of cognitive and emotional responses. Participants described them as providing both verbal, e.g., a change in subject or a minimization of the issue of race, and nonverbal responses, e.g., facial expression, indicating dismissal of the topic of race or the conversation about the racial microaggression.

Participants described instances of clinicians engaging in explicit dismissals of race. For example, one clinician told a participant she had Black friends in an apparent effort to absolve herself of guilt, another questioned the intensity of a patient's reaction to racial discrimination, and another clinician offered an alternative explanation for the patient's distress despite an acknowledgment of racial dynamics. Research has indicated that individuals tend to engage in cognitive processes of categorization and association to familiar stimuli (Barsalou et al., 1998; Bastian et al., 2011; Casper et al., 2010). Thus,

implicit biases or negative feelings about race may have prompted clinicians to unconsciously avoid racial material with the patients of color to defend against their anxiety. Patients perceive clinicians' racial biases in the relationship; however, there is little research on the clinicians' subjective experience of their own racial biases.

Therapists' reactions of minimization might have been driven by the common desire to preserve their self-concept as good, moral people; however, the underlying cognitive dissonance caused blind spots resulting in clinicians' inability to recognize the occurrence of a microaggression (Altman, 2006; Mazzula & Nadal, 2015; McIntosh, 1990). The more explicit cases of dismissal of racial material seemed to indicate that, in an effort to protect themselves, clinicians harmed the patients and the therapeutic alliances, to the extent they existed. In some of these cases, patients reacted with frustration and anger as opposed to withdrawal and silence.

One of the most salient indications of this study is how a clinician's mishandling of a microaggressive rupture influences the participant's perception of the clinician's cultural competency and skill in general. After experiencing microaggressions, participants expressed concerns that their therapist was not capable of helping participants with: a) the distress in the moment of the microaggression, b) the racial stress experienced outside of therapy, and, in some instances, c) their general mental health. Some participants were pessimistic that their therapists would be able to change or correct their behavior and thus felt the dynamic would not improve. When other participants experienced their therapists engaged in the process of repair, they were pleasantly surprised, the therapeutic relationship became closer, and they felt more confidence in the therapist's skill.

Patient hesitance to verbalize reactions. When therapists did not take ownership of the rupture, or at least recognize the moment, they not only relegated the responsibility of making the decision whether to initiate a repair to participants, but placed participants in the precarious position of responding in an environment where they perceived the therapist's anxiety projected onto them. Although most participants seemed to be able to recall in some detail for the current study how they reacted to, and in some cases, responded verbally to racial microaggressions, they also described barriers to expressing their thoughts and feelings to their therapists related to the incident. Participants reported several reasons for their hesitating to respond to the microaggression despite their strong feelings, including: a) the power dynamic, b) psychological distress, c) not being sure what to say, d) not seeing the benefit of the conversation, and e) fear of potential consequences. This reaction is consistent with the literature on models of microaggressions which show the tendency of people of color to second guess the validity of a perceived microaggression, and then to feel conflicted about how to respond (Sue et al., 2007).

The participants who identified the power dynamic as influencing their hesitancy to respond or decision not to respond generally expressed the view that they saw the therapist as a professional or expert. Feeling this differential in power, patients found it difficult to take the agency to shift the conversation to meet their needs. This was particularly evident for participants who were new to psychotherapy and expected that the interventions they were engaging in would be purposeful and meaningful at the time.

Some participants who identified psychological distress as influencing their hesitancy to respond or decision not to respond reported that the microaggression was superseded by the distress related to their presenting problem and discussion of the

microaggression would have diverted energy from their higher priority, and possibly add to their level of distress, particularly if they had little confidence that repair would result.

Some participants expressed not knowing what to say or doubts as to what would have been acceptable to say. Some perceived a need to defend their racial ethnic group and avoid confirming a stereotype with their response. This protective instinct of acting in a way that is designed to prevent additional microaggressions after one perceived microaggression is consistent with the microaggression process literature regarding motivations for not responding to microaggressions (Sue et al., 2007). Participants also stated that they did not see the value in having the conversation because they anticipated poor outcomes, e.g., more misunderstanding, a lack of attunement from the therapist.

