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RACIAL MICROAGGRESSIONS AND THE
THERAPEUTIC ENCOUNTER: A
QUALITATIVE STUDY ON THE
EXPLORATION OF THE INTERSECTION IN
A CROSS-RACIAL DYAD WITH WHITE
CLINICIANS AND CLIENTS WHO ARE
SECOND GENERATION ASIAN AND
LATINA AMERICAN WOMEN OF COLOR

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Abstract

Research has found that racial minorities suffer from poorer mental and physical health in comparison to Whites; and perceived discrimination has been linked to mental and physical health outcomes. Issues of race, power, privilege, language and cultural sensitivity can influence the client provider relationship and clients' utilization of services. Microaggressions, a term originally used by C. Pierce in the 1970s to denote the subtle, often automatic and nonverbal communications by Whites intended to 'put down' African Americans, oppress, create disparities in our society toward marginalized groups and contribute to psychological stress and distress for these groups (Sue et al, 2007). While research outlines the impact overt racism has had on the self-concept of people of color and their perceptions of the mental health system, the topic of microaggressions within the therapeutic context remains largely unexplored. Current research on racial microaggressions has not made the distinction between the experience of first and second generation immigrants. Through the qualitative analysis of eleven second-generation Asian and Latin American women of color's experiences of racial microaggressions within the therapeutic context, the microaggression experience, means of coping utilized, as well as the impact therapeutic relationship and the participants' perceptions about therapy were examined. The inquiry resulted in the emergence of the following five constructs: 1) types of racial microaggressions in therapy, 2) influences of client's reactions to racial microaggressions in therapy, 3) navigating the racially microaggressive experience in therapy, 4) the role of therapists, and 5) practice recommendations. Implications for practice and research are discussed.

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RACIAL MICROAGGRESSIONS AND THE THERAPEUTIC ENCOUNTER: A QUALITATIVE
STUDY ON THE EXPLORATION OF THE INTERSECTION IN A CROSS-RACIAL DYAD WITH
WHITE CLINICIANS AND CLIENTS WHO ARE SECOND GENERATION ASIAN AND LATINA
AMERICAN WOMEN OF COLOR

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Dedication

This dissertation is dedicated to all second generation people of color,

those on their journey,

finding, found, and in-between.

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It is with deep and sincere gratitude that I offer my thanks to the many people who have helped me write this story and walk this journey. First and foremost, I could not have completed this dissertation or pursued graduate school without the support and love of my family and friends. My parents, Daniel and Lourdes Miranda, made this all possible through their support and sacrifice, along with my brother, Francis Miranda, who inspired me to go into this profession. Through their ceaseless demonstration of the power of love, will and faith, they remind me of what is possible. Thank you for your love and patience; I could not be who I am or where I am today without you all. This is our degree. To my childhood friends, Janette Razon, Karen Landeverde, and Jonathan Graf, for their listening ear, words of encouragement, and faith in me. To Melanie Miller and Yoon Kane, for believing in me during moments when I could not do so myself. To the kindred spirits in my cohort Marilyn Valenciano, Kirk James, and Matt Ditty, thank you for your friendship, for helping me recognize the importance of my voice, and for being my rock these past three years. To my other family, Kaveh Sarfehjooy, Nic Venegas, Cecelia Ciamaga, and the Rockaway community, thank you for all you have given me and all that you have taught me. You all are such a blessing in my life.

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ABSTRACT

RACIAL MICROAGGRESSIONS AND THE THERAPEUTIC ENCOUNTER: A QUALITATIVE STUDY ON THE EXPLORATION OF THE INTERSECTION IN A CROSS-RACIAL DYAD WITH WHITE CLINICIANS AND CLIENTS WHO ARE SECOND GENERATION ASIAN AND LATINA AMERICAN WOMEN OF COLOR

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Research has found that racial minorities suffer from poorer mental and physical health in comparison to Whites; and perceived discrimination has been linked to mental and physical health outcomes. Issues of race, power, privilege, language and cultural sensitivity can influence the client provider relationship and ultimately the client's continued utilization of services. Studies reveal that microaggressions, a term originally used by C. Pierce in the 1970s to denote the subtle, often automatic and nonverbal communications by Whites intended to 'put down' African Americans, oppress, create disparities in our society toward marginalized groups and contribute to psychological stress and distress for these groups (Sue et al, 2007). While research outlines the impact overt racism has had on the self-concept of people of color and their perceptions of the mental health system, the topic of microaggressions within the therapeutic context remains largely unexplored. Current research on racial microaggressions focus on monoracial populations, but have not made the distinction between the experience of first generation and second generation immigrants, which remains a gap in the literature. Through the qualitative analysis of eleven second-generation Asian and Latin American

women of color's experiences of racial microaggressions within the therapeutic context, the microaggression experience, means of coping utilized, as well as the impact therapeutic relationship and the participants' perceptions about therapy were examined. The inquiry resulted in the emergence of five main constructs which are of the following: 1) types of racial microaggressions in therapy, 2) influences of client's reactions to racial microaggressions in therapy, 3) navigating the racially microaggressive experience in therapy, 4) the role of therapists, and 5) recommendations for practice. Under the domain of *Types of racial microaggressions* are more specific, key themes, with five microaggression themes directed towards Asian American women consisting of 1) alien in one's own land, 2) pathologizing cultural values and means of communication, 3) ascription of intelligence, 4) colorblindness, and 5) invisibility. Four microaggression themes directed towards Latina Americans included 1) passing for racial majority, 2) ascription of intelligence, 3) colorblindness, and 4) assumption of superiority. Implications for practice and research are discussed.

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Introduction

In the 2000 Census, roughly 30 percent of the population identified as belonging to an ethnic or racial minority group, with the number projected to increase to 50 percent by 2050. With the shift in the population, there is a question whether current health systems can meet the needs of an increasingly diverse public. It is well documented that racial and ethnic minority groups currently have poorer access to quality health care services and different patterns of utilization relative to White Americans, including lower use of preventive services, greater likelihood of not having a usual source of care, and a greater likelihood of being uninsured (Mayberry et al., 2000). However there are a confluence of intersecting factors that influence the attainment of treatment and health outcomes: on the macro level, such factors as outdated policies and institutionalized practices, and on a micro level, contributing factors include the individual's culture and beliefs, socioeconomic status, health insurance status, among others. A midcourse review of the Healthy People 2010 program showed "significant differences remain along racial, ethnic, and socioeconomic status lines" (Adler & Stewart, 2010, p. 5). Additional research by Bravemen and Egerter (2008) found twice as many African Americans and Hispanic Americans report fair to poor health in comparison to White Americans, and differences were more pronounced along socioeconomic status lines. Disparities however, include not only health conditions and outcomes, but also that of access to health care, utilization of services, and insurance status. Those who do not speak English or do not fully understand the US healthcare system encounter barriers in health care services (Office of Minority Health and Health Equity, 2009). Short, Cornelius, and Goldstone (1990) found that African Americans are likely to have public insurance;

while, Hispanic Americans are more likely to be uninsured when compared to White Americans. It is not surprising then to see research trends indicate Hispanic Americans are also almost twice as likely as White Americans to lack a consistent source of care and treatment (Zuvekas & Weinick, 1999).

When examining the research on mental health care, racism was identified as one of the “potential stressors contributing to racial disparities in mental health (Wang, Siy, & Cheryan, 2011). According to the US Department of Health and Human Services (2001), “racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.” Research has found that racial minorities suffer from poorer mental and physical health in comparison to Whites (Williams & Mohammed, 2009); and perceived discrimination has been linked to mental and physical health outcomes (Williams, Yu, Jackson, & Anderson, 1997). When reviewing population-based studies, it was found that greater reports of discrimination were associated with increased mental illness (Williams & Mohammed, 2009; Williams, Neighbors and Jackson, 2003). Over the past two decades, public health officials and researchers have made it their mission to improve the health status of people of color. However, the findings communicate clearly that racial disparities in mental health is a public health issue requiring immediate, rigorous intervention, yet remains a burgeoning area of inquiry.

Current research indicates that people of color underutilize psychotherapy services and have high rates of dropping out of treatment and turnover. Research on client-provider communication has generated evidence that effective communication can

improve outcome measures such as client satisfaction, adherence to treatment, and disease outcomes (Ferguson & Candib, 2002). Review of the literature on doctor-patient communication and culture, reveals recommendations of culturally competent interventions; however, the interventions have been heterogeneous and the studies themselves descriptive, with little documenting the impact on patient satisfaction and outcomes. The interventions commonly discussed in the cultural competency literature include interpreter services, recruitment and retention of staff members of color, formal staff trainings in cultural competency, coordination of care with family and /or traditional healers, and culturally competent health promotion (Brach 2000; Anderson et al., 2003; Giger, Davidhizar, Purnell, Taylor Harden, Phillips. & Strickland, 2007). In a study by Saha et al. (1999), it was noted racial, cultural and communication barriers between minority client and white health care provider might arise due to cultural or linguistic incongruity, from lack of mutual trust or from racial discrimination; Vasquez (2007) also noted that related causes for high drop out rates include cultural misunderstandings and miscommunication between worker and client. Cross-cultural practice places the clinician at the center of a conflict central to all psychotherapy practice which is that of knowing how to know without knowing or listening without the need to understand (Dyche & Zayas, 2001). Language and cultural sensitivity, clear communication and common understanding between client and provider are underscored as key to initially creating the foundation for a strong therapeutic alliance.

Building a common understanding within a therapeutic context requires recognition of the power dynamics inherently present when a client is seeking assistance from a provider, who is perceived as an expert. Additional research noted that there are

experiences of racism and discrimination in the cultural histories of clients that can consciously or unconsciously influence whether people of color stay connected to systems providing treatment (Thompson & Neville, 1999; Buser, 2009). Stanhope and colleagues (2005) noted the mistrust (by people of color) arises from a recognition that the system is unable to recognize the needs of or to collaborate with people of color to provide culturally appropriate treatment. Other studies highlight that the manner in which information is communicated can influence client perceptions of the health care system and affect adherence to prescribed health regimens, as well as satisfaction and use of the health care system; in addition it was noted that a lack of formal professional cultural sensitivity training can predispose health care providers to discriminatory practices, even without the intention of being biased or culturally insensitive (Majumdar et al., 2004; Saha et al, 1999). Issues of race, power, privilege, language and cultural sensitivity can influence the client provider relationship and ultimately the client's continued utilization of services.

Racism directly impacts the lives of people of color on a daily basis and is an issue that is not openly discussed. Exploration of issues of race brings to the forefront how the structures of power and privilege operate. According to Thompson and Neville (1999), the dynamics of race are based on dialectics of deprivation and domination, powerlessness and control and privilege and rejection. The maltreatment of people of color has an impact on a micro and macro level; health and educational disparities are widely documented among communities of color. With a history of being perceived by the majority population as inferior and with a documented lack of access to resources, it is inevitable that people of color face challenges to improve their circumstances and have

their voices and perspectives be heard, given societal and systemic inequities (Thompson and Neville, 1999). Racism has evolved from that of overt and blatant forms of discrimination and prejudice to subtler forms of racism, such as aversive racism or implicit stereotyping, (DeVos & Banaji, 2005; Pearson, Dovidio & Gaertner, 2009) and racial microaggressions (Sue et al, 2007). With aversive racism, individuals are motivated consciously by egalitarian values; while, anti-minority sentiments are held unconscious (DeVos & Banaji, 2005; Banaji, Hardin & Rothman, 1993; Tinsley-Jones, 2003; Dovidio & Gaertner, 2004; Pearson, Dovidio & Gaertner, 2009). According to Pearson, Dovidio and Gaertner (2009), they will not overtly discriminate against people of color as they are motivated to

“avoid feelings, beliefs, and behaviors that could be associated with racist intent...however, the non-conscious feelings and beliefs will produce discrimination in situations ...when the guidelines for appropriate behavior are unclear,...or when one’s actions can be justified or rationalized on the basis of some factor other than race”

p.318

These acts have an impact and can harm people of color regardless of the original intention of person (Sue, 2003; Sue et al, 2007).

Racial microaggressions can be considered as a pervasive, dynamic manifestation of demarcation between the experiences of dominant White culture and that of people of color (Sue, 2003); its importance cannot be overlooked as microaggressions have major consequences for marginalized groups (Sue, 2003; Sue, 2010). (Microaggression was a

term originally used by Pierce in the 1970s to denote the subtle, often automatic and nonverbal communications by Whites intended to 'put down' African Americans (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978). Research reveals that microaggressions oppress, create disparities in our society toward marginalized groups and contribute to psychological stress and distress for these groups (Sue et al, 2007). The cumulative nature and continuing day in and out experience of racial microaggressions contribute to the following: hostile and invalidating educational and work climate, devaluing of social group identities, lower work productivity and educational learning among people of color, perpetuation of stereotype threats, and can ultimately create physical health problems as well as harm mental health of these marginalized communities (Sue & Sue, 2008).

Sue and colleagues expanded on this work researching, identifying and developing a taxonomy of racial microaggressions that fall into three main categories: microinvalidation, microinsult, and microassault (Sue et al., 2007). Microinvalidations and microinsults are both often unconscious communications; however, microinvalidations involve interpersonal comments or behaviors and environmental cues that exclude, negate, or nullify the psychological thoughts, feelings, beliefs, and experiences of the target group which may be enacted as attack or denial of the experiential realities of social devalued groups, while microinsults consist of interpersonal interactions (verbal/nonverbal) or environmental cues that convey rudeness and insensitivity that demean a person's identity or heritage (Sue et al, 2007; Sue & Sue, 2008). Microassaults can be thought of as overt racism as it is a conscious communication of biased beliefs or attitudes held by individuals and intentionally

expressed overtly or covertly toward marginalized groups (Sue et al, 2007; Sue & Sue, 2008). Solórzano, Ceja and Yosso's (2000) study was one of the early studies examining the manifestations of microaggressions and their impact; African American college students participated in focus groups that explored their lived experience of the phenomena of microaggressions and how it influenced the racial climate in both the academic and social spaces of a college environment.

The experience of people of color in America from colonization of the New World until the Civil Rights Movement was largely overlooked, which exemplifies the marginalization that people of color have historically experienced in the United States; essentially while it is not widely discussed or "linguistically encoded", it constitutes the fabric of daily psychic experience (Leary, 2000). The lack of discourse speaks to the hegemony where the experience of the "Other" is not recognized or acknowledged as integral to the country's cultural history, but instead cast aside or made to exist, at times invisibly, on the periphery. While research outlines the impact overt racism has had on the self concept of people of color and their perceptions of the mental health system (Thompson & Neville, 1999; Ridley, 2005; Sue, 2010), the topic of microaggressions within the therapeutic context remains largely unexplored.

Studies on cross-racial dyads typically are from the perspective of therapist or researcher resulting in limited scope and understanding of client's experiences (Knox et al., 2003). Since therapy can be seen as a microcosm of race relationship in larger society, it can activate an array of coping strategies for dealing with the anxiety of cross-racial interactions (Chang and Yoon, 2011). While racism has been examined as a variable that informs the dynamics between clinician and client (Ridley, 2005), the process of

racism and its influence on clinicians' responses to people of color seeking mental health care is an area in need of greater exploration (Whaley, 1998). Current research on racial microaggressions focus on monoracial populations, but have not made the distinction between the experience of first generation and second generation immigrants, which remains a gap in the literature. It will be through the qualitative analysis of second generation American people of color's experiences of racial microaggressions within the therapeutic context can voice be given, meaning created, and understanding garnered as to how these encounters impact and affect people of color. Understanding how a person of color makes sense of race and similarity/dissimilarity between oneself and the clinician on the treatment relationship can assist the therapist in responding in a way that strengthens the alliance and foster the client's growth (Chang and Yoon, 2011). It is through exploration of the subtle and unconscious dynamics that occur within the dyad that social work practice and intervention can be shaped to be more culturally sensitive, informed, and inclusive.

Phenomena for Study

Since the topic of inquiry is that of the microaggressions, qualitative research is the most appropriate approach as it focuses on meaning, sense-making and communicative action; in other words it looks at how individuals make sense of what occurs and the meaning of that occurrence (Smith, Flowers, & Larkin, 2009). Through the use of intensive interviews, a more clear sense of the essence of the experience of a people is distilled and provides concrete information about an otherwise abstract concept (Charmaz, 2006). The phenomena to be explored are the following: 1) From a clients' perspective, what reactions do second generation American people of color have when

racial microaggressions occur in the therapeutic dyad? 2) How do microaggressions impact the therapeutic encounter? 3) What coping strategies are utilized when having experienced a racial microaggression? 4) How do microaggressions affect second generation American people of color's perception of psychotherapy? 5) What, if anything, would have been helpful in repairing the rupture in the relationship?

Definition of Terms

Racial microaggressions can be understood as commonplace verbal, behavioral or environmental indignities, whether unintentional or intentional which communicate hostile, derogatory, or negative slights and insults to people from marginalized groups (Sue et al., 2007). Therapeutic encounter is defined as the contact between at least two individuals designed to enhance the health of one or more of those engaged in the interaction (Jonas, 2005).