One of the fears shared by many participants was the potential for negative consequences if they advocated for themselves following the perceived racial microaggression, including: a) the difficulty in finding another therapist if the present relationship was terminated as a result; b) fears of mental illness or distress becoming worse which overrode their concerns about remaining in an unhealthy relationship with the current therapist; (c) limited access to alternatives due to their preference for a therapist of color, or because of financial or insurance coverage issues, and d) concern that the therapist would feel badly if they expressed their thoughts and feelings about the racial microaggression. For the few participants who mentioned concerns about therapist feelings, the patients valued their perception of the therapist's emotional needs over asserting their own feelings and needs—a vivid illustration of an unbalanced power dynamic in a therapeutic relationship. Given participants' hesitation to respond to perceived microaggressions, it is incumbent upon clinicians to be attentive and attuned to what is unsaid in psychotherapy as well as what is said.

Underrepresentation of clinicians of color. In addition to the many prospective patients who are unaware that they can choose a therapist on the basis of racial/ethnic identity, as discussed above, patients who know of this option, whether they are new to therapy or because of negative experiences with therapists regarding racial identity and related issues, may request racial matching in the hope that it would aid in their sense of comfort and readiness to work with difficult themes. It is a struggle, however, to find such therapists, reflecting the underrepresentation of people of color in mental health fields. According to a 2013 APA study, 83.6% of active psychologists were White; with the remaining 16.4% identifying as Black/African American (5.3%), Hispanic (5.0%), Asian (4.3%), and other racial/ethnic groups (1.7%) (APA, 2015).

Suggestions for therapists from the patient point of view. Participants expressed a desire for clinicians: a) to be honest, authentic, apologetic and open to expanding their knowledge of diverse racial and ethnic groups beyond their training by engaging in and valuing relationships with people of color; b) to proceed with curiosity and collaboration with clients, or center their experiences and let them lead; c) to allow the identities in the room to be named and discussed explicitly in terms of power and privilege; and d) to ensure that clients are heard, seen, and validated. These are not necessarily quantifiable qualities that can be achieved or attained in psychotherapy training and will vary across therapeutic relationships. Most of participants' suggestions, relevant both to prospective clinicians and those currently in practice, related to training. This challenges institutions to develop cultural training curriculum that help clinicians to understand that their personal growth and involvement demands efforts beyond gaining knowledge about racial/ethnic groups.

Rupture and repair as micro-trauma and post-traumatic growth. Ruptures might be caused gradually by minor transactions or be manifest in dramatic negative processes (Safran et al., 2011). Psychotherapy can be a corrective emotional experience when patients experience support and safety in a relationship after a rupture (Gaztambide, 2012), and successful processing of this type of impasse can facilitate a repair of the therapeutic relationship.

The processing of prior experiences of racism that exist in the patient's sense of self and object relations is indicated as they emerge in the therapeutic alliance. Microaggressions occurring in a help-seeking context can be particularly jarring in that they may be perceived by patients of color as threatening reminders of the violence and discrimination they have often encountered and that have been visited upon their communities outside of the therapy room. An analysis of the results revealed a striking similarity between the ways in which participants described their experiences encountering perceived racial microaggressions and trauma. Rupture may be conceptualized as a form of interpersonal trauma in a therapeutic relationship due to its potential to recapitulate other race-related traumas in the patient's life.

Research has shown that traumatic experiences shift the individual's ability to trust others and see the world as reliable and relatively predictable. Trauma victims may experience the surrounding world as frightening and unsafe (Constantine, 2007). It is not surprising, then, that participants described a feeling of unsafety. Participants described becoming more vigilant about what the therapist might say next or how their comments might be taken (re-experiencing), thus engaging in avoidance, such as withholding information, zoning out, or diverting the conversation to other topics in order to not re-

experience the rupture related to race. Once the therapeutic alliance is compromised due to the absence of safety, the stage is set for potentially less meaningful work or harm.

Other reactions described by participants consistent with how trauma is conceptualized included participants: a) describing negative thoughts and feelings about the therapist, in some cases about themselves, and in some cases about the field of mental health services in general; b) feeling more distant and isolated within the relationship after the occurrence of the microaggression; c) seeking out nearby communities of color, e.g., on their campuses, to manage the distress from racial issues that were not able to be discussed and processed in their therapy relationships.

A further similarity to trauma was some participants' reactions of irritability and aggression, expressed either directly to the clinician and/or others after the fact. A few participants described becoming defensive and hostile with their therapist after experiencing a perceived microaggression in an effort to protect their sense of self and identity within what they felt were oppressive institutions. While feelings of anger and irritability may have motivated the participants to assert and advocate for themselves, they might also have resulted in a lost opportunity to gain from the recapitulated interpersonal trauma of covert racism.

Other participants did offer examples of successful repair. These, as well, have parallels to trauma as repair is similar in process to posttraumatic growth in that an individual or community may become more resilient after experiencing a single incident or chronic experiences of trauma (Calhoun & Tedeschi, 2014). A few participants reported that the impasse resulting from a racial microaggression had been resolved, resulting in an improved therapeutic alliance. They were able to utilize coping skills to manage their anxiety, speak freely about their experience, and learn from the rupture.

Participants were also able to see that their therapist was fallible, and could make mistakes and admit them. The openness of the processing of the microaggression may have also provided an environment of increased trust and safety, so that growth could occur for both patient and therapist whose shared experience may have left them with the resilience and skills to manage future occurrences such as these.

Limitations of the Current Study

The nature of the current exploratory qualitative study included limiting factors that impacted the generalizability of the findings, interpretations, and applications. Readers are cautioned to avoid generalizing these results to all people of color who have been in therapy and experienced microaggressions in therapy. In addition, these results do not sufficiently reflect the experiences of all mental health professionals who work with people of color. Other limitations could be attributed to the nature of the sample, such as a small sample size; recruitment through the researcher's network and selection bias; the retrospective self-reported nature of responses; and lack of a randomized control group for comparison.

The sample consisted of 12 adult people of color who reported having experienced a racial microaggression from a mental health professional during the course of therapy. Several factors may have contributed to the difficulty in recruiting a larger sample, including: a) research supports the underutilization and premature termination of people of color in therapy, therefore the population meeting the requirements for the study may be disproportionately smaller than the total population of individuals who have utilized therapy; b) potential participants may have been reluctant to volunteer due to the stigma associated with seeking mental health treatment both in general and specific to their respective cultural lens; c) concerns about confidentiality and disclosure of the

details of their experience in therapy; and d) the topic of the investigation may have evoked potentially difficult emotions that individuals might have wanted to avoid.

The sample was recruited through email, social media, and word of mouth advertisement among the researcher's personal and professional network. The sample consisted of students and professionals, many in the field of psychology or a related field that could have given them exposure to a diverse population, e.g., education, social work. These participants may have already had a more nuanced understanding of racial identity, therapeutic process, and microaggressions. The participants' possible identification with the researcher as a person of color may have also impacted their responses and the level of bias present during the interview process.

Due to the nature of recruitment, the sample may have consisted of individuals who are particularly interested in psychology, culture, and social justice topics. The participants may also not be representative in that a particularly negative experience in therapy may have compelled them to volunteer for the study. Given the high probability of selection bias, the study may have limited external generalizability to the wider population of people of color who have accessed mental health services. There may also be demand characteristics considering the nature of the interview. Participants may have answered the questions in a way they perceived as desirable to the interviewer, also a person of color.

The retrospective nature of the responses may have limited the amount of data participants were able to recall. They were asked to respond to items addressing the contents of the microaggression as well as their reaction. Participant responses potentially included additional associations, feelings, and reinterpretations of the event in the past that informed their current disclosure. There was no uniform standard as to how much

time had elapsed since the therapeutic relationship investigated ended, thus participants were responding to events that could have occurred years before or more recently. The possibility exists that a greater passage of time might have allowed for greater potential alterations to the narrative.

In terms of the design of the study, the qualitative, grounded-theory nature of the design was exploratory and limited the conclusions or generalizations that could be drawn from the results. There was no randomization or control group for comparison, which limited the conclusions that could be drawn about the impact of the participants' experiences. There was also variance in the credentials of the therapists, type of therapy, and duration of therapy. Despite these limitations, the researcher aimed to illuminate the experiences of people of color in therapy and to inform current practice and training of mental health professionals working with this population.

Implications

Implications for future research. The gaps in the current literature call for a profound exploration of the theoretical underpinnings of microaggressions, including: a) critical race theory, b) racial identity development, c) social cognition, d) implicit bias, e) affect theories, and f) psychodynamic object relations theory. Future studies may examine this phenomenon with quantitative measures to reach a broader scope of individuals with shared experiences. Future research may also aim to examine additional dynamics including: a) the intersections of gender and sexual orientation, b) the quality of the therapeutic alliance as related to the type of therapy used, and c) the impact of supervision and multicultural education on therapists' ability to manage ruptures.

Another area requiring additional investigation is the discrepancy between clinician and patient perceptions of the salience of race, ethnicity and culture in the

relationship, and within the context of the presenting problem. A greater discrepancy in this domain, whether through overemphasis of racial difference or dismissal, made rupture more likely and outcomes poorer. Many participants began to question the skill and competence of their therapists after the microaggression process. This discrepancy could form the basis of future research investigating the difference between clinician and patient perceptions of the therapist's competence or cultural humility. Additionally, investigating the microaggression process from the perspective of clinicians who work with people of color might be helpful in understanding and addressing the issue of early termination with this population.