Literature Review

Racism has evolved in its manifestations and become more sophisticated with the passing of time. While overt discriminatory practices may not be as prevalent as they were in the early twentieth century, racism quietly persists in subtler forms in ways often unknown consciously to us individually and as a society (Nadal, 2008). As a social construct and tool of pseudo scientific classification, race was used to define, classify, categorize, control and perpetuate ideas of inferiority among men, thus making "the Other" a powerful symbol of difference, constructed as a result of perception and fear of difference (Clarke, 2003); however, race can embody a multitude of ideas and concepts encompassing variables such as skin color, education, income, and geographic location

(Thompson, 1996). The definition of racism has evolved to encompass structures and practices of discrimination and exclusion based on prejudice and embedded in a process of racial and ethnic categorization rooted in stereotyping (Clarke, 2003). An example of this is microaggressions, which can be understood as commonplace verbal, behavioral or environmental indignities, whether unintentional or intentional which communicate hostile, derogatory, or negative slights and insults to people from marginalized groups (Sue & Sue, 2008). This new definition highlights that there is a dynamic exchange taking place that is not simply contained within the realm of the mind of an individual but involves contact with another, a symbolic representation of “the Other.” Berzoff (2011) writes that racism is pervasive and that people of color have been and continue to be victims of microaggressions. There are consequences to this. According to bell hooks (1995)

“Collective failures to adequately address the psychic wounds inflicted by racial aggression is the breeding ground for a psychology of victimhood wherein learned helplessness, uncontrollable rage and/or feelings of overwhelming powerlessness and despair abound in the psyches of black folks yet are not attended to in ways that empower and promote holistic states of well-being”
(p.137)

It becomes even more pertinent then to understand how these processes can be enacted specifically within the context of the therapeutic relationship and its impact on the client who is a person of color, as it has broad implications in terms of mental health and how people of color perceive and utilize mental health treatment.

Mental Health Treatment in Cross-Racial Dyads

Most clinicians are White and trained in Western European models (Sue & Sue, 2003). As a result of this, the biases and prejudices of their predecessors and the larger society of which they are a part are internalized (Burkard & Knox, 2004; Sue, 2003). In the therapeutic encounter between White therapists and clients of color, microaggressions may occur during the interactions between clients and clinicians; microaggressions delivered by well-intentioned clinicians have been found to discourage usage of mental health services by clients of color, result in premature termination of sessions, and result in the unintentional oppression of clients (Sue, 2010; Sue et al, 2007). Therapists who are not aware of their biases, racism or privilege may unintentionally perpetuate oppression against clients of color during the therapy process (Burkard & Knox, 2004). According to Constantine and Sue (2007), counselors may assume they are incapable of initiating a microaggression as a result of training and one's motivation to become a therapist; however, it was an inaccurate assumption. In Constantine and Sue's (2007) qualitative study, the experience of racial microaggressions in a cross-racial supervisory dyad was examined, specifically that of racial microaggressions by White supervisors who were supervising ten African American doctoral supervisees in counseling and clinical psychology. It was found that the microaggressions the students of color experienced consisted of invalidation of racial issues, supervisors making stereotypic assumptions about both African American supervisees and clients, supervisors exhibiting reluctance to provide feedback in fear of being perceived as racist, and offering culturally insensitive treatment recommendations (Constantine & Sue, 2007). In a quantitative study by Burkard and Knox (2004), two hundred forty seven psychologists who were

identified as having, low moderate, and high color-blind racial attitudes, a specific type of microaggression in which the individual claims to not perceive differences in race, were evaluated on empathy and their attribution of client responsibility for the cause of and solution to a problem. It was found that the therapists' level of color blindness was directly related to capacity for empathy and to their attribution of responsibility for the solution to a problem with African American clients but not clients of European American descent (Burkard and Knox, 2004). This particular microaggression, colorblindness, is damaging and detrimental to counseling (Sue, Nadal, et al., 2008; Buser, 2009). How do these experiences of racial microaggressions then impact the therapeutic encounter, how a client perceives treatment, and most importantly, what can be done to repair such ruptures?

For a client who is a person of color, lack of acknowledgement of one's experience, on an individual level and in a societal context as a member of community of color, can exacerbate feelings of inferiority since the communication is that one's experience is inconsequential. In Quershi's (2007) qualitative study, an intensive interview was conducted with an African American man who had been in therapy with a European American therapist and the most salient themes that emerged were the multidimensionality of the experience and the lack of direct discussion of race in the therapy process; it was noted specifically that issues of trust, perceived cultural issues and the issues for work, contributed to and detracted from the experience. Acknowledgement of race, the history of power, privilege, oppression associated with it, along with internalized racial attitudes, can thus be considered as integral to engagement within the therapeutic relationship since it creates a space for understanding on the part of the

clinician and the client. Traditional practice wisdom does not necessarily transfer as there are specific aspects of the experience of people of color that influence their perceptions of and level of engagement with the mental health system. One of the most frequently cited issues in providing mental health services to minority groups is the cultural and linguistic mismatch that occurs between clients and providers (Kelly & Green, 2010). Applying the concept of fit at the client–therapist level has generally meant that more therapists who are people of color familiar with ethnic cultural values are recruited into the mental health field, students and therapists are educated on different cultures and communities, and treatment is modified since they are geared primarily for mainstream Americans (Sue & Zane, 2009). The development of a therapeutic relationship based on respect and a willingness to recognize and understand the unique characteristics of the client is important for trust to develop and change to occur (Kelly & Greene, 2010).

It seems the most important explanation for the problems in service delivery involves the inability of therapists to provide culturally responsive forms of treatment as most therapists are not familiar with the cultural backgrounds and life-styles of various ethnic-minority groups. Having received training primarily developed for Western, predominantly White American culture, consequently therapists are often unable to devise culturally appropriate forms of treatment; ethnic minority clients frequently find mental health services strange, foreign, or unhelpful (Sue & Zane, 2009). The degree of familiarity and difference present in the client/worker dyad can either facilitate or limit on-going dialogue, which creates an alliance that either promotes growth or creates distance (Allen-Meares & Burman, 1999). It is likely then that the client will not be

sufficiently engaged and the client may drop out of treatment due to not feeling adequately helped or understood. In a study by Cooper and Lesser (1997) it was found that Black professional women who sought therapy in the dominant White culture found it challenging to convey their feelings to a White clinician who has not experienced racism; they went on to note how color blindness inhibits the clinician's ability to question, the client's willingness to disclose and thus places constraints on the therapeutic relationship. Cultural competence and the capacity for empathy were factors impacting the development of an alliance. In a study by Fuertes, Stracuzzi, Bennet, Scheinholts, Mislouack, Hersh, and Cheng (2006), combined client ratings of therapist expertness, attractiveness, and trustworthiness are significant in predicting both therapists' and clients' satisfaction; however there is deviation in that ratings of the working alliance are also significant for therapists, while, ratings of therapist multicultural competence and empathy for clients are also significant. While some research indicates that a counselor of a dominant group cannot be sensitive to a client of color's problems and experiences due to differences in experience (Brown, 1973; Fry, Kropf & Coe, 1980), other studies have demonstrated there is no conclusive evidence that same racial therapeutic dyads are more successful (Michalopoulos et al., 2009).

Both the clinician and the client bring with them their own personal biases, prejudices, cultures, and histories into the working relationship. The task of the therapist who is of the dominant culture, particularly therapists with no experience with oppression, must be to learn to recognize his or her own privilege and simultaneously manage the accompanying feeling of guilt or shame they experience; those differences may have a significant impact on the therapeutic relationship, development of rapport,

client's experience, and treatment effectiveness (Kelly & Greene, 2010; Dyche & Zayas, 2001). Shonfeld-Ringel (2001) writes that an awareness of the influence of the therapist's power and authority on the treatment process, both on a social, political level and a psychological level, are important variables in the cross cultural therapeutic alliance. Given the importance and enormity of the task placed upon the clinician during the engagement phase, it becomes imperative for clinicians to adequately equip themselves with knowledge, sensitivity and a willingness to be open. Barbara Solomon (1976), a pioneer in fostering dialogue about oppression and empowerment of marginalized communities, writes that a non-racist practitioner should possess the following characteristics:

“the ability to perceive alternative explanations for any behavior, particularly those alternatives which the self might most strongly reject as false, possess the ability to collect objectively through the sense those verbal and nonverbal cues which would help to identify out of all possible alternatives the one which is most likely or most probably for a given client, the practitioner should have the ability to feel warmth, genuine concern, and empathy for people regardless of race, color, or ethnic background, and should be able to confront the client when true feelings of warmth, genuine concern, and empathy have been expressed but have been misinterpreted or distorted by the client” (Solomon, 1976, p. 313)

By creating an atmosphere in which the client can feel understood, heard, seen, and cared for, there is greater likelihood that a positive alliance can be fostered. According to Sue and Zane (2009), credibility, the client's perception of the therapist as an effective and trustworthy helper, and giving, the client's perception that something was received from

the therapeutic encounter, are particularly relevant considerations in working with culturally diverse groups as they are related to notions of expectancy, trust, faith, and effectiveness in therapy. A practitioner who possesses cultural knowledge is viewed as having credibility and competence. Without it, clinicians would be unprepared to deal with possible cultural discrepancies in conceptualizing the problem, finding appropriate means to resolve problems of the client, and setting goals for treatment if they did not know the cultural values of a specific minority group; however, because of the connection between cultural knowledge and the process of credibility, “therapists can avoid confounding the cultural values of the client’s ethnic group with those of the client” (Sue & Zane, 2009, p. 9). It can be said then that possessing this knowledge is integral to developing credibility in the eyes of the client.

The therapeutic alliance can be thought of as a complex relationship where the therapist and client strive to form a meaningful human relationship amidst the challenges of social inequalities and social prejudices. In a study examining the therapeutic alliance in multicultural practice, Coleman (2000) found that there is empirical support for improved working alliance resulting from the therapist acknowledging cultural differences and communicating awareness of the client’s culture. Phares (1984), notes that client outcomes are better when they believe in their clinician and the methods utilized. If the style of the counselor does not match with the communication style of the client then there is a risk of premature termination, difficulty establishing rapport, and cultural oppression of the client; therefore the ability of the worker and client to send and receive both verbal and nonverbal communications appropriately and accurately is critical to the therapeutic relationship (Sue & Sue, 2009). The client worker relationship

is complex because it touches upon various levels. At the working alliance level, clients from differing cultural backgrounds will have varied expectations and understanding of psychotherapy and will have preferences for certain therapist styles; while, at the emotional therapeutic alliance level, the therapist may become a transference figure for which they are not culturally prepared, and at the same time, be confronted with their own conscious and unconscious internalization of racist socialization (Coleman, 2000). The clinician must be willing to adapt one's methods while at the same time being aware of the conscious processes of self and client. In addition, it is recommended that the therapist approach the culturally different client with "respectful curiosity" and allow the client to inform the therapist of his or her unique cultural background in order to foster a supportive, non-judgmental space for the relationship to flourish (Coleman, 2000). It is essential then that therapists exhibit awareness and be flexible in their style and approach in order to adequately meet the needs of the client, establish trust, and foster an alliance.

Cultural Competence

With the increasingly diverse population of the United States and globalization, multicultural practice has evolved over time. In 1980, the American Psychological Association adopted a professional competence practice requirement and highlighted that culturally sensitive practice was essential to competent practice (Encyclopedia of Social Work, n.d.) Shortly thereafter, a position paper was published in 1982 on cross-cultural counseling that advocated there be specified multicultural knowledge, awareness, and skill areas in counseling psychology. In 1989 Terry Cross developed the first full-scale organizational paradigm on cultural competence (Encyclopedia of Social Work, n.d.).

The Preamble of the National Association of Social Workers (NASW) Code of ethics states that the mission of social work profession is to enhance human well-being, help meet the basic human needs of all people, with particular to the needs and empowerment of individuals who are vulnerable, oppressed, living in poverty, as well as be sensitive to cultural and ethnic diversity in order to end discrimination, oppression, and other forms of social injustice (NASW, 2000a). According to the NASW Standards for Cultural Competence,

“Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations” (NASW, 2000b, p 61)

Professional organizations overseeing standards in mental health practice and increasing amounts of research advocate for the use of culturally competent multicultural practice as a mechanism to address disparities; however, there are differing definitions among practitioners and researchers, as well as means of implementation. The culturally competent practitioner is described as one who is in the process of becoming aware of his/her own assumptions about human behavior, values, biases, preconceived notions, personal limitations, tries to understand the world view of his/her culturally different client, and develops and practices appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different client (Sue & Sue, 2008). It can be said then that multicultural counseling competence is defined as

“the counselor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society, and on a organizational/ society level, advocating effectively to develop new theories, practices, policies and organizational structures that are more responsive to all groups.” (Sue & Sue, 2008, p 46)

Cultural competence developed conceptually and may best be thought of as a social construct composed of a number of concepts and principles, some of which might qualify as theories and others not; it involves the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings as a means to improve service quality, thereby producing better outcomes (Gallegos et al, 2008). However, even this current understanding is a departure from the earlier approaches to multicultural practice as it represents a philosophical shift in defining ethnic and race relations, traditionally viewed as a conflict involving assimilation versus pluralism (Sue, 1998). (Assimilation is a process whereby minority groups become more like the majority; while, cultural pluralism refers to the coexistence of groups maintaining their essential identities with whatever “melting” that occurs being ineffective in changing these identities (Solomon, 1976). The shift from assimilation to cultural pluralism is evidence of an evolving orientation to that of a more abstract understanding of cultural difference. Neither assimilation nor cultural pluralism have been completely accepted; however, multicultural counseling approaches have changed over time so as to now encompass processes that use modalities and define goals consistent with the experiences and values of clients, recognize client identities to include various dimensions (individual, group,

and universal), advocate for the use of universal and culture-specific strategies and roles, and balance individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems (Sue & Sue, 2008). Culturally competent multicultural practice is a growing area of focus in research particularly because of its potential to impact the relationship with the client.

Increasing amounts of research advocate for the use of cultural competency as a mechanism to address disparities; however, there are differing definitions among organizations and researchers, as well as means of implementation. Cultural competence can be thought of as the act whereby a medical professional develops awareness of one's existence, thoughts and environment without having those aspects have an undue influence on those for whom care is provided; it is the adaptation of care in a way that is congruent with the client's culture, which can be manifested as care designed to meet the needs of marginalized groups and communities of people who have some distinct characteristics that differentiate them from the mainstream (Giger et al, 2007) .

Betancourt, Green, and Ananeh-Firempong (2003) goes on to state that variations in patients' health beliefs, values, and behaviors, which include ability to communicate symptoms to provider, patient recognition of symptoms, expectations of care, are factors that influence patient and physician decision making and the interactions between patients and the health care delivery system, thus contribution to health disparities.

Kritek (2002) stated that cultural competence was recommended as an educational tool to redress issues of health disparity. Another way of conceptualizing cultural competence however, may be that of adopting or working towards cultural humility, which requires practitioners to self –reflect and self-critique as lifelong learners, to evaluate and be

aware of the power imbalances inherent in the dynamics of provider-patient communication, and develop and maintain mutually respectful partnerships (Tervalon & Murray-Garcia, 1998). It is through this approach that practitioners can “learn to identify, believe in, and build on the assets and adaptive strengths of communities and their often disenfranchised members” (Tervalon & Murray-Garcia, 1998, p. 122). Cultural competence training is an area of burgeoning focus in research particularly because of its potential to impact the relationship with the patient.

While cross-cultural work continues to be an important issue of focus within the mental health field, many questions as how to cultivate sensitive and effective practice remain. Cross-cultural practice presents a greater challenge in areas of establishing meaningful relationships and removing obstacles to engagement, as similar backgrounds and experiences have been shown to facilitate connection and the ability to relate to common groups (Allen-Meares & Burman, 1999). At this time there is a limited empirical basis on which to understand how racial and cultural difference affects the unfolding of psychotherapy (Quershi, 2007). Although some research indicates a general reduction in the expression of racial prejudice by White individuals toward Black individuals (Jackson, Brown, & Kirby, 1998; Sears, 1998), negative attitudes toward people of color continue to be manifested in various ways, direct, indirect, blatant and subtle (Ridley, 2005; Bobo, Kluegel, & Smith, 1997). It is therefore essential that researchers devote increasing energy to exploring the dynamics of racial attitudes along with their underlying emotional, cognitive, and developmental influences (Utsey, Ponterotto, and Porter, 2008). It is these aspects, which provide a sense of knowing and

understanding about the historical and current hardships that effect people of color, as well as their legacies and accomplishments (Allen-Meares & Burman, 1999).

Awareness of racial attitudes is essential in working with clients of diverse racial, ethnic, and cultural backgrounds. (Utsey, Ponterotto, & Porter, 2008) In the client-worker dyad, it cannot be denied that the client and the worker's backgrounds are framed by "historicopolitical and sociocultural contexts associated with race relations and power differentials" (Comas-Diaz & Jacobsen, 1995, p. 94). According to Comas-Diaz and Jacobsen (1995), the therapist of color can also symbolically represent the "Other" in the interethnoracial therapeutic dyad and it is in this identification of "otherness" whereby, an individual's conception of people of different racial and cultural backgrounds helps the person to define his or her own concept of self. Being a culturally competent therapist involves understanding, accepting, and incorporating awareness of microaggressions into effective multicultural/social justice counseling practices (Chung, Bemak, Ortiz, and Sandoval-Perez, 2008). In addition it requires an awareness that frequent exposure to negative media messages and other forms of institutional racism may lead mental health professionals to consciously or unconsciously internalize harmful views of immigrant or minority groups; the conscious or unconscious internalization of such views may result in negative reactions counselors have in counseling situations that involve clients from immigrant, and by extension other ethnic/racial minority populations (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008).