Participants in the current study also demonstrated that they became more informed consumers of therapy after the difficulties they experienced during their therapeutic relationship. Empowering communities of color to access mental health services through the technique of participatory action research might be a further area to pursue. This method actively engages the participants as researchers in the investigation of an issue impacting their community, with the goal of achieving action-oriented outcomes (Fine et al., 2004). Employing this approach might be effective in researching topics of particular salience to communities of color, such as: a) methods to combat stigma, b) identifying barriers to accessing therapy, c) identifying common microaggressions, d) explaining the process of psychotherapy, and e) describing how to advocate for oneself when ruptures occur.

Participants in the present study indicated a progression in their level of distress as they experienced ongoing unrepaired ruptures in their therapeutic relationships. Further exploration of these unspoken dynamics and their impact might be encouraged. In addition, an investigation of the conceptualization of rupture as a form of interpersonal

trauma in a therapeutic relationship would be helpful in understanding the degree of harm ruptures can have on patients.

Further research into the relationship between context and microaggression would facilitate an understanding of the role and meaning of social context clues and would be a valuable and needed contribution to microaggression literature. Such research may provide information regarding attitudes pertaining to locations certain social groups are welcome, e.g., person of color followed in luxury department store; and how different environments are viewed, e.g., wealthy suburbs are safe, inner cities are dangerous; and how microaggressions might be more likely to occur where distance is the norm.

Psychotherapy research explores the specific processes and mechanisms that impact outcomes (Hardy & Llewelyn, 2015). This method of research, performed with the patient's permission, often draws upon transcriptions of psychotherapy sessions over the course of a therapeutic relationship to examine the narrative of the interaction between the patient and the therapist. A future study examining the process of racial microaggressions using this technique would address one of the limitations of the present study, i.e., its utilization of retrospective self-report, and allow the material to be more current. Also, with multiple coders, interrater reliability would strengthen the interpretation of the data.

Future research could also be conducted utilizing one-way mirrors and spontaneous feedback methods currently implemented in family therapy supervision, research and training in individual therapy regarding the domains of race and ethnicity. One potential limitation of this method might arise from recruitment difficulties, particularly when mental illness and help-seeking carry stigma for many individuals, as a third element would be added to the relationship between the patient and the therapist. An

investigation of this nature, however, would help clinicians to practice what many participants of the current study hoped for: skillful and reflective reactions in the moment mistakes were made.

Implications for clinicians and clinical training. Many participants commented on the difficulty in finding a therapist of their race, and several were even unaware that they could request to be treated by a therapist of the same racial and/or ethnic background. Participants who were aware of the option of racial matching had considerable difficulty engaging such a therapist, indicating that the mental health profession may have to become more reflective of the diverse populations in need of its services. Clinicians have a responsibility to advocate for patients to become informed consumers of the services they seek. When vulnerable populations appear for intake they should be able to find an adequate representation of clinicians from diverse backgrounds.

The contributions of professionals with lived experience as people of color can also contribute to the growth of others in training programs. Perhaps program directors and faculty need to actively recruit potential students of color in professional training programs in the mental health field. Also, professionals working in systems should encourage counseling centers, mental health centers, and clinics in hospitals to actively recruit clinicians of color. It would benefit the public to consolidate lists and professional biographies of clinicians of color so that potential patients can locate them.

A few participants mentioned the lack of follow up after they terminated services early. Although the field has investigated the characteristics of patients who tend to terminate therapy prematurely, it may be beneficial on an administrative level for institutions to develop a system to follow up with these patients, and incorporate their feedback into best practices to prevent attrition.

The opportunity exists for clinicians to consider the continuation of the idea of trauma-informed practice across their clinical work, especially with marginalized populations such as people of color. This lens would allow clinicians to become more aware of their potential impact on patients of color and inform the stance of cultural humility.

Everyone is influenced by racism, including mental health professionals, some in ways that are unknown to the individuals (Vasquez, 2007). By becoming aware of our biases and then developing flexible, honest, respectful, trustworthy, confident, warm, interested and open interactions with our help seekers, we can develop more positive alliances. In addition, techniques important to healthy alliances should be employed in our practices. These include exploration, reflection, discussing previous therapy, facilitating the expression of affect, and attending to the patient's experience (Vasquez, 2007). We can grow through interactions with colleagues, in our own therapy, and supervision with competent and experienced professionals.