As part of the therapeutic work, a cognizance of these dynamic and historical legacies becomes key to fostering a positive alliance. African American professional women seeking therapy reported that they found it difficult to convey their feelings to a

clinician who has not experienced the “subtle, insidious, and pervasive impact of racism” (Cooper & Lesser, 1997, p. 325). What appears consistent is that in cross racial and cross cultural dyads, clients of color may require therapists to demonstrate the ability to take risks and prove their awareness, sensitivity, and skill in dealing with racial and ethnic matters (Constantine & Kwan, 2003). In a qualitative study by Knox et al (2003), the experience of 12 licensed psychologists in addressing race in cross racial therapy dyads were explored and it was found that the African American clinicians routinely addressed race with clients of color or if the issue of race was part of the client’s presenting issue. European American providers indicated that the topic would only be addressed if the clients raised the topic; however, some also reported that they did not normally address race with racially different clients and admittedly felt uncomfortable addressing it (Knox et al, 2003). An important finding of the study however was when the discussions of race did occur; it had a positive effect on the therapy (Knox et al, 2003). Constantine’s (2007) empirical study examined forty African American clients’ perceptions of their White counselors specifically in the areas of perceived racial microaggressions, the counseling working alliance, the counselor’s general and multicultural counseling competence, and counseling satisfaction. Findings indicate that the higher the prevalence of perceived racial microaggression by African American clients, the weaker the alliance with the therapist, which then predicted lowered ratings of general and multicultural counseling competence and satisfaction ratings. What the study did not address however is the impact of perceived racial microaggressions in counseling on the mental health functioning of African American clients, how clinicians might learn to identify racial microaggressions in themselves and in others, and how to address these biases and

ruptures in treatment so as to repair the therapeutic alliance. Sue et al (2007) notes that most interracial encounters are prone to microaggressions and that there is no established theoretical or conceptual model of racial microaggressions to explain their impact on the therapeutic process. As there is limited research currently available specifically from the clients' perspective about 1) how racial microaggressions within the therapeutic relationship impact second generation American people of color's perceptions of mental health treatment and sense of self, 2) their means of coping with such encounters, and 3) by extension their ability to engage or remain in treatment, it becomes an even more pressing issue to further explore as it has broader implications in practice for clinicians.

Immigrant Status and Mental Health

A gap that remains in the racial microaggression literature however is that of the experience of second generation American people of color whose parents are foreign born and immigrated to the US. The population samples in the studies evaluating racial microaggressions tend to be monoracial (Sue et al., 2008; Constantine, 2007; Constantine & Sue 2002; Knox et al 2003, Solarzano, 2000; Sue et al., 2008, Torres et al., 2010; Sue et al 2007, Wang et al, 2011a; Huynh & Fuligni, 2010; Rivera, Forquer, & Rangel, 2010) but heterogeneous in immigration status/ experience, not making the distinction between first generation Americans, who are foreign born then immigrated to the US, and second generation Americans, who are the children of immigrants born in the US. It is important to make the distinction between groups as perceptions of racism, mental health, the mental health system, and attitudes towards seeking treatment are effected by immigration factors; according to the APA (2012), immigrant parents and their children live in different cultural worlds since immigrant parents are immersed primarily in one

cultural context and their children in another. Immigrants are discriminated against for reasons including immigration status, skin color, language skills, and income and education levels (APA, 2012); however, how these are interpreted and experienced by first generation versus second generation American remains unexplored. Many immigrants who come from countries that are monoracial do not have experience dealing with race-specific issues (Williams et al, 2007; Miller, Yang, Farrell, & Lin, 2011). Relatively little attention has been paid to variation between Black Caribbean immigrants and African Americans in terms of mental health issues (Williams et al, 2007); in addition, previous mental health research on Latino and Asian populations note that characteristics of nativity and the immigrant experience are associated with mental health issues (U.S. Dept of Health and Human Services, 2001). Previous studies on Asian Americans have been based on unrepresentative samples of the population, such as college students seen in university counseling settings (Gim, Atkinson, & Whitley, 1990; Atkinson, Lowe, & Matthews, 1995) and those seen in public mental health service settings (Matsuoka, Breux, & Ryujin, 1997; Barreto & Segal, 2005); for Latino Americans, population estimates of mental illness may be incomplete when estimating prevalence across Latino subgroups due to lack of comparison between foreign-born and US-born Latinos (Potte, Rogler, & Moscicki, 1995) and failure of studies to examine migration history, issues of language, and number of years living in the US (Kessler, Chiu, Demler, Merikangas, & Walters, 2005).

Recognizing the need for further research, efforts are being made by researchers to examine mental health status and service utilization among U.S. and foreign born adults. In a report by the Centers for Disease Control and Prevention, researchers Dey

and Lucas (2006), sought to present national prevalence estimates of selected measures of physical health status and limitations, health care access and utilization, and mental health status among the population of U.S.- and foreign-born adults in four race-ethnicity groups. It was found that there were significant differences in mental health status among U.S.-born and foreign-born adults, namely that foreign-born non-Hispanic black and Hispanic immigrant adults experienced fewer symptoms of serious psychological distress compared with their U.S.-born counterparts (Dev & Lucas, 2006). In a special edition of the American Journal of Public Health in January 2007, findings from the National Survey of American Life (NSAL) and the National Latino and Asian American Study (NLAAS) on the prevalence of mental disorders and patterns of mental health service use among minority immigrants and subsequent generations born in the US were published; it was found that immigrants appear to have lower rates of mental disorders than second-generation individuals, but that within each group, risks for particular psychiatric disorders may vary depending on ethnic subgroup, gender, English-language proficiency, years of living in the United States, and age at immigration (Williams, Haile, Gonzalez, Neighbors, Baser, and Jackson, 2007; Takeuchi, Zane, Hong, Chae, Gong, Gee, Walton, Sue, and Alegria, 2007, Alegria, Mulvaney-day, Torres, Polo, Cao, and Canino, 2007; Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegria, 2007). Most notably, second generation Asian Americans were observed to be similar to immigrants in patterns of service use and treatment ratings of perceived helpfulness which suggests that more general factors or even cultural factors may act as constraints to service use (Abe-Kim, et al, 2007). According to Ta, Holck and Gee (2010), the diverse networks (namely social networks outside of the nuclear family) of second Asian

Americans may be more encouraging of mental health service use than the family network of the first generation, which is the primary social network for immigrants. In a review conducted by Escobar, Hoyos, & Gara, (2000), five large-scale studies that examined the prevalence of mental disorders among Mexican-born immigrants and U.S.-born Mexican Americans; the results indicated that Mexico-born immigrants have better mental health profiles than do U.S.-born Mexican Americans with possible explanations including research artifacts such as selection bias, the impact of traditional family networks, and a lower set of expectations about what success in the US looks like. Second generation children are at higher risk of more behavioral conditions such as substance abuse, conduct disturbance and eating disorders (Szapocnik & Kurtines, 1989; Miller & Pumariega, 2001; Pumariega, Rothe, & Pumariega, 2005). Rothe, Pumariega and Sabagh (2011) state that the increased risk may be a result of second generation children facing chronic stressors

“created by poverty, marginalization, and discrimination without the secure identity and traditional values of their parents while not yet having a secure bicultural identity and skills” (p. 78)

It becomes an even more important to be aware of the nuances within the racial and ethnic minority populations so that culturally sensitive intervention can be implemented. According to the APA Presidential Task Force on Immigration and Public Interest Directorate (2012),

“one in five people living in the United States is a first-generation immigrant (born abroad to foreign-born parents) or a second-generation immigrant (born in

the United States to a foreign-born parent or parents),...thirty percent of young adults between the ages of 18 and 34 are first- or second-generation immigrants, and...immigrant-origin children have become the fastest growing segment of the child population with one in three children under 18 projected to be the child of an immigrant by 2020”

With a growing percentage of the minority population consisting of second generation immigrants, it is pertinent that clinicians recognize immigrant history and status as important aspects of variation within the experience of minority populations (Williams et al , 2007; Takeuchi et al, 2007, Alegria et al , 2007) and as factors impacting perceptions of mental health and utilization of mental health services.

Racial Microaggressions and Mental Health

The impact of racial microaggressions on the experience of African Americans (Sue et al., 2008; Constantine, 2007; Constantine & Sue 2002; Knox et al 2003, Solarzano, 2000; Sue et al., 2008, Torres et al., 2010), Asian Americans (Noh, et al, 2007, Sue et al, 2007, Wang et al, 2011a), and Latino/a adolescents (Huynh & Fuligni, 2010) and adults (Rivera, Forquer, & Rangel, 2010) have been studied. In the research by Rivera, Forquer, and Rangel (2010) eight major domains were identified in their study on microaggressions and the life experience of Latino/a Americans: 1) ascription of intelligence, 2) second class citizen, 3) pathologizing communication style/cultural values, 4) characteristics of speech, 5) Alien in own land, 6) criminality, 7) invalidation of the Latino/a experience, and 8) other assumed Latino/a attributes. A study conducted by Sue and colleagues (2007) focused on racial microaggressions and the Asian

American experience and identified similar themes in research conducted prior, but also outlined new categories; the eight microaggression themes included the following: 1) alien in own land, 2) ascription of intelligence, 3) exoticization of Asian women, 4) invalidation of interethnic differences, 5) denial of racial reality, 6) pathologizing cultural values/communication styles, 7) second class citizenship, and 8) invisibility, with a ninth category used to classify “undeveloped incidents/responses” mentioned by a few study participants. While the research on microaggressions continues to expand, greater exploration is needed to understand how microaggressions impact the mental health of people of color. In an integrative review of literature on the psychological and emotional impact of racism on people of color, Carter (2007) noted the importance of recognizing the “systematic, covert, subtle, and unconscious” (p 17) ways in which racism operates so that the potentially traumatic impact of it can be better understood; Carter went on to note that due to the cumulative nature of racism, a minor event may trigger a stress reaction. In sum, there was evidence that racism has a negative impact on the mental health of people of color, which can manifest as symptoms of depression and anxiety and lower well being (Carter, 2007; Utsey et al., 2008, Williams, Neighbors, & Jackson, 2003).

In another study examining race-related stress and stressful life events, it was found that race related stress was a more powerful predictor of psychological distress (Utsey et al., 2008); racial microaggressions can be seen as more harmful and damaging to African Americans than stressful life events. Sue (2010) posits through his theoretical work that this may be likely since

“1) microaggressions are symbols and reminders of racism, sexism, and heterosexism; 2) microaggressions are continual and perpetual...3)

microaggressions impact nearly all aspects of the target's life... and 4) stressful life events have a recognizable cause while microaggressions are often ambiguous and invisible" (p.96)

Given that people of color experience discrimination in some form on a daily basis in comparison to the racial majority group, it is inevitable that the experience of microaggressions will have an impact.

There is evidence that the subtlety to racial microaggressions can affect mood and somatic symptoms. Microaggressions can potentially be harmful because of their ambiguous nature, specifically creating doubt in the recipient as to whether the individual misinterpreted or was overly sensitive (Sue et al., 2007; Harrell, 2000). Emotional reactions, cognitive appraisal of discrimination (specifically feeling exclusion, powerlessness, shame, and discouragement) and depressive symptoms were associated with subtle discrimination among Korean immigrants (Noh, Kaspar, & Wickrama (2007).

It has been found among various ethnic minority populations that experiences of microaggressions have an impact on mental health. Research shows that perceived stress mediates the association between microaggressions and depression among African American graduate students and professionals; Torres, Driscoll, and Burrow (2010) state "given that racial microaggressions contribute to perceived stress, African-Americans have the added burden of managing these race-related events, which ultimately puts them at greater risk for experiencing depressive symptoms" (p 1094). Among the Asian American Pacific Islander population, perceived discrimination negatively impacted physical and mental health (Sue et al., 2007; Gee, Spencer, Chen, Yip & Takeuchi,

2007), as well as that of Latino adolescents who endorsed more depressive and somatic symptoms (Huynh & Fuligni, 2010). Connections between racial microaggressions and anger, frustration, and resentment among Asian American college students were found (Wang, Leu, & Shoda, 2011). One study examining the experiences of African American college students who encountered microaggressions noted feelings of isolation, feeling drained and a questioning of their experiences (Solórzano et al, 2000). It seems those who experience multiple discriminatory instances may become increasingly angry which then places the individual at risk for poor psychological outcomes (Mahon, Yarcheski, & Yarcheski, 2000).

People of color have found adaptive and maladaptive means to manage microaggressive stressors. It was observed that typical reactions to microaggressions consist of hypervigilance, forced compliance, rage and anger, fatigue and hopelessness, and strength through adversity (Sue, 2010). Hypervigilance or a cultural mistrust towards majority group members may have developed as a response to multiple experiences of discrimination and anticipation of prejudice (Ponterotto et al., 2006; Ridley, 2005). Forced compliance can be understood as censoring one's true feelings and behaving in such a way that is not threatening to Whites (Sue & Sue, 2008). Rage, anger, fatigue and hopelessness can result from frustration and feeling overly taxed from microaggressive stressors (Sue, 2010). Strength through adversity is the idea that people of color can survive, thrive, and function adaptively in a society that is not accepting (Sue, 2010). While it has been observed that people of color who experience microaggressions utilize these coping responses, it remains unclear however as to what impact microaggressions have within the context of a therapeutic encounter, for the client who is second

generation American, for the therapeutic relationship, and what can be done by the clinician, if anything, to address this rupture.

Theoretical Frameworks

While no single specific theory is identified as the basis for the concept of racial microaggressions, social learning and cognitive theory, specifically schema theory, critical race theory, racial identity formation theory, and object relations theory seems most applicable as they pertain to shaping of perspective based on one's past experiences (or fears), the influence one's past experiences have in appraisal of situations, and the dissonance that can result in intercultural interactions.

Schema Theory

Developmental psychologist Jean Piaget introduced the term schema when describing cognitive development. Piaget theorized that cognitive development occurs in stages, and is dependent on maturational and environmental/experiential factors (Tudge and Winterhoff, 1993). He argued that learning is a process of interaction between the individual and the environment with knowledge constructed based on cognitive structures and experiences (Piaget, 1964). The main components of Piaget's cognitive theories include schema, assimilation (making information fit with preexisting knowledge), accommodation (changing information to fit if there are discrepancies between existing mental schemata and events), and equilibrium (balance of information) (Piaget, 1964). Schemas are generalized collections of knowledge of past experiences and of incoming information which are organized into related knowledge groups and used to guide our behaviors in familiar situations; they provide a simplified framework integral to

perceiving, organizing, understanding, recalling, representing, and inferring (Garro, 1999; Nishida, 1999). Schema theory was developed by Sir Frederic Bartlett in the 1920s to account for data that he gathered on memory; it was from this work that he conceived of schemata, unconscious mental entities like images (Brewer, 2000). Bartlett (1932) stated that in the recall of pictures “inferences...are mingled unwittingly with the actual recall of perceptual matter or patterns” (p. 52); he goes on to state that in the recall process

“The need to remember becomes active, an attitude is set up; in the form of sensory images, or, just as often, of isolated words, some part of the event which has to be remembered recurs, and the event is then reconstructed on the basis of the relation of this specific bit of material to the general mass of relevant past experience or reaction.” (p.209)

In discussing self schemata, Markus (1977) highlighted that once established these schemata function to determine whether information is attended to, how it is structured, its meaning, and subsequent course of action, which may be used as a basis for future decisions and inferences. Interpretations are constructed to make sense in terms of prior accrued knowledge and experience (Garro, 1999). When interacting or talking with the members of the same culture in certain situations repeatedly, schemas are generated and stored in our brain; the development of schemas is a product of direct experience and also by talking about schema related information (Nishida, 1999). Self-schema enables processing of information about the self with relative ease, retrieval of behavioral evidence, prediction of one’s future behavior and resistance to counterschematic information about oneself (Markus, 1977). In schema theory, a change in the environment elicits a change in a context schema, and this further impacts role, strategy,

and procedure schemas (Nishida, 1999). Intercultural interactions can then be thought to challenge one's schema. For example, when people encounter unfamiliar situations in the host culture where they lack appropriate schemas, or means of mediating, individuals can become stressed because of the disintegration of context and other related schemas; in order to address this individuals often selectively direct their attention to integrate information using their native culture schemas (Nishida, 1999). This sheds light on the position from which both client and provider who are of differing cultural backgrounds construct meaning and understanding during exchanges. Nishida (1999) goes on to further highlight this point by stating that interactants in intercultural communication may not share the schemas of each other's cultures, which then calls for accommodation. Each time a schema adapts to a novel situation or event, one's mind registers the results, and slowly over time the shape and complexity of the schema is modified to the requirements of the environment (Nishida, 1999).

Culturally competent multicultural practice can be thought of similarly in that clinicians acquiring new skills and understanding through training and education can better mediate the demands of a diverse client population. Rentsch and colleagues (2007) highlighted that a schema for cultural understanding may aid novices to quickly learn unfamiliar cultural tenets, allowing for development of a schema for cultural knowledge, having cultural concepts serve as a guide even when one's familiarity with a specific culture is limited. This method of mental organization dominates thought processes. Categorical accounts of ethnicity begin with a conglomeration of ethnic "traits" or lists of things believed to be descriptive of persons in a particular group; this approach involves a mental process of sorting and matching specific traits so that one can identify individuals

on a predetermined schema of what people in specific identified groups are believed to be like (Green, 1999). Categorical thought comes with a set of assumptions about assimilation and the degree of match between the individual and the constellations of traits that are believed to describe a specific group of individuals (Green, 1999). As noted in the work of Nishida (1999) and Garro (1999), schemas are used to guide behaviors in situations; however in unfamiliar intercultural situations where there appears to be dissonance in categorical thought (that are part of the schema), accommodation occurs so that the schema is modified accordingly to be inclusive of the uniqueness of the client, which can be thought of as an integral aspect to culturally competent multicultural practice.

There is a danger on operating from a categorical approach as it requires that the observer (likely from the dominant culture) view the ethnicity of others as combination of traits that *they* (rather than us) exhibit; there is also a tendency to ascribe solely to the norms of White families as healthy without regard to diversity in class, ethnicity, and sexual orientation (Green, 1999; Reid, 2002). Since the professionals' role is to conduct assessments, which involves seeking information and interpreting client's behaviors, the clinicians' own behavior is left relatively unscrutinized due to their position of authority within the dyad (Whaley, 1998). While useful in the processing of information, there is a danger in assuming homogeneity through this approach. Vasquez (2007) writes that the challenge in learning about different cultural groups is stereotyping and instead what should occur next is to use the information and knowledge to deepen understanding and assess the degree of application of various cultural values, behaviors, and expectations with one's particular client. What makes cultural pluralism more socially acceptable, and

palatable, is that it stresses distinctiveness of ethnic groups and appreciates cultural differences. When individuals from different cultures interact, there is always the potential for the cultural difference to create the context for self-definition in opposition to the other; however it is through perspective taking of the culturally different other that psychically integrative movement can occur (Altman, 2009). It is through this fluid, transactional approach where boundaries between groups are emphasized, differential expression of surface features within groups is presumed, conceptual complexity within a comparative perspective is sought, resolution within indigenous frameworks is the focus, and resistance to political and cultural dominance is expected (Green, 1999). It becomes important then to recognize the influence of schemas in shaping perceptions, especially within the therapeutic context where the clinician and client are of differing racial/ethnic backgrounds, as there may be an inclination on the part of the clinician to integrate information using their native culture schemas in order to address the stress that arises in lacking appropriate schema for the other (Nishida, 1999), instead of consciously creating space for what the client brings.

For people of color, similar processes/schema are activated. Most people of color are capable of demonstrating racial sensitivity when interacting with whites as they have extensive exposure to whites and learn early on as to what leaves the latter feeling racially comfortable (Laszloffy and Hardy, 2000). This schema then influences the ways in which people of color interact with whites. In a study by Chan and Yoon (2011) it was found that clients of color intentionally concealed aspects of their personal histories and experiences in order to lower their exposure (real or imagined) to microaggressions; the participants indicated that while in treatment there was the delicate task of trying to

protect themselves against “exposure to oppressive or discriminatory treatment from the therapist” while also wishing to reveal their authentic self. As it is documented that rates of utilization of mental health services by people of color is lower than that of whites, it becomes even more important for therapists to connect with clients during the initial stages of counseling.

While schemas provided a framework for understanding, organizing and inferring (Garro, 1999), there was potential for stereotyping to occur (Vasquez, 2007). As globalization increased our contact and communication with different communities and cultures, perspectives evolved to reflect deeper understanding of cultures. Within the therapeutic relationship, the postmodernist task is to interpret narratives, recognizing that in speech the speaker/interpreter and the hearer/interpreter are both equally involved in a reality-creating activity; it offers something new in that therapeutic dialogue is not translated by the worker/listener into the globalized, totalizing categories that are the hallmark of much academic writing, research, etc., rather “we seek to understand what to our clients is local knowledge and how that knowledge is expressive of certain kinds of qualities of experience” (Green, 1999, p 41). The shift in multicultural approaches is also informed by the social constructionist movement in, which the social aspects of knowing and the influence of culture, history, politics and economic conditions are highlighted (Dean, 1993). In essence, working towards cultural competence through cultural humility, specifically in engaging in self reflection and self evaluation, having awareness of power dynamics within the provider-client relationship, and fostering mutually respectful and beneficial partnerships, so as to effectively and respectfully deliver care to diverse populations (Tervalon & Murray-Garcia, 1998). Clinicians work with a diverse

client base who suffer from social and economic inequities that impact the extent to which his or her beliefs and values are determined by his or her position in the world; individuals live and understand their lives through socially constructed narrative realities that create meaning and help to organize their experience (McNamee & Gergen, 1992). The idea of cultural competent multicultural practice as intervention seems appropriate to bridge the gap in fostering cultural understanding; however, one must be wary so as not to make generalizations as well as inadvertently reinforce oppressive power dynamics within the relationship.

Critical Race Theory

Critical race theory utilizes the strengths of multiple disciplines, epistemologies, and research approaches (Scheurich & Young, 1997), in order to specifically address the complexity of race and racism by exposing the dynamic ways in which they interact, unfold, and manifest both with and within various systems (Solarzano, 1998). A product of its time, critical race theory developed in the 1970s as a response to stalled progress of civil rights litigation which during that period was struggling to produce meaningful racial reform (Taylor, 1998). Mari Matsuda (1991) defined critical race theory as:

“the work of progressive legal scholars of color who are attempting to develop a jurisprudence that accounts for the role of racism in American law and that works toward the elimination of racism as part of a larger goal of eliminating all forms of subordination”. (p. 1331)

More recently, it has been applied by diverse disciplines wishing to examine how racism operates on implicit, explicit, institutional, and individual levels to impact how Whites

and people of color live (Brown, 2003) and intersects with other forms of subordination such as gender and class discrimination (Crenshaw, 1989, 1993). Critical race theory highlights race and racism as endemic, difficult to comprehend and possibly impossible to remedy given structures of privilege entrenched to benefit the self-interest, and power of whites, and as socially constructed categories that society invents and manipulates; however critical race theory allowed for the creation of space for people of color and other oppressed populations by acknowledging and legitimizing their experiential knowledge (Brown, 2003). By challenging the normative standard of the White experience and grounding its framework within the distinctive experiences of people of color (Taylor, 1998; Solarzano, 1998), space is created for a multitude of experiences while acknowledging that, “perceptions of truth, fairness, and justice reflect the mindset, status and experience of the knower” (Taylor, 1998, p 122.) Taylor (1998) goes on to state that “the social and experiential context of racial oppression is crucial for understanding racial dynamics, particularly the way the current inequalities are connected to earlier, more over, practices of racial exclusion” (p 122). A valuable component of critical race theory is that of counterstorytelling. According to Solarzano (1998), counterstorytelling is a method

“of telling the stories of those people whose experiences that are not often told (i.e. those on the margins of society)... a tool for exposing, analyzing, and challenging the majoritarian stories of racial privilege. Counterstories can shatter complacency, challenge the dominant discourse on race, and further the struggle for racial reform. Indeed, within the histories and lives of People of Color, there are numerous unheard counterstories. Counterstorytelling these experiences can

help strengthen traditions of social, political, and cultural survival and resistance.”

p 94-5

Within the context of psychotherapy, the client, not the therapist, is expert on his or her experience, and in constructing a dialogue and shared space between therapist and client, deeper understanding and empowerment occur (Taylor, 1998). With the emphasis on the client's use of language, there is room for the uniqueness of the cultures that inform his or her understanding and perceptions of his or her experience (Taylor, 1998). The therapist is not to act as expert and make interpretations, which can be viewed as objectifying but instead respect the client's knowledge. This shift to a more comprehensive understanding of culture then allows for recognition of the client's individual personal traits, in addition to cultural values, and creates space where pre-determined rigid schemas once limited understanding and perception of the client.

Racial Identity Development

Multicultural counseling approaches have evolved to also encompass the role of racial identity development. Current research suggests clients' reactions to therapy, the therapeutic process, and therapists are influenced by racial identity, with retention rates connected to the clinician's ability or inability to assess the cultural identity of clients (Sue & Sue, 2008). Studies also indicate that perceptions of discrimination were influenced by racial identity statuses of people of color (Watts & Carter, 1991; Hall & Carter, 2006; Pieterse & Carter, 2010) with racial identity potentially offering a form of psychological protection for Black Americans when encountering racism or discriminatory experiences (Cross, Parham, & Helms, 1998). However it is important to

recognize sociopolitical influences as a factor in tandem, in shaping the identity of people of color (Helms, 1986; Sue & Sue, 2008), namely in the experience of navigating different worlds, existing and living in a society centered on the White hegemony while also simultaneously living within the at times invisible world of people of color. Pieterse and Carter (2010) caution that “racial identity in and of itself might not have specific utility with regard to protecting against the psychological harm associated with racist incidents” (p 1045) but nonetheless is an important variable to consider.

Racial identity can be understood utilizing the conceptual framework of Root’s biracial identity development model, Pope and Reynolds’s Multidimensional Identity Model, Cross’ model of black racial identity and the racial/cultural identity model developed by Atkinson, Morten, and Sue (1989). The Cross model is a five-stage model that includes pre-encounter, encounter, immersion/emersion, internalization, and internalization/commitment. Pre-encounter involves the absorption of many of the beliefs and values of dominant white culture, specifically internalization of stereotypes which manifests as attempts to assimilate in order to be accepted by white society (Helms, 1986; Sue & Sue, 2008). The encounter phase is when the person of color’s identity as member of marginalized group becomes more salient as an identified “Other” (Sue & Sue, 2008). Immersion/ emersion involves one surrounding oneself with symbols of his or her own racial identity; while internalization and internalization/commitment phases, signal a positive internalized image of self, greater inner security, and a readiness to connect and build coalitions with members of other oppressed groups (Sue & Sue, 2008). The concept of dual identity can be thus thought of as both partial product and part of the process as one moves along the continuum of Cross’s model.

The Racial/cultural identity development model originally proposed by Atkinson, Morten, and Sue (1989, 1998) was later elaborated on by D.W. Sue and D. Sue (1999) to be more inclusive of a broader population. The model describes the stages of development that oppressed people move through as they attempt to understand themselves in terms of their own culture, the dominant culture, and the relationship between the two (Sue & Sue, 2008); it encompasses the stages of conformity (similar to Cross' pre-encounter stage), dissonance (conflict between information or experiences that challenge current self-concept), resistance and immersion (feelings of guilt and shame for "selling out" his/her racial group and then anger towards the oppressive dominant group), and introspection, and integrative awareness, which involves a sense of security with his or her own culture as well as that of the dominant culture (Sue & Sue, 2008).

The preceding models however, did not necessarily accommodate for the identity development process of those with multiple identifications. Building off of other models' early stages of identity development among people of color, the Root (1990) model for biracial identity takes into account various components of identity and for that reason may be able to more fully capture the nuanced experience of second generation people of color since, similar to the experience of biracial individuals, a major source of internal conflict involves "a core sense of definition of self" (p 204). Noting tension in the areas of family and society, Root (1990) proposed four possible outcomes in identity development: 1) acceptance of the identity society assigns, 2) identification with both racial groups, 3) identification with a single racial group, and 4) identification as a new racial group. Within this model there is space for various aspects of identity, as well as flexibility to fluidly move among the possible outcomes. Pope and Reynolds (1991)

further expanded on Root's model in order to deepen understanding of the existing "options for identity resolution for members of more than one oppressed group" (p. 178), creating the Multidimensional Identity Model (MIM); in the model, the options include passive acceptance by identifying with one aspect of identity assigned by society, actively and consciously identifying with one aspect of self, identifying with multiple aspects of self by living in disconnected worlds, and identifying as a new group by focusing on the intersection and integration of these multiple identities (Pope & Reynolds, 1991). The dynamic, nonlinear process of the MIM not only creates space to hold an individuals' multiple identities, but it also demonstrates that there are opportunities for pride and self esteem (Pope & Reynolds, 1991). It is in understanding where a client is in his or her racial identity development, the sociopolitical factors informing his/her experience and perspective, as well as how it may affect how racial interactions are perceived and internalized, that clinicians can thus have a deeper grasp as to the client's narrative and how he or she experiences cross-racial interactions.

Object Relations Theory

Object relations theory, as developed by Melanie Klein in the early 1900s, specifically focused on the dynamic unconscious, the libidinal drive, and the aggressive drive; however, one of the most notable aspects of her work was that it framed development as "organized around the vicissitudes of object relationship and conceptualized the dynamics of all forms of psychopathology as object relationship conflicts" (Summers, 1994, p.73) Klein was influenced by the work of Sigmund Freud, who introduced the idea of the unconscious and drive theory, which highlights that babies are born with libidinal and destructive drives, and depending upon development of and

relationship between these drives, influence functioning (Greenberg & Mitchell, 1983; Summers, 1994). Melanie Klein's work addresses the intersection between internalized interactions with others and defensive processes and others have used her framework to demonstrate the dynamic process of racism (Altman, 2009; Clarke, 2003). Object relations theory focuses on interaction that an individual has with others and the process through which those interactions are internalized. It maintains that all people have an unconscious world of relationship and that these internal mental representations of others and the self are just as important as real world relationships held by individuals (Flanagan, 2008). Melanie Klein's work was innovative and complex as it focused on the more primitive, darker aspects of the mind. Klein's theories made it possible to have deeper understanding of the negative aspects (i.e. aggressive, hostile) of self by presenting the self as already inherently containing the negative emotions, such as anger and envy (Cushman, 1995). Klein's theories of the paranoid-schizoid position, projection, splitting, and projective identification are especially pertinent in understanding racism. In discussing stages of development of the infant, Klein highlighted two stages or "positions", the paranoid schizoid position and the depressive position. With the paranoid schizoid position, the main fear is that persecutory parts of objects will get inside the infant, overwhelm and possibly annihilate it; while, the depressive position involves the child becoming more integrated, realizing that the good person/self that gives love is also the bad person/self who hates (Flanagan, 2008). These positions, or internal states, are part of the lifespan and experienced throughout the life cycle (Flanagan, 2008).

In object relations theory, the neonatal period, the first stage of life for the infant can be perceived as a frightening time in which the child attempts to organize and manage its environment (and experiences of otherness) through use of defense. Projection, splitting, and projective identification are all defenses; however, Klein is best known for her theory of projective identification, which involves both splitting and projection. In splitting, the positive and negative aspects of self/others are experienced as separate or kept apart while projection involves getting rid of wanted parts of the self and placing them into others. (Flanagan, 2008). When an individual splits unwanted parts of him or herself and projects it onto another, the recipient is made to feel the same way. In the process, the individual has achieved a degree of separateness while still in some ways merged with the recipient. Splitting can be thought of as masking the intolerable and the unthinkable (Yanay & Siles, 2009). An individual's internal world can be thought of as representations of self and other, formed by ideas, memories, experiences with the outside world, which can take on deep emotional resonance and endure over time (Flanagan, 2008).

Racism (with microaggressions being a manifestation) can be viewed as dynamic in that it consists of delineation and rejection of difference and internalization of those representations . Using an object relations framework, Timimi (1996) posited that racism is driven by the underlying anxiety (fear and apprehension) that is associated with a person's difficulty in tolerating people who are racially different from themselves and the inability to resist attempts at controlling or dominating those persons. Individuals for whom racism serves as a means of controlling external objects that are different from them tend to manifest increased levels of underlying anxiety (Greenberg & Mitchell,

1983). In Melanie Klein's concept of projective identification, despised parts of ourselves are projected out and onto the world/other (Klein, 1946). If applied to the concept of racism, it can be said that in the process of projective identification, the other is filled with the bad and that the subject "completes the split by using denial and omnipotence to support a sense of paranoia," meaning that the subject sees him/herself as good, the Other as bad, and the Other therefore is dangerous and threatening (Thomas, 2008, p.188). It seems as if throughout this unconscious process, there is an element of awareness, or pre-consciousness, that as the subject has done this to the Other, the Other can respond similarly. The subject then has a fear that in expelling parts of him/herself into others, s/he can be invaded by the Other, controlled, and persecuted; it is this fear, which reinforces paranoia (Clarke, 2003). Projective identification can be a vehicle to enact the phantasy (mental processes) that the Other possesses these negative traits and, thus, is dangerous. Altman (2009) writes that racial categories seem to take on a life of their own as people reify them and use them as the basis to establish a sense of identity (through projection, which involves placing into the world experiences and characteristics that are part of oneself as if they are part of someone else, and introjection, understood as taking in and internalizing experience and parts of objects) and solidarity with others.

Wilfred Bion (1988), an analyst who was a follower and contemporary of Melanie Klein made an important contribution to the concept of projective identification by making a distinction between pathological and normative functioning. The aim of pathological projective identification is to rid oneself of the unwanted internal experiences by projecting them into someone else, thereby gaining a sense of control over

them. When operating in a racist mode, pathological projective identification involves an enormous degree of hatred and splitting, loss of ego, omnipotent control and a desire to destroy awareness, with the recipient acting as a container of feelings of fear and hatred (Clarke, 2003). The construction of race via projective identification, a defensive-reality obscuring process, by white people thus erases the subjectivity of black and brown people (Altman, 2009, p.138). Normative projective identification however involves creating a state of mind and feeling in the other person that enables communication about what may otherwise be an unbearable internal experience, which in the process can engender empathy (Weber, 2005). This distinction highlights that identification processes are dynamic and that there are different ways in which the subject and object participate in the interaction. Altman (2009) goes on to state that

“to the extent that black people come to believe that their identity is defined by their image in the minds of whites, white projections become not merely a fantasy in the minds of white people, but also, in fact, black people can become the dumping group that whites need in order to deny their own negative qualities, in the service of constructing an idealized image of themselves.” (p. 109)

His statement calls to mind the importance of how integral one’s sense of identity is in shaping one’s experience and perception of him/herself and others. Through projective identification, the subject in a way makes the phantasy real.

For people of color and other oppressed populations who have been subjected to violence or maltreatment because of their difference, the induced response of fear and inferiority is tangible. Oppression, prejudice, and discrimination are all powerful

experiences that get inside the internal world, just as interactions with family do; racism also can get inside the individuals who suffer from them, shaping and coloring their world (Flanagan, 2008). While it is true that “bad” parts are projected onto the “Other” it is also true that the environment creates and reinforces the dynamic. Fonagy and colleagues (2002) discussed how an individual’s sense of self is derived from the perceived experience of oneself from how others hold him or her in mind; on a social scale, black people are subjected to the white world’s stereotypes that are constantly in media, schools, stores and on the streets (Altman, 2009).

Within a cross racial therapeutic dyad consisting of a White clinician and a client of color, racial and cultural difference cannot be overlooked. How difference is acknowledged and addressed is integral to the therapeutic process and will affect the therapeutic relationship. Given the documented racial disparities in mental health utilization, it is even more pressing to explore what is contributing to the trend and what specific interventions are effective. Racial microaggressions as viewed from the lens of schema theory and object relations theory involves a dynamic process between individuals in which one’s perspective is informed by past experiences or fears that then impact one’s perception and subsequent behaviors. While racism is acknowledged as a factor impacting the dynamics between client and clinician, the process of racism within the cross-racial dyad and how it influences clinician’s way of responding to clients of color remains of area of inquiry. Ultimately having a deeper understanding of how people of color experience, navigate, and cope with such experiences is not only an opportunity for clients of color to give voice to their experience, it also informs

clinicians' practice so as to potentially reduce the likelihood of therapeutic rupture, as well as offer insight into repair.