Microaggressions are an easy issue to encounter and a difficult problem to resolve, but as individuals dedicated to enacting positive change, it is important that we take on the challenge of learning our own biases, recognize our mistakes, and not miss opportunities for empathy, particularly in cross cultural therapeutic relationships (Vasquez, 2007). When mistakes are made in therapy, its effects may be greater due to acts of discrimination that patients encounter on a daily basis and they often bring up significant emotions. The repair of those ruptures in therapy can have significant value for the client extending beyond the therapy room.

The difficulty in suggesting implications for clinical training is avoiding the already existing tendency to create a tangible rubric of skills that can be checked off in

the domain of cultural competency. This reifies the idea that cultural competency has a definite ending point in terms of quantifiable skill and proficiency. However, the measure of skill in this domain may have to change altogether. Instead of cultural competence, there is a continuing shift toward the idea of cultural humility, or a therapeutic approach of openness, curiosity, and acknowledgment of limitations. Training directors and professors might encourage this stance by challenging trainees to be honest about their biases and limitations which, like a therapeutic alliance, will require a foundation of safety, trust, and mutual respect.

Programs might also incorporate specific didactic and experiential training on microaggressions and rupture and repair in therapy across populations, especially with marginalized or vulnerable populations. Clear examples of microaggressions, such as those described in this study, could be helpful to clinicians who may unintentionally create ruptures with their clients of color in the process of therapy. As trainees are assessed on various competencies during their education, perhaps a more explicit assessment of their development in the area of reflecting on their own identities and cultural humility could be implemented. Given some of the disappointing results of the current study, programs may begin to consider cultural humility in practice as an ethical and social justice principle which, when not present, has the potential to harm patients.

Implications for culturally-informed practice. As with many professions, continuing education occurs in addition to research and training of mental health professionals to ensure the use of best practices in clinical work. In response to the current study, it may be important that supervision include constant reinforcement of the importance of culture in the transference and countertransference in the therapy room. Supervisors have a responsibility to guide emerging clinicians or peers in terms of their

blind spots and limitations. This can also be a practice in maintaining one's own reflection of racial and cultural identity in terms of volunteering personal reflections on identity to model for supervisees and other clinicians the value of thinking along the lines of cultural humility.

Participants in the study provided suggestions to emphasize the autonomy of the patient and follow the lead of the patient in terms of what is presented as salient or concerning in the therapy. Clinicians and supervisors must intentionally engage in the practice of examining from where their inquiries emerge and whether they serve themselves, the patient, or the relationship. Having divergent goals can disrupt the therapeutic alliance. Finally, participants hoped for more openness and honesty from mental health professionals. In practice, clinicians and supervisors must emphasize the barriers that prevent the therapist from being honest and authentic in clinically appropriate ways.

Conclusion

The goal of the current study was to examine the subjective experiences of people of color in psychotherapy who have experienced racial microaggressions from their therapists, and the impact of these occurrences on the therapeutic alliance. The foundation was a synthesis of the qualitative data with the literature on microaggressions, therapeutic alliance, racial identity development, critical race theory, social cognition, implicit bias, affect-focused, and psychodynamic object relations theory.

As one of the few investigations of the phenomenon of racial microaggressions in therapy, the study uncovered, from the patients' point of view, some of the mechanisms that contribute to ruptures in therapeutic alliances and encourage or inhibit repair. Participants' experiences indicate that cultural competence is more complex and intricate

than the quantifiable knowledge of cultural groups and therapeutic skills that therapists may have obtained. Although many of the therapeutic relationships ended prematurely, participants may consider this aspect of their experience as they become more knowledgeable consumers of therapy over time. This study, in addition to others to come, may influence a paradigm shift in which therapists adopt a stance of cultural humility. The ability to be mindful, open, and curious about one's own and the patient's identities, while also being honest about mistakes, biases and limitations, will provide more fruitful and therapeutic work for both therapists and patients.

Finally, the perspectives that the participants in this study have shared should serve to challenge clinicians to reflect on themselves as they move through their training and career. At the center of this project is a willingness to listen to the voices of patients of color.