Methods

A qualitative approach was utilized, specifically, semi-structured interviews were conducted and data was analyzed through the lens of grounded theory. The qualitative approach is particularly useful in that the researcher is trying to “make sense of the participant trying to make sense of what is happening to them” (Smith, Flowers, Larkin, 2009, p3). The exploration will aid in establishing a broader base of knowledge in the realm of multicultural practice as well as providing a space to have the experiences of people of color shared. Grounded theory emphasizes systematic rigor and thoroughness from initial design, through data collection and analysis, resulting in generation of theory, which starts with basic description, moves to conceptual ordering and then development of theory (Patton, 2002). Participants’ experiences were systematically analyzed in stages starting with open coding, to categorization, to axial coding, and then synthesizing those categories into meaningful interrelated constructs (Glaser & Strauss, 1967). The qualitative approach is useful for developing a deeper understanding about a shared experience about a particular phenomenon, which then will inform interventions, as well as provide a larger information base for a topic scarcely explored in the literature.

Inclusion and Exclusion Criteria

To be included as a participant, the interviewee self-identified as a person of color, a second generation Asian-American or Latino/a American, a child of immigrants, raised primarily in the US, English speaking, and as having previously been in outpatient individual psychotherapy for a minimum of two sessions within the past 5 years with a white clinician. Individuals who identify as a first generation American, person of color

were excluded from the study as perceptions and attitudes about race and/or racism may differ if the individual identified as a racial minority or racial majority member within their country of origin. Snowball sampling was utilized in order to recruit for total of 12 participants, consisting of 6 second-generation Asian Americans and 6 second-generation Latino/a Americans.

Interviewer

The interviews were conducted and coded by the DSW candidate, who is a licensed clinical social worker, and identifies as second generation Filipina-American. The principal investigator, an African American doctoral level social worker served as an auditor; a co-coder who is also a DSW candidate and familiar with qualitative research, coded transcripts as well in order to reduce researcher biases and provide an outside perspective.

Procedures

The targeted sample size was that of 12 interviewees (six second-generation Asian Americans and six second-generation Latino/a Americans) with all one to two hour interviews conducted within a six month time frame. The researcher did outreach to colleagues who work in agencies and academic settings, as well as professional associations for potential participants by way of an email and flyer that included mention of inclusion/exclusion criteria and a brief comment on areas of exploration in the interview. It is important to note, the researcher specifically refrained from recruiting the participant within the clinic she works at or recruiting within her social circle. Outreach was done to chairs of anti-racist organizations in New York City (NYC), as well as the

minority task forces (Asian American Social Work Task Force, Task Force of Social Workers of African Descent, and Latino Social Work Task Force) affiliated with the National Association of Social Workers – NYC chapter, as well as through social work programs alumni list-serves and university counseling centers, highlighting aims of the research and seeking support for the recruitment of study participants. Standardized text for recruitment can be found in Appendix A. Prior to the start of the interview, a face sheet was completed by each participant; the researcher highlighted the purpose of the study, specifically focusing on the participant's experiences of subtle racism in the therapeutic dyad, and the term racial microaggressions was defined. Examples of microaggressions were provided.

Confidentiality was discussed, the consent form reviewed, signed, and any questions about the study answered. The interview was held in a colleague's private practice office, which had been reserved for two hours specifically to conduct the interview. The interviews were recorded and transcribed by the researcher. Participants who lived outside of the New York City metropolitan area were interviewed through Skype. Each participant was given a code number and his/her name (as well as other identifying information) deleted from the data after the interview. Consent forms and data are stored in a locked cabinet in the researcher's office to which only the researcher has access; consent forms and transcripts are kept in separate drawers. As an incentive, participants were given a \$50 dollar Barnes and Noble or CVS gift card. The face sheet and interview protocol are included in Appendices B and C. In addition to being presented with consent forms at the start of the interview, the interviewee was asked several questions for the face sheet, including date, time, and location of interview. The

participant was asked about his/her racial identification, ethnicity, age, gender, religion, where he or she was born and raised, education history, history of outpatient psychotherapy (specifically type of setting, length and duration of treatment), and racial/ethnic background of treatment providers. To ensure that all participants were provided with similar opportunities to address specific topics, a series of questions were prepared in order to facilitate participants' discussion of their experiences. The questions were focused on the microaggression experience, how microaggressions affected the participant, his or her reaction and means of coping, as well as how the experience impacted the participant's relationship with the clinician and the participants' perceptions and feelings about therapy. Through this inquiry, it was hoped that there could be a richer understanding garnered as to the participant's thoughts and feelings about experiencing microaggressions in therapy, the way it influenced perception of the clinician and therapy, and impacted continued engagement.

Data Analysis

Coding Procedures

Through the use of an intensive interview, a clearer sense of the essence of the experience of a people was distilled and provided concrete information about an otherwise abstract concept. Twelve audio taped interviews were transcribed, a series of coding done, first with initial open coding, followed by axial coding in order to establish recurrent themes/categories and connections among them. Analytic memos were included as the collection of interpretations and notes made by the researcher from the start to end of the study became part of the data that enhanced the analytic process

(Morrow, 2005). The only individuals who had access to the participant related material (i.e. audio taped interviews, consent forms, transcripts, etc.) are the researcher who listened and transcribed the interviews in the researcher's office where study consents, audio tapes, interviews were kept in a locked cabinet in different drawers.

The interviews were coded with initial open coding, then axial coding, in order to establish recurrent themes/categories and connections. Initial open coding of the data, which involved the researcher identifying concepts and their properties and dimensions (Strauss & Corbin, 2008), resulted in over 500 concepts or experiences. Strauss and Corbin (1998) state that the purpose of axial coding is to "begin the process of reassembling data that were fractured during open coding" (p. 124), which involved grouping category notes into main and subcategories. Through the process, five main categories representing the experiences of the majority of the participants emerged. A memo was written for each category examining its properties and dimensions. Selective coding is the process of integrating and refining categories with the goal consisting of developing a theory explaining the relationship among the categories (Strauss and Corbin, 1998); a core category that captures the experience of the participants would then be identified. The main categories were reviewed, resulting in seven theoretical categories. Through axial and selective coding, a central phenomena was identified, specifically navigating racial microaggressions, and causal conditions, consequences and strategies used, were explored.

Trustworthiness

Member checking was done in order to ensure validity (Mays and Pope, 2000). Maxwell (1996) states that member checking, or soliciting feedback from participants, is the “single most important way of ruling out the possibility of misinterpretation of the meaning of what they say and the perspective they have on what is going on” (p. 94).

Study participants were contacted via email after coding of the data and invited to discuss the preliminary findings to assess whether the researcher accurately captured the participants' experience and were representative of the main points the participant thought were important; study participants' reactions to preliminary findings were incorporated from notes into the results of the study. Confidentiality was maintained throughout, namely that transcripts did not provide information that could lead to identification of study participants; in the consent form there were clear guidelines and rules about participation in the study, which also addressed risk that disclosures that reveal harm to self or others which would require that confidentiality be overridden (Hewitt, 2007). To increase the trustworthiness of the classification process, another researcher (a DSW candidate)/co-coder who is familiar with qualitative methods, specifically grounded theory, separately coded and classified the interviews. If there were disagreements in the coding, ways to refine the category were discussed until the researchers, and the auditor reached consensus; in addition, dissertation committee members also reviewed and provided commentary about the emerging categories.

Reflexivity

To ensure that the study meets rigorous standards and bias was addressed, I carried out reflexivity within the context of the study. As the researcher is an instrument,

I was mindful of attending “systematically to the context of knowledge construction, especially to the effect of the researcher at every step of the process” (Malterud, 2001).

Research indicates that reflexivity begins through identifying preconceptions brought into the study by the researcher, presenting previous experiences, pre-study beliefs about the topic for investigation, motivation and qualifications for exploration of the field (Malterud, 2001; Hewitt, 2007; Morrow, 2005). Reflexivity was carried out through self – reflective journaling from start to end of the study. In the journal, an ongoing record was kept including my reactions, experiences, and awareness of biases, which could be set aside or incorporated into the analysis (Morrow, 2005)

In my experience, racism is an experience all people of color encounter as well as negotiating a duality of experience, mediating their existence between the world amongst people of color and within the dominant White American culture. The experience of going between two different cultures has influenced the ways in which I interact with others as well as how I perceive myself; issues of identity and connection to community are constantly in flux since how I present myself in one setting may not be the norm in another. While my identification as a person of color makes me inherently more sensitive to issues race and oppression generally, it also activates a kinship, an intimate awareness of the experience of people of color and the struggles they face. Based upon my own experiences negotiating multicultural and social contexts, I anticipated that microaggressions potentially impacted the therapeutic relationship and people of color’s perceptions of psychotherapy; however the degree to which it was acknowledged or addressed varied.

Human Subjects

This research study was guided by the ethical principles set forth in Belmont Report of respect for persons, beneficence, and justice (Department of Health, Education, and Welfare, 1979, <http://or.org/pdf/BelmontReport.pdf>). In order to protect human subjects and maintain the ethical principles, the following measures were implemented:

- IRB Approval:

The study was reviewed by and approved by the University of Pennsylvania Internal Review Board in order to assure compliance with Federal and University regulations regarding human participants in research before contact was made with human participants (IRB Protocol: 817137).

- Confidentiality:

The research interviewer was trained as to the necessary procedures to protect participants from potential violations, including storing all participant related materials (face sheets, audiotapes, transcribed interviews, consent forms, etc.) in a locked cabinet with identifying data kept in separate drawer from the qualitative data, and all personal information kept confidential from any third parties and only used specifically to achieve the research purposes. No identifying information was included in the final paper/dissertation. Pseudonyms, rather than participants' names, were used during analysis and throughout the dissertation.

- Informed consent:

All the study participants were voluntary and participated freely and were informed of their right to withdraw their participation at any time from the research without any

negative consequences to them. Participants were given consent forms that outlined procedures, the purposes of the research, risks and possible benefits, and a statement offering the participant an opportunity to ask questions and to withdraw at any point from the study. Inclusion and exclusion criteria were also noted. There was minimal risk involved in the study. While there was no direct benefit to the participant, participation assisted researchers in understanding the impact of racial microaggressions and by extension, informed culturally sensitive treatment. See Appendix D for copy of consent form.

Findings

Participants

All interviewees were over age 18, female, and identified as people of color. The age range of participants was from 23 to 45, with the mean age being 30.5. When asked about racial identification, six indicated Asian, two as Hispanic, one as White, one as Native American, and one as biracial. In terms of ethnicity, one identified as Chinese and Malagasy, one as Columbian and Ecuadorian, two as Dominican, three as Filipina, one as Japanese, one as Puerto Rican, and one as Sri Lankan Tamil. Regarding education level, nine participants either completed masters degree programs in social work, education, arts or sciences, or were currently enrolled in a program; two participants had completed undergraduate degrees. All interviewees resided in major metropolitan areas with two being based on the west coast, and nine on the east coast. When asked about religion, two identified as atheist/agnostic, one as Buddhist, five as Catholic, and three as Christian. Participants were also asked about the setting in which they received outpatient psychotherapy as well as duration of treatment; the majority (8) met with

clinicians who were in private practice and the remaining three met with clinicians in university counseling centers. Two participants met with their clinician for 2-4 sessions with nine continuing therapy for 5 or more sessions. Six second generation Asian Americans and five second generation Latina Americans participated in the study. All demographic information can be found in Table 1.

Table 1

<i>Characteristics of Interviewees (N = 11)</i>	
Characteristic	Numbers/Frequencies
Age	
Range	23-45
Mean	30.5
Racial Identification	
White	1
Black	0
Asian	6
Hispanic	2
Native American	1
Biracial	1
Ethnicity	
Chinese and Malagasy	1
Colombian and Ecuadorian	1
Dominican	2
Filipina	3
Japanese	1
Latina	1
Puerto Rican	1
Sri Lankan Tamil	1
Religion	
Atheist/Agnostic	2

Buddhist	1
Catholic	5
Christian	3
Education	
College graduate	2
Graduate degree in progress	4
Graduate degree	5
Outpatient Psychotherapy Setting	
Private Practice	8
University Counseling Setting	3
Duration of treatment	
2 sessions	1
3-4 sessions	1
5 or more sessions	9

In this section, findings from the study are shared. As mentioned in the introduction, the purpose of the study was to explore the reactions of second generation American people of color when racial microaggressions occur in the therapeutic dyad, the impact the microaggressions have on the therapeutic encounter, the coping strategies utilized when having experienced a racial microaggression, the impact microaggressions has on second generation American people of color's perception of psychotherapy, and possible interventions that would have been helpful in repairing the therapeutic rupture. The interview questions focused specifically on the microaggression experience, how microaggressions affected the participant, his or her reaction and means of coping, as well as how the experience impacted the participant's relationship with the clinician and the participants' perceptions and feelings about therapy. The emergent domains consist of five constructs which are of the following: 1) types of racial microaggressions in therapy, 2) influences of client's reactions to racial microaggressions in therapy, 3) navigating the racially microaggressive experience in therapy, 4) the role of therapists, and 5) recommendations for practice. Under the domain of *Types of racial microaggressions* are seven more specific, key themes. (Refer to Table 2.) The domain of *Influences of client's reactions to racial microaggressions in therapy* consists of racial identity development, coping and perceptions of therapy, experiences of microaggressions in everyday life, and navigation of multiple identities. The next section provides an in-depth examination of the constructs that comprise the emergent domains and categories. Interview questions are noted. The section begins with an exploration of the types of racial microaggressions encountered in therapy. In discussing each domain and theme, direct quotes are included to assist in illustrating the emergent constructs. As

discussed in the methods section, each participant was given a pseudonym and quotes are presented under their name. Participants also provided recommendations for practice.

Research Questions pertaining to messages about microaggressions experienced in therapy: In thinking about the racial microaggressive encounter in therapy, what are your thoughts about it? What was your sense of how you were perceived or understood?

Racial Microaggressions in therapy. In discussing the racial microaggressive encounter in the context of therapy with a White clinician, the most common type of racial microaggressions encountered were that of microinsults and microinvalidation. The primary themes that emerged from the interviews with the Asian American participants included colorblindness, pathologizing of cultural values and communication styles, invisibility, alien in one's own land/being perceived as foreigner, ascription of intelligence. Colorblindness, negotiating multiple identities, and alien in one's own land are microinvalidations; pathologizing cultural values and means of communication and ascription of intelligence are microinsults. When Latina American interviewees were asked about the racial microaggressive encounter in the context of therapy with a White clinician, the most common type of racial microaggressions encountered by interviewees were that of microinsults and microinvalidation with primary themes including colorblindness, negotiation of multiple overlapping identities, ascription of intelligence, assumption of superiority, passing as part of the racial majority. Colorblindness and negotiating multiple identities are examples of microinvalidations; assumption of superiority and ascription of intelligence are examples of microinsults. Negotiation of multiple overlapping identities and passing as part of the racial majority are two

categories that emerged from the interviews. Interestingly, while specific themes stood out for each racial/ethnic group, there was overlap in two areas, the themes of colorblindness, ascription of intelligence, and negotiating multiple overlapping identities; both Asian American and Latina American interviewees' responses will be presented together when discussing the two themes.

Second Generation Asian Americans

Invisibility. A consistent theme amongst respondents was the sense of being invisible and “not seen”. In discussing their experiences to the clinician, respondents recalled being met with both verbal and nonverbal indicators of the lack of connection and understanding. Given the perceptions of mental health and therapy by interviewee's families/cultures of origin as something shameful and stigmatizing, taking the step to initiate therapy brought with it its own feelings and reactions, which makes the importance of being understood that much more meaningful and valuable. The following are two passages by two participants who engaged in therapy for the first time and were seen by White clinicians; they both discontinued therapy after 2-3 sessions. Describing her first therapy experience, which consisted of two sessions, Ruby, a 30 year old Filipina, found the therapist's facial expressions and body language conveyed a lack of understanding, with an absence of rapport and genuine curiosity. She stated:

“The purpose of psychotherapy is, like to allow someone else to figure out their own solutions but it has to be done in a space that feels safe and I don't know that I felt safe sharing, because when it, when you're telling your story or your perceptions of things to a person who is a complete blank slate and has no

understanding of the context of what you're talking about, its very scary. To put yourself out there and when they're nodding their head and trying to empathize or whatever, you, you see the blank, and that was my understanding of it's blank – and this whole interaction is blank...blank expression or the furrowed brow of '*I don't get that*'."

Debbie, a 25 year old Chinese and Malagasy woman, shared similar sentiments of not being completely seen or understood. She stated:

"It's hard to talk to someone when you are already nervous about talking to them. It made it feel like whatever I was saying just, just kind of doing this like lost in translation kind of. I mean, I'm sure she, I'm sure she saw me, I just am not sure that she saw me how I was trying to be seen, and in the context of therapy, and that is kind of important. So yeah it just really felt like a huge misunderstanding. And that's not something that's unfamiliar to me, so it's like, '*Ok, fine*'. I brought up that I was like more anxious than usual to come to therapy. She's like '*You're usually anxious when you come to therapy?*' and I'm like, '*Yeah*' and I was like, that's when I said '*It's not normal quote unquote normal for me to be here, you know. It took a lot of like wheels turning for me to end up here.*' Then she was trying to say, '*Oh, yeah me too*' It felt like what I had said was not relevant to what we were talking about. And maybe it wasn't at the time, but it felt like- because it was- it um, you know practically dismissed as a thing, I guess it became relevant to me, you know."

The experience of not being seen was particularly salient and one that impacted participants' perceptions of and engagement in therapy. Both Debbie and Ruby discontinued therapy. The sense of invisibility was further heightened specifically when there was further engagement around cultural values and communication styles and subtle communication about being perceived as a foreigner. While invisibility was a shared common experience in therapy, it is notable also that it is one that reflects the interviewee's experience in the greater world.

Alien in one's own land. Interviewees reported experiencing subtle comments that touched upon immigration status that communicated a sense of "other", separateness, and the idea that being American meant rejecting their family of origin's culture. When discussing with the therapist how she saw herself trying to negotiate challenges within family interactions, Ruby, a 30 year old Filipina stated:

"I found that I had to explain a lot, and almost, what's the word I'm looking for, defend myself to a certain extent. It was like '*Oh but why does that matter to you?*' or you know '*Why do you care about that so much? Do you know how old you are? Do you know where you are?*' And she meant – she meant to say it like in an empowering way."

The communication by the therapist implied that there was an assumption that the participant was foreign born and that the client's perspective was not oriented to an "American" paradigm; while the participant was aware of the therapist's intent to be supportive, it served to further highlight the gap in understanding of the participant's perspective.

Pathologizing of Cultural Values and Communication style: Another theme that surfaced during the interviews was that of pathologizing cultural values and communication style. Essentially what is communicated by the therapist is that the value set and communication style is flawed, inadequate, or incorrect; these types of communications were evident when participants were attempting to address and work through issues with interpersonal relationships and were often met with feedback from the therapist that their framework for their decision making process and manner in which to navigate the interactions, were problematic and needed to be changed. In the context of psychotherapy, when White therapists are unable to understand or create space for the experiences of their clients of color, it leads to a feeling of defensiveness, a sense of separateness and divide, on the part of the client. The therapists imposed their value set, operating from a American, Western, White centric perspective, pathologizing client's cultural values and ways of communicating/navigating interactions with those in positions of power. The participants acknowledged that it was particularly challenging to address and manage these types of microaggressive experiences. Gina, a 36 year old Filipina shared her experience discussing with her therapist important values she held that informed her way of interacting with her family.

“I would be defensive of this whole family honor thing, like shaming my family. Um and I don't know, I mean, I in some, in some instances, she would treat me with kid gloves and then in some instances she would go *“Oh, so you're defending your family's honor again”* kind of thing. Like *“You know, you know Gina, it's ok to, you know, to feel for yourself, to think for yourself. You're always, it's not always about that whole, you know, collective good thing”* ...And

I think my frame of reference was always, you know, how would it affect those other people? Hell with how it affects me, I'm but one person... So, I'm not sure if that, if that was kind of her imposing her values on me, but it was a pain, it was very frustrating... I mean this is how I've been, this is how I've framed issues in my life, all my life and you know for me to be here and then, and have these moments where I feel like it's being invalidated or were in some ways attacked. Like, well, or minimized. You know minimized, like you know, "*That's ok there, but now we're here,*" Now we're here, there, where, when, where is there? *There* meaning what? Just with my people or with my family or what? My community?... You (the therapist) and I are not the same person. We don't see like the same way."

The therapists operated from an individualistic and US centric orientation, which became the central organizing paradigm and lens to view client's issues. Participants verbalized frustration with the lack of understanding therapists had about key cultural values and norms of communicating; the message conveyed was that their cultural values were flawed and that the White US American way was the correct way to view and manage things, all subtly alluding to assimilation which caused them to feel a greater distance culturally and relationally from the therapist. Tina, a 33 y/o Filipina American, shared her experience in which she was aware that the therapist was advocating for her to intervene in a way that was not culturally sensitive or consistent with Tina's perspective. She states:

"This is actually a common thing that happened with two therapists, trying to explain the difficulties of um, you know, being the daughter of immigrant parents,

and even though...I've always been kind of the outcast of the family, still having that cultural struggle of *'I know I have to do this because it's just the right thing.'* I mean not quite duty, you know, but I mean, yeah. Maybe it is duty, but I mean, still, that should have fallen on my older sister and not me, but just knowing that I'd have to step up to do these things. And both of their responses were definitely from the Western perspective of *'You're independent.'* You know, it was independence versus interdependence. It was definitely the individual versus the family unit, like *'You have to separate yourself from that'* kind of thing, you know."

Tina, who was attempting to navigate family issues and trying to work through the feelings that

surfaced, recognized that her cultural frame of reference was being dismissed and recalled the

therapist saying:

“*'You're an adult and you can make these decisions'*, and so that kind of response, if I was gonna just completely use my Western reference and not be sensitive towards my own culture.”

In each scenario, the prevailing message was that the *correct* way to manage familial issues was that of an individualistic, Westernized perspective and doing otherwise led to judgment and a tone of condescension by therapists about the participants' relational orientation.

Second Generation Latina Americans

Assumption of superiority. The therapist's assumption of superiority was another theme that surfaced in the course of the interviews. Interviewees noted that it became clear that the therapist's racial/cultural point of reference was the dominant organizing framework, with communication alluding to perceptions of the participants' inferior status. Anna, a 23 year old Latina, described her therapist's nonverbal reactions which were so noticeable that she asked him whether or not he was "ok"; she went on to describe how he would generalize experiences of other people of color in his elaboration, which only created distance and left her feeling disconnected from him. When asked about her thoughts about the interaction, Anna reported:

"In some of the things we were talking about, I just felt like again I was, I felt like I, like '*Of course you're this troubled person because you're Hispanic.*' And like he's White and he's up here. And I, I can't tell you exactly the words he would use, but in terms of our dialogue, that's how it felt."

Candela, a 27 year old Hispanic woman, echoed similar sentiments, noting that she came away from session with the impression "my value was different or maybe less than other people." In describing her sense as to how she and her family were perceived by her therapist, she stated:

"Clinicians will accept your struggles as...well... it's something expected or it's something that's sort of ok, acceptable because of your background. And by implication your problems exist because of your background, you know?...I mean my, let's say my mother. She's very poor, speaks English as a second language,

and, she's not very acculturated... a lot of times clinicians will speak as though her value in general might be not that great."

Both Candela and Anna had the experience of working with male therapists as well, which is another variable to consider, as they were the only cross-racial and male psychotherapist/female client dyads in the study; the role of gender involved in the power dynamics within the therapeutic dyad is an important factor however it is unclear as to the degree race and/or gender influenced the interactions and how the microaggressive encounter unfolded. Questions about gender were not specifically asked when Candela and Anna were interviewed. Candela reflecting on comments made by her White male therapist, noting the social hierarchy of White men in the positions of privilege and noting her awareness of her own status as a Latina American, stated:

"He would talk about his patients as sort of like a bundle of problems instead of like a whole person. I mean this is a White clinician and it's dealing mostly with sort of communities of color, but you know, you can't, you don't wanna say that it is racially motivated, but you can't underestimate the role of you know, phenotype and appearance and skin color."

In the interactions with their therapists, the Latina American participants reported an awareness of being judged and that the therapist was operating within the purview of privileged White clinician who had a limited understanding of the clients themselves, and more generally the nuanced experience of communities of color or individuals who were dissimilar to them.

Passing as Part of the Racial Majority. An additional theme that surfaced, but pertained specifically to that of the Latina American interviewees, was that of passing as part of the racial majority. One of the interviewees acknowledged that being “light skinned” and passing as White, impacted how she was perceived by others; she noted that her identification with her racial and ethnic group was something that may or may not be part of the dialogue as she could “choose” to identify or disclose information about her racial and ethnic background. One interviewee acknowledged that her experience as a Latina American differed from that of her brothers who had “darker complexions”, and went on to note her awareness of her “light skin privilege”. Erica, a 24 year old Colombian and Ecuadorian woman, stated:

“They (White coworkers or classmates) think that I identify as being White and I’m not White...I guess for the most part I mean, I know that I have light skin privilege where I, like I don’t have to, it’s my choice if I can just say whether I’m Latina or not and usually it’ll go unnoticed unless I bring it up.”

The idea of passing is one that is complicated in that while the interviewee identifies as a person of color, there is a recognition that how she is perceived and treated by Whites differs in comparison to those within her family and community who do not have the same “light skin privilege”, which fostered a sense of separateness and difference from those with whom she identifies. The participant noted that in therapy her racial/ethnic background was not discussed, which led her to question later as how she was perceived and understood by the clinician.

Second Generation Latina American and Asian American Experience

Colorblindness. The issue of race and culture was discussed to varying degrees among clients and therapists. Some participants stated that culture was not explicitly discussed or mentioned, or if it had been, it was touched upon so briefly that it was not particularly meaningful. Debbie, a 25 year old Chinese and Malagasy woman, stated that race and identity were issues she was seeking to actively explore in therapy and while she did communicate that to the therapist, it was not a point of focus. Debbie stated, “We did not talk about it. We did not open it up...the tone was not such that we were really going to talk about race.” When asked about her feelings as the sessions continued and her presenting issue of race and identity were not discussed, she said, “(I felt) confused...it just felt like, ‘OK, so what, what are we doing?’ And things became, I think, things because less focused because suddenly there were more issues in the space.”

Erica, a 24 year old Colombian and Ecuadorian woman reflected on how much of her presenting issue was due to feelings of confusion and conflict with her family’s cultural values and that of what she was being exposed to within White American culture; however culture, race, and identity were not a point of focus. She states,

“Culture was completely like void of our conversation. And I think she saw me as like, ‘OK you grew up in this like White community. Like you were raised in America.’ And I think the advice or, it wasn’t really advice I think that she was giving me, but just the encouragement of what I was saying at the time – like how I should feel and that I, I shouldn’t feel obligated to, you know, take care of my family. I felt like it wasn’t just taking everything into consideration. And I felt, I felt like we kinda jumped to a conclusion without really examining where that was coming from.”

The message conveyed in the theme of colorblindness to the study participant was a denial of her as a racial/cultural being and experiences, which impacted the therapeutic relationship, as well as the participant's willingness to continue with therapy.

Ascription of intelligence: For the Asian American interviewees, there was an acknowledgement that references to intelligence and academic achievement are common stereotypes for Asian Americans however within the therapeutic context, it was with limited degree that the theme surfaced. While perhaps intended by the therapist to be complementary, the interviewee for who the theme was salient, noted feeling judged and burdened by it. When discussing her presenting issue with a therapist, Valerie, a 29 year old who identifies as Sri Lankan Tamil, recalled being met with the following response:

“I would be talking about this and these therapists would comment like you know, *‘Oh you, it’s funny that you’re talking about all of this because you look so well’* or *‘you look so professional’* um you know. Or *‘Is your family a family of academics, like you look like you come from a family of academics’*. So these weird stereotypes around like intelligence, being articulate, being an academic, being professional, dressing professional, like being able to, to function at a high level. So that just felt like because of those assumptions that you’re making based on the way I look and not just the way I dress but like my skin color you’re going to start talking about my family being academics you know?...I felt really put upon in those moments like well I don’t know why I’m telling you anything if that’s what it’s going to boil down to, then I just shouldn’t be experiencing these things because, because I’m an academic.”

The comments by the therapist may have been well intentioned and geared towards establishing rapport with the interviewee; however, it had the opposite effect, instead communicating to her that she was being judged and labeled, which, according to the participant, left her feeling constricted by what the assumptions implied and her issues thus minimized.

When asked about the racially microaggressive encounter experienced in the context of therapy, a theme that surfaced consistently in the interviews with Latina American participants was that of what they believed were the therapist's perceptions of their intelligence, which were conveyed indirectly through tone, manner of speech, and facial expression. Participants described being addressed in a way that communicated that therapist was questioning their intelligence and competence. Candela, a 27 year old Hispanic woman described it as:

“Being told that you’re sort of being reminded that you’re stupid by being – like ‘*Stupido!*’, saying you know, ‘*You’re actually articulate*’ all the time, you know, or people questioning who you are...” I mean all of these things sort of telling you that, you know, sort of ‘*Stay, stay where you are – sort of, stay in the subordinate position because that’s where you come from. That’s where your people are.*’”

In exploring their thoughts and feelings, participants reported feeling judged which then impacted their way of relating to their therapist, as well as the content disclosed in session.

Table 2

Types of Racial Microaggressions	
Asian Americans	Pathologizing cultural values/styles of communication
	Alien in one's own land
	Invisibility
Latina Americans	Assumption of superiority
	Passing for racial majority
Both	Ascription of intelligence
	Colorblindness

Research Questions about participants' racial group and Identity: How do you identify racially? How would you describe the demographics of your social group in terms of race, ethnicity, and culture? What are some messages you've received about your racial group? How active are you in terms of being involved with your racial group outside of your own immediate family? How do you feel about your own racial group?

Influences of Clients' Reactions to Racial Microaggressions in Therapy

Racial Identity Development. As part of the study, all participants were asked to discuss how they self identified, to describe their involvement with their racial group outside of their families, their feelings about their racial group, and messages they have received about their racial group. Participants were asked about their racial identification as well as the stereotypes that were associated with their racial group.

For the second generation Asian American participants, all mentioned perceptions of high academic achievement as well as being viewed as foreign, with emphasis given to language fluency and being viewed as exotic. The majority of Asian American interviewees also mentioned having a sense of not truly being seen by non-Asian Americans, noting that generalizations were often made about Asian Americans, highlighting a lack of awareness in the cultural and interethnic diversity. The second generation Latina American participants were asked about their racial identification, and identified stereotypes that were associated with their racial group. The second generation Latina American interviewees acknowledged that the stereotypes they encountered in general about their racial group centered on intelligence, competence, socioeconomic status and immigration status. The majority of Latina American interviewees also

described feeling as if their racial group was viewed as inferior, particularly in areas of academic achievement, intelligence, and in socioeconomic status. When asked about racial identification, interviewees responded as follows: two identified as Asian, two as Filipino American, one as Asian American/Japanese American, one as Sri Lankan Tamil American, one as White Hispanic, one as Latina, one as Hispanic, one as Black and White, and one as Hispanic Dominican. (Refer to Table 3.)

Table 3

Self-identification of interviewees (N=11)

Identification	Numbers/Frequencies
Asian	2
Filipino American	2
Asian American/Japanese American	1
Sri Lankan Tamil American	1
Hispanic Dominican	1
White Hispanic	1
Hispanic	1
Latina	1
Black and White	1

In the Asian American sample, participants were varied in their involvement with their racial group with two noting that they were strongly connected to their community with much exposure to their racial group growing up, two having some exposure and involvement to their racial group, and the remaining two as having slim to marginal involvement. The participants who had some exposure described having contact with those of same racial background either through professional/educational avenues or through familial connection. The participants with limited involvement with their racial group indicated that they did not have much exposure to Asian Americans growing up, as the communities they found themselves in were predominantly White, and it was not until later in life that they had more opportunities to connect with those of similar racial/ethnic background. It was found that those who reported strong identification and connection with their racial group had generally positive feelings towards their social group; while those with varied to limited involvement, expressed having mixed feelings, specifically acknowledging that there was a heightened awareness of identity particularly because of moving between racial groups and not necessarily feeling as if they fit in with either group, as a result of receiving messages from both groups that they did not appear to completely belong. Tina, a 33-year-old Filipina American, who grew up in a predominantly White area, describes herself and her social group, which consisted of other people of color, stated:

“All of our families were immigrants, all of our parents were immigrants, we all had that kind of similar struggle with just identity and ‘*where do you belong*’. And you know, there wasn’t a lot of Ethiopians, so my best friend didn’t, you know, she was considered the whitewashed Black girl. And I didn’t hang out

with a lot of Filipinos, so I was considered the, you know, whitewashed Filipino girl, like when it came time that I started to hang out with Filipino people.”

Among the Latina American participants, three participants reported growing up with other Latino/a Americans and/or having exposure to other Latino/as, and that they remained a strong source of social support for them; the remaining two participants described having limited contact and exposure to other Latino/as growing up as they resided either in predominantly White communities or in communities that did not have a large Latino/a population. When asked about their feelings about their racial group, participants provided a range of responses with one indicating a strong sense of pride with others noting mixed feelings, primarily due to a sense of not completely belonging or being perceived as “Latina enough”.

Based on the information provided by the participants, it seems that identity development is complex, and informed by a myriad of experiences and factors; however, as shared by the interviewees, being seen in the way one wishes to be seen versus in the way that others perceive them is challenging, as it typically involves experiences of being Othered and of having to claim, explain, and/or defend one’s identification. With the theme of Passing as Part the Racial Majority, there is a specific voice being given to the second generation Latina American experience, namely that experiences of discrimination can be varied depending upon factors including language fluency, physical appearance, and acculturation. Participants find themselves in a similar place of identifying with multiple aspects of self but also recognizing the disconnection amongst those worlds. For the participants this process involved racial identification, questions as to the intersection between racial identity and conceptions of being American, possessing

the awareness that perceptions of *American* stereotypically from the White hegemony do not represent or include Latino/as and Asians, and culminating in their claiming of identity, even if there is dissonance between their chosen identity and that which is imposed. Having an understanding of the client's racial identity status, as well as other factors informing her experience, enables clinicians to have a deeper understanding of the client as well as how she perceives cross-racial encounters.

Negotiating multiple identities. A major theme identified for the interviewees was that of negotiating multiple identities, which involved holding, embodying, and making visible these intersecting identities in the areas of race, culture, ethnicity, as part of communities of color, in terms of nationality, and also as women. Being second generation American, there are cultural ties to their family of origin's country of origin as well as to that of the American culture that they were born into; however, being connected to and growing up with exposure to both cultural influences, lent itself to having a multifaceted awareness of the components of identity. Respondents described often feeling as if they are living between two worlds when discussing culture, having one part of themselves connected and deeply influenced by the White, American culture outside of their families homes and another part of themselves connected to that of the culture of their family of origin's country of origin, which at times possess different and opposing orientations and values. The negotiation internally with themselves as to how they personally identify, as well as externally, with how others (their family, those around them, and their therapist, etc.) viewed them and by extension, the identity that was then imposed upon them by these entities, was a main point of reflection, as it has broader implications as to how they navigate and participate within each cultural sphere. Key

aspects of this negotiation included racial identity development, communication regarding identification, and experiences of Othering.

Research Question about Perceptions about Psychotherapy: What are your thoughts about psychotherapy and what messages did you receive about it growing up?