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Appendix A

Demographic Composition of Participants

Participant	Age	Race/Ethnicity	Nationality	Language	Gender	Sexual Orientation	Years of Education	Field of Study	Occupation
1	26	Black	USA	English	Cisgender Female/womyn	Straight	19	Urban Ecologies	Graduate Assistant
2	32	Black	Canada	English, Jamaican Creole	Female	Bisexual	20	History	Student
3	30	Black	USA	English	Female	Straight	19	Political Science, Childhood Education	Teacher
4	28	Indian	India	English, Hindi	Female	Straight	18	Psychology	Student
5	25	South Asian (Pakistani)	USA	English	Female	Straight	17	Counseling Psychology	Research Assistant
6	31	South Asian (Indian)	USA	English, Hindi	Female	Questioning	21	Higher Education	Graduate Assistant
7	25	Black (Jamaican and African American)	USA	English, Spanish	Ciswoman	Queer	18	Marriage and Family Studies	Teaching Assistant
8	38	Black, African American	USA	English	Male	Straight	18	History (Africana Studies) and Education	Assistant Manager (Public Health)
9	39	African American	USA	English	Female	Bisexual	23	Critical Media Studies	Student
10	29	Asian (Sri Lankan, Indian)	USA	English, Spanish, Tamil, Malayalam, American Sign Language	Male	Straight	18	Public Health	Surveillance Officer
11	28	Indian	USA	English, Malayalam, Spanish	Female	Bisexual	16	Law	Paralegal
12	22	Asian, Chinese	USA	English, German	Female/ Genderfluid	Pansexual	16	Psychology in Education	Student

Appendix B

Advertisement

**Are You A Person Of Color Who Has Had A Difficult Experience in
Therapy?**



Dear _____,

My name is Mercedes Okosi and I am a fourth-year doctoral candidate in the Clinical Psychology Psy.D. program at The Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

I am conducting a study to explore the **impact of racial microaggressions on therapeutic relationships with people of color**. Racial microaggressions might be described as subtle slights, misunderstandings, miscommunication, insensitive comments and/or indignities an individual finds to be offensive based on their racial and/or ethnic identity. I am exploring the impact of microaggressions toward patients by therapists on the relationship between the two. **Do you identify as a person of color who has had this difficult experience in therapy? If so, please consider participating.**

Participants will be interviewed for **60-90 minutes** about their attitudes toward therapy, experiences in therapy, the impact of racial and/or ethnic microaggressions on the therapy relationship with the therapist, attempts to repair ruptures in the relationship, and suggestions for mental health professionals.

If you are interested in participating or learning more about the study, please contact Mercedes Okosi by the phone number or email below. In addition, if you know anyone who may be qualified and interested to participate, please consider forwarding the message to them.

Thank you for your time and consideration.

Sincerely,

Mercedes J. Okosi, Psy.M.
GSAPP, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ, 08854

Tel: (856) 472-9387

Email: mercedes.okosi@rutgers.edu

Appendix C

Consent Form

Informed Consent Agreement

Study Title: Racial Microaggressions Experienced in the Therapeutic Relationship by People of Color

Invitation to Participate: You are invited to participate in a research study that is being conducted by Mercedes J. Okosi, Psy.M, an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision.

Purpose: The purpose of this research study is to explore the perceptions and experiences of people of color who have experienced racial microaggressions, or covert and unintentional racial insults, in therapeutic relationships. The study also aims to examine how the relationship between therapist and patient was impacted. These experiences may not be discussed when they occur in the moment, thus an opportunity to process them in the context of the relationship is missed. This information will be valuable in terms of improving training in cultural competence for graduate students and early career mental health professionals as well as continuing education for professionals.

Participants: The study will consist of a network sample of 10-20 adults who identify as people of color (any non-white identity including Black, Latinx, Native American, Asian, Middle Eastern-North African). These individuals will have been in therapy or have received services by any mental health professional for at least one session in one on one therapeutic relationship. Participation in this study is contingent on the return of this signed consent form.

Procedure: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location. It is expected that the interview will take 60-90 minutes to complete. However, the length may vary depending on the depth of the answers provided. All interviews will take place in-person at a location in New York or New Jersey, or via video conferencing, mutually agreed upon by you and Mercedes J. Okosi via phone or Skype. All in-person interviews may be conducted in your home or office or in a secure room at Rutgers University to ensure a private, comfortable setting that is convenient for the interviewees. For those interviews taking place via video conferencing, it is important to choose a place to talk that is comfortable and private. In case of video conferencing, the interviewer will be alone, at home or in a secure room in the Psychology Building at Rutgers University.

Compensation: There will be no compensation for your participation in this research study.

Cost: There is no cost for your participation in this research study.

Risk/Benefit: There are minimal risks associated with your consent and participation in this research study. Talking about difficult experiences may create discomfort for some participants. You can indicate that you would like to stop the interview at any time. If you experience any discomfort recalling memories or discussing personal matters, it is important that you notify the principal investigator immediately so she may discuss these feelings with you and provide you with referrals to local counseling services if necessary. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services. Participation in this study may not benefit you directly; however you will play a major role in helping other researchers, social workers, psychologists, and others to understand the experiences of people of color in therapy.