Coping and Perceptions of Therapy. Interviewees were asked about perceptions of mental health, psychotherapy, and means of coping. It was noted by respondents that American culture embraces and normalizes accessing psychotherapy; however to other cultures, it remains something not well understood, and perceived with stigma. The majority of the Asian American participants reported their initial impressions of therapy were negative, verbalizing uncertainty as to its effectiveness, acknowledging that part of the resistance to it was the perception psychotherapy was meant for those with very serious psychiatric issues, and essentially was stigmatizing; while the remaining few reported having limited exposure and understanding of it. The Latina American interviewees noted a range of perceptions from that of stigmatizing to that of it being helpful and beneficial. When asked about their family of origin and cultural perceptions of mental health and therapy, both the Latina American and Asian American participants acknowledged that psychotherapy was perceived negatively, typically seen as an intervention for those with serious emotional problems, and generally something that was not discussed. Participants cited the issue of cultural norms that private and personal family matters were generally not to be discussed beyond the familial network, and family and faith were viewed as sources, which one could access so as to obtain support. For all of the interviewees however, the challenge was that the issues for which they were struggling with often were personal and familial relationships and/or pertained to identity,

making accessing networks of family and friends, as well as faith, a catch-22, thus propelling them to seek alternatives. While their perspectives on psychotherapy were not completely favorable given the microaggression experienced in therapy, there was an acknowledgement as to how psychotherapy could potentially be helpful. Eventually, after this microaggressive encounter, they accessed culturally traditional support networks consisting of family, friends, peers, as well as religion and spirituality.

Research Question about the experience of the microaggressive encounters: What stood out about that incident? What was your understanding of the incident? How did you feel?

Experiences of Racial Microaggressions in Everyday Life. The invalidation of their identification as American was also a common theme among respondents, noting specifically how Asians are viewed as foreigners, even when explicating stating how they identify. Erica, a 33 year old Filipina American, said:

“When people see Asian and Asian people in general, not even identifying whether they’re Asian American or not, they see them as being different, you know. They see them as being of a different color and automatically it’s that you’re from somewhere else...I speak English, and I was born in the United States, but I’m not seen as American because of my color ‘cause I don’t look like what an American looks like.”

The experience of feeling “Other” in the context of being surrounded by Whites as well as within their own racial community was particularly salient, further highlighting a sense of distance and disconnection with being able to fully feel accepted and as if one belongs.

Patricia, a 45 year old Hispanic woman, describes how identity has been imposed upon her by those around her and stated:

“I get it all the time. People who call me a ‘sellout’ because I don’t live in a neighborhood where it’s primarily Hispanic. If I go to the supermarket, I don’t go to Bravo...It’s a constant struggle, even for me at work with the people that I work with (who are mostly White), or the people who tell me ‘*You’re not even Spanish! You’re really a White girl trapped in a Hispanic body*’. It’s just the strangest thing because, again, if you don’t live up to the stereotype, then you can’t possibly be Hispanic.”

Similar to the Asian American participants’ experience, there were judgments about the Latina Americans’ racial and cultural identity, which were imposed upon them by both those of the same racial background and by Whites. Not only is there a feeling of difference and separateness fostered, but also a process of having to elaborate, question and/or defend how one identifies. Erica, a 24 year old Colombian and Ecuadorian woman, described her experience of having her identity questioned and invalidated in the following:

“It’s being in the middle (between identities). And then not to mention I think growing up again in that (White) community, like, I feel like people would say, ‘*Well you dress White*’, like, ‘*You look more White than, um, than like someone who would be from South America.*’ So, I think that’s hard, especially since I do identify as a person of color. But I feel like that’s never the end of it, like there’s always an explanation after, like I’m justifying that.”

Research questions pertaining to impact of racial microaggressive encounter: What effect do you think experiences such as these had on your relationship with your clinician? How about on you? On your feelings about the therapy?

Navigating the Racially Microaggressive Experience. The racial microaggressive experience in therapy is one that is delicate to navigate for the female client of color in part because she is obtaining services from the White practitioner, who inflicted the microaggression. Participants reported being either aware that the microaggression had occurred during session or having come to the realization after the appointment. All expressed experiencing various negative emotions including frustration, anger, confusion, upset, discomfort, or feeling misunderstood, after the incident however only three (all Asian Americans) reported directly addressing the issue with the clinician, with only one clinician actively attempting to address the encounter and repair the therapeutic relationship. In taking the step to challenge the therapist, the focus then shifts to that of the therapist's response, namely his or her awareness and willingness to examine the microaggressive encounter, which can impact the therapeutic alliance and the trajectory of treatment. For the Asian American participant who was able to discuss the racial microaggression experience with her therapist, she reported that the therapist was the one who facilitated the process, specifically acknowledging what had occurred, apologizing to the client, and working through collaboratively enabling the client to have the space and support to discuss the meaning and impact of that moment. Valerie, a 29 year old Sri Lankan Tamil woman, states:

“ There was no way in hell I was gonna talk to her first. Um and so that I think was maybe the dominant feeling, you know, if she's going to minimize me I'm

not going to – I can't cave first...And then she called. She called pretty soon. I think it was either the next day, I think the next morning – I think, or the next night...a lot of you know, '*believing*' like, '*You seemed*', um you know, nothing definite being put out there, so that –that really signaled to me that she was trying really, really hard to, you know, not put anything more on me...so she was acknowledging my reaction and you know, trying to explain why she was doing it without taking away um how I felt in that – or without taking away how she perceived I felt in that moment.”

The other participants, who addressed the microaggressive incident with the therapist, were met with initial defensiveness and dismissal, which prompted the client to discontinue discussing it further. Tina, a 33 year old Filipina American, stated:

“I would initiate the conversation, and as I was getting responses, sometimes I'd correct (the therapist's misinterpretations) and then sometimes I'd just be like, this is just not what I'm looking for. Like that answer wasn't what I was looking for, and I mean, the thing is too, is I would also do a lot of processing when I'd get home. Then wonder, is my reaction the reaction of just being defensive, or you know, is this some of my own stuff with a White clinician? You know, I would think about some of these things and I would just kind of dismiss it as, '*Okay, you know what? Its just not that serious. We're just not gonna talk about that 'cause I don't have the strength to go into it.*' I don't know if I want to go into it, um, and sometimes I would, but yeah, I think after a while it (the content of the session) was pretty censored.”

Censoring is not an uncommon means of coping with microaggressions that have occurred. Grace, a 36 year old Filipina, expressed similar feelings of frustration when addressing racial microaggressive moments with the therapist stating:

“I felt it was really important to tell her that, um I have to have some say in how this time goes right? I don’t necessarily want you to tell me what I need to hear, just tell me, tell me what I wanna hear, but if this is not working, like, I feel like, ‘I’m banging my head against the wall when we, when we, when we go, when we go in this direction (of therapist challenging and diminishing client’s cultural values)’ ...I did share that I would come away feeling frustrated, um come away feeling frustrated, feeling like banging my head against the wall when we talk – (asking therapist) ‘Can we talk about something else?’ ... I just didn’t think it was constructive. And there were moments when I would call her out on it and there were other times when I was over it.”

Research question about the therapeutic relationship and the microaggressive encounter: How did you manage or cope with your feelings? Was it discussed with your therapist? What was said? Was there anything said by your therapist which was or was not helpful?

Interactions with the Therapists. As discussed previously in exploring the notion of colorblindness, the denial or dismissal of a person of color’s perspective in the context of therapy silences the client, creating distance between themselves and the practitioner which impacts the sense of safety in the therapeutic space and the relationship. Nine participants acknowledged that the relationship had changed and that

the power differential was more salient and their degree of comfort as well as sense of safety were compromised. The questions that arose after encountering the racial microaggression were varied including 1) appraisal of their perception of the incident, 2) whether it should be addressed with particular concerns as to how the clinician would respond and treat the client thereafter, and 3) not knowing how to respond. When asked how they proceeded and coped after the racially microaggressive encounter, four of the participants indicated discontinuing with therapy shortly thereafter; all participants reported having an internal dialogue dissecting the interaction and their perception, often rationalizing that they misinterpreted it, choosing to change topics so as not to “waste the session” or become silent, particularly because feeling unheard or frustrated. Debbie, a 25 year old Chinese and Malagasy woman, discussed these questions and feelings of conflict, and stated:

“The trouble with microaggressions is that they can be subjective and then its like, ‘*Well, are we crazy?*’ like ‘*Was that really a thing? Did that really happen?*’ you know?...It doesn’t feel like I should have to be like, ‘*Hello?!*’ You know, like I said before, like wave the flag of ‘*Don’t you know that race is pertinent here in this moment right now?*’ I don’t, I don’t. It’s so tiring...I mean if you’re a White therapist and you wanna talk about race...I guess like being shy does no one any good, especially you are the person holding all the power.”

The issue of power is one that was alluded to in several forms, when discussing the power differential between therapist and client, when looking at the therapeutic dyad of White provider and client who is a person of color and how racial difference, which brings with it both privilege and oppression, intersect, and in a few instances with that of

male White clinician and female client of color, adding the factor of gender. In the accounts of the participants' experiences, there is keen awareness as to how their racial group is viewed and stereotyped, which was particularly upsetting to be met with in a therapeutic setting, especially because therapy was seen negatively, according to the cultural beliefs of their families of origin. Choosing to access psychotherapy brought with it its own challenges and secondly participants are placed in a familiar situation of having to negotiate with someone, who is in a position of power and privilege, as how they identify and want to be seen versus who they are labeled and judged to be.

Research questions about recommendations for practice: Can you speak to what would have been helpful to you when the microaggression occurred? What advice would you give to therapists?

Recommendations for therapists. When questioned about their experience in therapy with a White practitioner, participants shared their perceptions of therapy prior to engagement and after termination. Comments reflect that accessing therapy was considered a deviation from their family's cultural norms due to shame and stigma in regards to mental health, as well as mistrust of a practice considered to be utilized by Whites primarily, further demonstrating the meaningfulness of the movement towards therapy. Some participants verbalized feeling resistant initially to therapy while others noted experiencing more a sense of ambivalence. Upon termination however, it was found that participants' perspective on therapy had shifted with some expressing an interest to continue therapy with a therapist who was also a person of color, or were more generally receptive to the idea of utilizing therapy with specific aims in the future, such as cognitive behavioral interventions and means of coping versus engaging in exploration

of relational dynamics, if working with a white therapist. It is important to highlight that most of the participants had no prior experience with therapy (nine of the eleven) and none had worked with a clinician of color previously.

As part of the study, participants were asked for feedback for White therapists who are working with clients of color, to which they emphasized the importance of discussion of culture, clinicians actively educating themselves on the populations they work with, acknowledging cultural difference during the session, recognizing and paying attention to the power differential not only as it pertains to the therapeutic relationship but also racially within the dyad, and also a willingness for the clinician to be self reflective and aware. Participants reported that culture was not consistently explored or mentioned, which lent itself to gaps in understanding of the client's perspective and experience. One 24 year old Latina American participant, Erica, stated:

“Culture wasn't discussed...like I guess (it was) inappropriately...it should have been and it was something that probably should have been discussed, like a lot...I mean I was upset. But then I think in the context of like, I remember being like, *'Well, she is white. She's not from Latin America. She might have like no idea what, like what that means'* You know...it kinda made me think of like all the advice that, not like advice, but like everything that we processed together cause I feel like it was only being looked at through one lens.”

As part of the self reflective process, it was highlighted that awareness of oneself, what one brings to the relationship in terms of racial, ethnic identity, status, and privilege, is as important as educating oneself about the racial cultural perspective and values of the

clients.; communication, namely a willingness to listen, create space, acknowledge missteps and challenging moment, and facilitate dialogue about cultural difference and values through exploration and clarification instead of adopting a position of infallible “expert”, became key in fostering a sense of safety and repair.

Upon reflection on the therapeutic relationship, Patricia, a 45 year old Latina, said:

“I think the reason why people don’t say anything is because there’s that fear that if you say something, there’s gonna be maybe a shift in the dynamic of the relationship...(as a therapist) You have to make sure that you’re always listening to the clients, and if you come across any feelings or anything – if you come across something that you don’t understand, there’s nothing wrong with you asking. I think sometimes therapist wanna come off as being the know-all – you know, the expert... it (exploring and asking) shows that you have an interest in your clients and that you really wanna help them, ...I think clients would find it a little bit more respectful...Don’t be afraid to say anything because if you can’t say it in that room, then there’s really no other place for you to say it, cause that’s probably the safest environment where you can just talk about anything.”

An additional point to be mindful of is how information and curiosity is communicated (verbally and nonverbally). The manner of communication, excessive or intrusive questioning, body language and facial expressions may also have the effect of therapist distancing him/herself from the client, only further highlighting the unspoken power differential, as it is the client who is making herself vulnerable by sharing her

story, exposing her internal conflicts, and need for support. Ruby, a 30 year old Filipina, noted:

“I feel like had that particular therapist started that conversation, like ‘*Are you comfortable with me, like, in my background, and ...sharing this space with you?*’ It probably, it may have worked better or it may have had the – been given the space or it may just feel more comfortable telling her, ‘*Look when you ask me all these questions to give contexts its kind of annoying.*’ So I’m not saying that having a white therapist wouldn’t work, I’m just saying that it needs to be different – or the conversation needs to be had about culture’s effect...acknowledging, ‘*Look, there’s a lot that I won’t understand but let’s talk about it, let’s go there.*’ Because I feel like when a therapist comes in with that idea of ‘*Oh, I’m gonna be able to understand,*’ or when they communicate, ‘*I will understand*’ and it’s not there – that’s more like the part of the microaggression that hurts the most. It’s almost like a bit of haughtiness on that side, like ‘*I have the capability of understanding you,*’ but really, you don’t.”

Discussion

Exploring racial microaggressions that occur between the client of color, in this case second generation Asian American women and Latina Americans, and the White clinician in the setting of psychotherapy revealed a layered and complex interaction among issues of identity, the role of cultural influences, perceptions of mental health treatment, interpersonal dynamics, and the role of power. Key aspects of the dynamic process involved the following: 1) the participants’ own racial identity, 2) the

participants' culturally informed perceptions of coping and therapy, 3) participants' experiences with racial microaggressions in everyday life, which consisted also of navigating multiple identities, 4) navigating the racially microaggressive experience in therapy, and 5) the interaction with therapists, involving perceptions of therapists' colorblindness/ racial identity, as well as therapist' reactions to racial microaggressions. It seems that for the second generation Asian and Latina American women of color who participated in this study, identity formation was influenced by their own connection with their own racial identity, as well as that of environmental factors; racial identity status was thus considered to be a factor as to how microaggressive encounters are experienced and understood. Cognizant of second generation people of color's culturally informed perspectives on mental health, psychotherapy, as well as other forms of coping and support that were utilized by their families, navigation of interactions with therapists experienced as racially microaggressive, were complicated as participants are seeking support but feeling stymied as how to move forward given the microaggressive encounter.

The participants entered the therapeutic space with their own sense of identity, perspectives on mental health treatment, and culturally normed means of coping and accessing support. The White clinician was perceived to bring with him or herself into the space, a degree of power embodied by racial privilege, a difference in culturally informed organizing paradigm (Western, individualistic and US centric), and authority due to status of his or her professional role. It seems that in coming together in the therapeutic space, a process was activated in which the subtle unconscious communications (microaggressions) by the therapist were decoded by the participants,

and resulted in the clients' heightened awareness of how they were perceived by the therapist (emerging themes), while simultaneously experiencing a sense of "Other"-ness. How the participants then navigated the therapeutic relationship varied, but it was clear that the microaggressive encounter affected the relationship.

Interviewees reported that the most common type of racial microaggressions encountered in therapy were that of microinsults and microinvalidation with Asian American participants describing emerging themes including colorblindness, pathologizing of cultural values and communication styles, invisibility, alien in one's own land/being perceived as foreigner, ascription of intelligence, and Latina American participants noting themes of colorblindness, negotiation of multiple overlapping identities, ascription of intelligence, assumption of superiority, passing as part of the racial majority. Colorblindness, negotiating multiple identities, and alien in one's own land are microinvalidations; pathologizing cultural values and means of communication, assumption of superiority, and ascription of intelligence are examples of microinsults. Negotiation of multiple overlapping identities and passing as part of the racial majority are two themes that emerged from the interviews with the Asian and Latina American interviewees in the study, which were not written about extensively in current racial microaggression literature. The specific themes stood out for each racial/ethnic group were consistent with current research pertaining to microaggressions experienced by Asian and Latino/a Americans (Rivera, Forquer, & Rangel, 2010; Sue et al, 2007; Sue, et al, 2007; Sue, 2010); however, there was overlap in the themes of colorblindness, ascription of intelligence, and negotiating multiple overlapping identities.

As per study findings, fostering culturally sensitive practice requires the therapist to cultivate an understanding of him or herself, to self reflect and self critique, so as to be aware of inherent power imbalances in the therapeutic encounter. Failure to do so had an impact on rapport and the interviewees' engagement; however, one study participant, who addressed the racially microaggressive encounter she experienced with her therapist, facilitated a dialogue and engaged in counterstorytelling, method informed by critical race theory, allowing for the rupture in the relationship to be repaired. The cultivation of cultural awareness, sensitivity, and humility, along with dialogue between client and therapist, as demonstrated by the previous example, were highlighted as important recommendations for practice, which are areas for continued exploration and research. By having a better understanding of the impact racial microaggressions have on the individual, on the therapeutic relationship, and on perceptions of psychotherapy, it was hoped that through this study, voice would be given to the experience of these eleven women so as to inform practice by providing insights and richer understanding.

Influences of Clients' Reactions to Racial Microaggressions in Therapy

Participants' Racial Identity. Participants discussed how they self identified, their sense of connection to their family of origin's culture of origin, as well as their social involvement with their racial group elaborating on the amount of exposure and contact they had both in their childhood and currently. Latina American and Asian American interviewees, who noted strong identification and connection with their racial group, had generally positive feelings towards their group. Those with varied to limited involvement with their racial group admitted having mixed feelings; the experience of moving between racial groups heightened their awareness of identity, noting a sense of

not belonging with either group, which resulted in receiving messages from both groups that they did not appear to completely belong. This finding was consistent with research indicating that perceptions of discrimination were influenced by people of color's racial identity statuses (Watts & Carter, 1991; Hall & Carter, 2006; Pieterse & Carter, 2010).