Confidentiality: This research is confidential. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, geographic location, and employer/school affiliation. Please note that we will keep this information confidential by limiting individual's access to the research data and keeping it in a secure location (password protected computer) in the researcher's residence. You will be given a code to which only the researcher has access in a password secured database. Names of people and places will be replaced with pseudonyms. All study data will be kept for three years after the completion of the research, and all documents with identifying information will be shredded and any audiotapes will be erased by the researcher after publication. You will not have access to study data.

Withdrawal: Participation in this study is **VOLUNTARY**. You may choose not to participate, and **YOU MAY WITHDRAW AT ANY TIME** during the study procedures without any penalty to you. You may refuse to answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact me or my dissertation faculty chairperson:

Mercedes J. Okosi, Psy.M.
GSAPP, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ,
Tel: (856) 472-9387
Email: mercedes.okosi@rutgers.edu

Nancy Boyd-Franklin, Ph.D.
Professor II, Clinical Core Faculty
GSAPP, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ 08854
Tel: (848) 445-3977
Email: boydfrank@aol.com

If you have any questions about your rights as a research subject, you may contact the

IRB Administrator at Rutgers University at:

Institutional Review Board
Rutgers University, The State University of New Jersey

Liberty Plaza/Suite 3200
 335 George Street, 3rd Floor
 New Brunswick, NJ 08901
 Phone: 732-235-9806
 Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix D

Permission to Record

Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: Racial Microaggressions Experienced in the Therapeutic Relationship by People of Color conducted by Mercedes J. Okosi. The principal investigator is asking your permission to audiotape and/or videotape the interview as part of this research study.

The recording(s) will include responses that you provide throughout the interview. Please avoid using names or any other identifying information. Names and names of places will be replaced with pseudonyms. The recording(s) will be used for analysis by the Principal Investigator (Mercedes J. Okosi) and to ensure that information from the research study has been recorded properly. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all subjects. The recordings will be transcribed to ensure the authenticity of your responses.

If the interviews are video-recorded, recordings will include full facial features. We will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password protected computer. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Principal Investigator Signature _____ Date _____

Appendix E

Resources



**Referral to Therapy Resources in the Community
(All resources are free, low cost, or sliding scale)**

1. Counseling ADAPS, and Psychological Services (CAPS) (for Rutgers students)

"CAPS is dedicated to the service of Rutgers University – New Brunswick students. Their mission is to ensure and promote positive mental wellness on campus."

<http://rhscaps.rutgers.edu/>
17 Senior Street
New Brunswick, NJ 08901
Mon - Fri: 8:30 AM - 4:30 PM
(Year Round)
848-932-7884

2. Rutgers Psychological Services Center

"Located at the Graduate School of Applied and Professional Psychology (GSAPP), the Psychological Services Clinic is part of the Center for Applied Psychology. The Clinic delivers psychotherapeutic and assessment services by advanced doctoral students under the supervision of faculty and clinical supervisors."

We are located on the Busch Campus of Rutgers University in Piscataway. The Clinic is on a bus stop serviced by the free intercampus bus line running throughout the New Brunswick / Piscataway area. We are open from 9 a.m. to 9 p.m. Monday through Thursday and from 9 a.m. to 8 p.m. on Friday."

<http://psychologicalservices.rutgers.edu/about.php>
Rutgers, The State University of New Jersey
152 Frelinghuysen Road
Piscataway, New Jersey 08854-8085
848-445-6111

3. Multicultural Family Institute

"About Us..."

The Multicultural Family Institute (MFI), incorporated in 1991, is a non-profit educational institution devoted to post-graduate family therapy training, research, and consultation to community institutions from a Multicultural Systemic perspective. We are committed to promoting social justice, and countering societal forces that undermine people because of race, gender, culture, class, sexual orientation, religion, or disability. We seek to create a world in which all members of our community share in the possibility of finding a "home place" where they feel safe and can receive educational, health, and mental health resources that allow them to function at their best. MFI began as a Family Training Program at the Community Mental Health Center of UMDNJ in 1974 and is now located in Highland Park NJ.

Our faculty have been working together for many years to promote a multi-contextual, systems approach to resolving human problems within a framework of community empowerment. We represent a diversity of cultural perspectives and are committed to individual, family and community experiences throughout the life cycle. Some of the issues considered are trauma and loss, children's problems, couple relationships, intergenerational relationships, conflicts, and cut-offs. We collaborate with a broad national and international network of colleagues similarly dedicated to evolving a multi-contextual cultural framework. Associate and Guest Faculty participate in our teaching programs and in our culture conference every spring."

<http://multiculturalfamily.org/>
328 Denison St, Highland Park, NJ 08904
(732) 565-9010

4. Catholic Charities Diocese of Metuchen

"Life's challenges can affect any individual or family. Catholic Charities, Diocese of Metuchen serves adults and youths struggling to cope with life in the face of psychological, behavioral and/or addiction issues. Programs offered throughout the four



Diocesan counties provide counseling, treatment, guidance and support to many who would not otherwise have access to these services."

<http://www.ccdom.org/counseling-services>
various locations in the surrounding community
1-732-324-8200

5. Institute for Family Health

"Behavioral Health

Feeling sad or hopeless? Anxious or worried? Trouble concentrating? Not interested in things you usually like to do? Concerned about a family member? Problems in your relationship?

We can help.

We offer counseling and other services for children, adolescents, adults and families. All services are completely confidential.

Counseling

Many people find that counseling with a professional therapist helps them to face difficulties in their lives and take action to improve their situation. Our psychologists, social workers, and counselors are licensed therapists with advanced training in individual and family therapy.

[...]

Psychiatry and Medication

If your therapist feels that medication may help you, you will have an appointment with a primary care provider, psychiatrist or psychiatric nurse practitioner who may recommend prescription medication for you."

<http://www.institute.org/health-care/services/behavioral-health/>
various locations in Manhattan, Bronx, and Hudson Valley
(212) 633-0800

6. Metropolitan Center for Mental Health

"The Metropolitan Center for Mental Health was founded in 1962 in order to provide low cost psychological treatment for people with emotional problems. For over 50 years, the clinic has provided affordable mental health services to the community, consulted with our agencies, and offered advanced training."

<http://www.metropolitancenter.com/>
various locations in Manhattan
(212) 362-8755

Crisis Contact Information IN AN EMERGENCY, DIAL 911

1. <http://crisiscalcenter.org/> 24/7/365 Crisis Hotline Call: (775) 784-8090 (National)
2. Rutgers Acute Psychiatric Services <http://ubhc.rutgers.edu/services/acute.html> 855-515-5700 (New Jersey)
3. <http://www.njhopenline.com/> 1-855-654-6735 NJ Hopeline (New Jersey)
4. <http://samaritansnyc.org/24-hour-crisis-hotline/> Samaritans 24-Hour Crisis Hotline (212) 673-3000 (New York)

Appendix F

Demographic Questionnaire

1. Age:
2. Race and Ethnicity:
3. Country of origin:
4. Languages spoken:
5. Gender:
6. Sexual orientation:
7. Years of education completed:
8. Major (if currently in college or completed any college):
9. Occupation (if employed):

Appendix G

Interview Protocol

I am going to ask you some questions about your thoughts on therapy, your identity, and your own experiences and difficulties in therapy. If at any time you feel uncomfortable or do not want to answer a question, please inform me.

1. How would you describe your attitude toward therapy in general?
2. When did your therapy occur?
3. In what setting did you receive therapy?
4. How long did you attend therapy?
5. What type of therapy did you attend?
6. What was the presenting problem leading you to seek therapy?
 - a. Was this problem connected to your racial/ethnic identity?
7. What was the race of your therapist?
8. Were you able to choose the race of your therapist?
9. How would you describe your relationship with your therapist at the beginning of treatment?
10. Describe the context around when the microaggression occurred.
11. What did the therapist say that you perceived in a negative way related to your race or ethnicity?
 - a. How did you react in the moment?
 - b. What feelings did you experience?
 - c. What feelings did you have toward the therapist?
12. Did you remain in therapy? If yes, what led to your decision to stay? If not, what led to your decision to leave?

13. Did you ever discuss the comment made by the therapist with the therapist?
 - a. Who initiated the conversation?
 - b. What was that conversation like?
 - c. Did you feel that it helped or hurt the relationship? Explain.
 - d. If no, what stopped you from addressing the issue? Explain.
14. If you remained in therapy, how would you describe your relationship with the therapist after this moment?
15. What could the therapist have done differently?
 - a. at the beginning of treatment
 - b. at the moment of the microaggression
 - c. after the microaggression occurred
16. Has this experience impacted your attitude toward therapy and therapists?
17. How likely are you to seek therapy in the future?
18. Do you have any suggestions for therapists who experience a situation similar to the one you described? How should they handle it?
19. Do you have any suggestions for therapists in training to address these issues?
20. Do you have any questions, thoughts, or feelings relevant to our discussion that were not yet addressed?

Thank you for your time.