In referencing the framework of Cross' model of black racial identity and the racial/cultural identity model, it appears that the process of identity formation for second generation people of color is one that evolves, influenced by environmental factors as well as connection and comfort with one's racial identity, with participants, in the encounter phase (or dissonance phase in the Racial/cultural identity development model modified by Sue & Sue, 2008) possessing awareness of their "Otherness", and movement occurring along the continuum in which immersion/emersion follows; a number of participants approached the stages of internalization and internalization/commitment where a positive internalized image of self is cultivated, as well as greater inner security, and a readiness to connect with members of other oppressed groups (Sue & Sue, 2008). In Sue & Sue's (2008) modified model, participants following a similar trajectory with the dissonance phase being followed by resistance and immersion, which can be understood as feelings of guilt and shame for "selling out" his/her racial group and then anger towards the oppressive dominant group, and concluding with introspection and integrative awareness phases when a participant finds herself being secure in her own culture as well as that of the dominant culture. Viewed through the lens of Pope and Reynolds's Multidimensional Identity Model (1991), participants find themselves connecting with multiple identifications however there is disconnection among those worlds. There is the flexibility however through the Multidimensional Identity Model for

participants to identify as a new group by focusing on the intersection and integration of these multiple identities (Pope & Reynolds, 1991), which accommodates for the various aspects of the self, and is particularly meaningful for marginalized and oppressed populations.

Participants' Perceptions of Coping and Therapy. Participants shared their perspective on psychotherapy as well as other forms of coping and support that were utilized by their families, which were culturally informed. Both Asian American and Latina American participants indicated that according to their family of origin's culture, psychotherapy was viewed with stigma, was accessed by those with serious emotional problems, and could not be openly discussed. They acknowledged that it was perceived as an US American practice and that to other cultures, there was a lack of understanding about it generally and was viewed with stigma, a finding that is consistent with current research on mental health service use by second generation Latino/a and Asian Americans (Dev & Lucas, 2006; Abe-Kim, et al, 2007). While participants' responses ranged from negative to favorable perceptions about psychotherapy, participants admitted feeling somewhat tentative about pursuing therapy, as they were aware that their families would not be accepting due to stigma, instead encouraging them to utilize culturally traditional means of coping, specifically accessing family networks and religious faith.

Experiences with Racial Microaggressions in Everyday Life. When discussing racial identity, participants also identified common stereotypes associated with their racial group. The stereotypes mentioned by the participants (perceptions of high academic achievement as well as being viewed as foreign, with emphasis given to language fluency, being viewed as exotic, invisibility, lack of interethnic and cultural

diversity) reflected what has been confirmed by research pertaining to Asian stereotypes; it is well documented in the literature that common Asian stereotypes include perceptions of being a model minority, foreigner, second-class citizen, invisible, homogenous as a racial group, and oversexualization/exoticization of Asian women (Sue, 2010).

The themes of colorblindness, pathologizing of cultural values and communication styles, invisibility, being perceived as foreigner, ascription of intelligence, that were consistent with the themes identified by Sue and colleagues, (2007) in their research on racial microaggressions and the Asian American Experience. With the themes of invisibility and pathologizing of cultural values and communication styles, it is notable that two participants for whom the themes were particularly a point of focus, discontinued with treatment after 2-3 sessions; the finding is consistent with current research which reported that barriers between minority client and white health care provider might arise due to cultural or linguistic incongruity, from lack of mutual trust or from racial discrimination (Saha et al.,1999) with causes for high drop out rates including cultural misunderstandings and miscommunication between worker and client (Vasquez, 2007). The theme of pathologizing cultural values and communication styles is particularly powerful as the underlying message is that the values and communication styles of White culture are ideal (Sue, 2010). The theme alien in one's own land, was one that was also identified as a common racially microaggressive experience as noted in the work by Sue, et al (2007) in their study examining racial microaggressions and the Asian American experience. The study's interviewees noted a sense that they were not perceived as American, either due to appearance or failing to operate from a US "American" paradigm, with the underlying communication being that they were foreigners (Sue,

2010); this data was consistent with research findings by Devos and Banaji (2005) who found that on an implicit level White Americans associated the concepts of “White” and “American” together, with Asian and African Americans less likely associated with the term “American”. The theme of ascription of intelligence, while seemingly a “positive” stereotype as it implies high academic achievement, carried much meaning for the interviewee who was the recipient of the microaggression, specifically feeling as if her presenting issues were minimized since she was labeled “an academic”; for the participant, being perceived as “the model minority” led to assumptions about her capacity to cope with issues, diminishing the impact of her experiences (Wong & Halgin, 2006; Sue, 2010).

The Latina American interviewees noted stereotypes centering on perceptions of inferiority, namely in areas of academic achievement, intelligence, and in socioeconomic status; current research supports this finding and indicates that Latino/as encounter discrimination as a barrier to educational attainment and in the workplace (National Survey of Latinos, 2002; U.S. Census Bureau, 2008, U.S. Department of Labor, 2008) . When discussing the microaggressive encounter in the context of therapy, participants identified typically being subjected to microinsults and microinvalidation; the primary themes that emerged included colorblindness, negotiation of multiple identities, ascription of intelligence, assumption of superiority, passing as part of the racial majority, and negotiation of multiple identities. While the majority of themes identified were compatible with current research on racial microaggressions and the Latino/a experience (Rivera, Forquer, & Rangel, 2010; Sue et al, 2007), the latter two new categories that emerged from the interviews were not previously identified in the research. These

findings are particularly significant as previous research does not make a distinction between first and second generation people of color nor were previous studies focused primarily on the experience of second generation women of color, making the identification of new categories that much more important in highlighting the unique and nuanced experience of second generation women of color in navigating issues of identity.

Interviewees noted the absence of meaningful dialogue around race and racial difference between themselves and the clinicians. This finding is in line with the work by Sue (2010) who referenced colorblindness as a common experience people of color encounter when attempting to address race issues or the impact racial discrimination has on people of color. Colorblindness, a theme for both the Asian and Latina American participants, specifically acts as a means to deny an individual's racial/ethnic experiences or even acknowledging the individual as a racial/cultural being (Sue, 2010). Colorblindness and Passing for a racial majority appears to be intersecting themes for one particular interviewee, who later questioned whether her therapist had a true understanding of her at all given the lack of dialogue about race and identity. The themes of ascription of intelligence and assumption of superiority seem to intersect in that the underlying message pertaining to assumptions of intelligence and competence based on race (Sue, 2010). The theme of negotiation of multiple identities, which was identified by both Asian Americans and Latina Americans, is one that surfaces in the context of navigating the therapeutic relationship and in the experience of "other"ness, which is elaborated upon further below.

Navigating Multiple Identities. In experiencing the racial microaggression, interviewees became aware of how they were perceived by the therapist, with the

microinsults and invalidations communicating a sense of not being truly seen, of feeling “other-ness” that highlighted the gap in understanding and lack of common experience between the interviewees and the therapist. A theme that emerged from the interviews was that of negotiating multiple identities, which involved claiming, communicating, and defending their self-identification that at times was at odds with what was being imposed upon them by other entities (family, peers, other figures of authority, etc.); the experience of being between worlds and not fully belonging is a major issue for second generation children, as their parents are immersed, anchored, in one cultural context and they are navigating another (APA, 2012). This navigation served as a parallel experience for study participants who found themselves between worlds culturally, racially, ethnically, when engaging with White clinician and their family of origin.

If conceptualized from an object relations perspective, there is a dynamic exchange occurring in the experience of Other-ness. Through the process of projective identification, people of color sense that their identity is “defined by their image in the minds of whites, white projections become not merely a fantasy in the minds of white people” with people of color acting as containers that whites utilize to deny their negative qualities in order to create/maintain positive images of themselves (Altman, 2009). A person of color’s sense of self can be thought of as co-constructed resulting from perceived experience of oneself from how others hold him or her in mind (Fonagy et al., 2002) with these lasting representations of self and other informed by experiences in the outside world (Flanagan, 2008). In that moment of assessment after the microaggression occurred, participants were aware of their racial/cultural identity, their relationship to the perpetrator, and the theme and underlying message of the

microaggression (Sue, 2010). In navigating multiple identities and the racially microaggressive experience in therapy, the interviewees were aware of how they were perceived. The incongruence of 1) participants' own self identification and racial identity status, juxtaposed with that of 2) identity imposed by the therapist, created a state of Other-ness in which participants' assessment/appraisal influenced how the relationship would then be navigated.

Navigation of the Racially Microaggressive Experience in Therapy

After the microaggression occurred, it was not an uncommon experience for the participants to assess how to move forward. Sue (2007) notes that questioning of the incident is common and typically part of the process when encountering a microaggression. Evaluating whether an event was racially motivated or not is a complex phenomenon which can be energy depleting. Interestingly, current research indicates that accurate assessments of racist occurrences are more likely to be made by those who are disempowered rather than those who are in positions of power and privilege (Jones, 1997; Keltner & Robinson, 1996). While very few directly addressed the incident with the therapist, the remaining participants found other ways to cope, namely changes in behavior and/or speech. According to microaggression research, censoring and purposefully behaving in a way that is perceived as nonthreatening to Whites, known as forced compliance (Sue & Sue, 2008), can serve as a means to tolerate the microaggressive encounter, as well as preserve the relationship between the recipient and the perpetrator. Some participants acknowledged that they felt unsafe in the space but also did not want to directly challenge the therapist due to concerns as to how it would impact the therapeutic relationship. The participant, who directly discussed the

microaggressive encounter with her therapist in order to repair the relationship, engaged in counterstorytelling, (which is a method informed by critical race theory involving the telling of stories of marginalized populations that exposes and challenges the majoritarian stories of racial privilege). She stated that not only was repair possible, but also highlighted that it strengthened the relationship. The finding was congruent current research that highlighted the importance of therapists' demonstrating the ability to take risks and prove their awareness, sensitivity, and skill in dealing with racial and ethnic matters, especially when in a cross-racial dyad (Constantine & Kwan, 2003). Critical race theory, suggests that the client's intervention is especially meaningful since it serves as a challenge to the normative standard of the White experience. Counterstorytelling reinforces that the client is the expert on her experience, which then allows for a construction of dialogue and shared space where deeper understanding and empowerment is fostered (Taylor, 1998; Solarzano, 1998).

If what occurs between client and therapist during the microaggressive experience is conceptualized through the lens of object relations, racism can be understood as anxiety related to a person's difficulty (in this case the therapist's) in tolerating those who are different from themselves (the client) and thus feeling compelled to dominate those individuals (Timimi, 1996). In the defensive process of projective identification, the Other becomes a container that holds the bad and the subject sees oneself as good "completing the split by using denial and omnipotence" (Thomas, 2008, p.188). Race, as constructed by Whites through projective identification, can be seen as a defensive-reality obscuring process where the experiences of people of color are negated or invalidated (Altman, 2009). Through the assessment process that occurs for the person of color after

being subjected to a microaggression, the participants are cognizant of their own racial/cultural identity, their relationship to the perpetrator, and are attuned to the theme and underlying message of the microaggression, all of which intersect with their own personal experiences of discrimination (Sue, 2010). How the clinician and client choose to proceed will have a direct impact on the relationships, which makes the possibility of confrontation potentially risky, but as noted by some participants, a necessary intervention in order to move forward, which is widely supported in the research (Allen-Meares & Burman, 1999; Coleman (2000). It is possible that the racial microaggression by the therapist was a product of a schema for cultural understanding, which instead of serving as cultural concept or guide (Rentsch et al, 2007), only invalidated and offended the client and minimized her experience; hence, highlighting the concept of cultural humility as integral to understanding the client in order to deepen the therapeutic work (Tervalon & Murray-Garcia, 1998).

Interactions with Therapists

Interviewees made reference to their therapists' race, gender, professional role, and conceptual orientation (US American, Western, individualistic), touching upon the impact it had on development of rapport and the unfolding of the therapy, especially after the microaggressive incident. Researchers have underscored the importance of the culturally competent therapist understanding, accepting, self reflecting and self critiquing, so as to consciously evaluate and be aware of power imbalances and microaggressions in the therapeutic encounter (Tervalon & Murray-Garcia, 1998; Chung et al, 2008).

Clinicians typically receive training developed for White, American Westernized culture and as a result, they are unable to provide culturally sensitive treatment since they are not

familiar with the sociopolitical backgrounds and histories of various communities of color. Hence, such clients find mental health services to be unhelpful and ineffective (Sue & Zane, 2009). Furthermore while clinicians may be well intentioned in their interventions, the microaggression may potentially result in unintentional oppression of the client (Sue et al, 2007; Sue, 2010). By being aware of such dynamics and receiving proper training, practitioners can enhance their practice and exercise more culturally sensitive practice. Operating from a critical race theory perspective which encourages challenging the normative standard of the White experience and working from a framework informed by the distinctive experiences of people of color (Taylor, 1998; Solarzano, 1998), creating a safe space for the client of color is paramount in order for deeper understanding to occur. Awareness of the client's self identification and racial identity status, and encouragement of counterstorytelling are each integral to developing a more nuanced and deep understanding of the client's experience, which will assist in strengthening the therapeutic alliance (Solarzano,1998; Sue & Sue, 2008; Taylor, 1998).

The main point of focus of the study has been the cross-racial dyad within the context of psychotherapy; however, the role of gender as it pertains to therapeutic context is an area for further inquiry. Two interviewees noted working with male clinicians and questioned the role gender played in tandem with racial difference. Gender stereotypes and discrimination against women institutionally, interpersonally, and culturally continue to be prevalent (D. Sue, D.W. Sue, & S. Sue, 2010). Negative perceptions of women as inferior have been a pervasive phenomenon in various societies (Zastrow, 2004). While it is no longer considered politically correct to exhibit discriminatory/sexist comments and behaviors, according to Sue (2010), sexism has evolved and manifests more subtlety

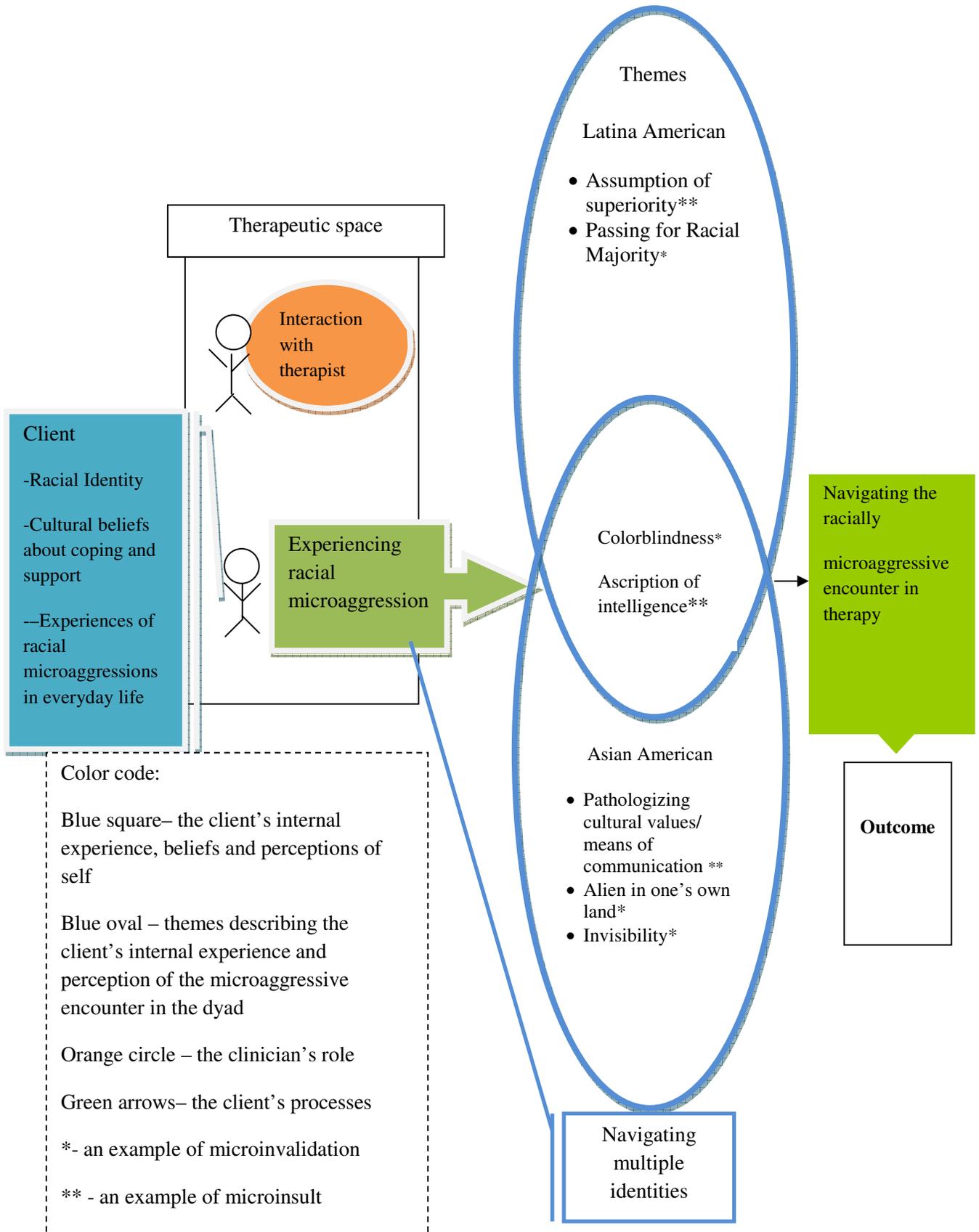
today as “denial of personal bias and prejudice toward women, a general conscious belief in equality of sexes, but unconscious attitudes that foster nonsupport for programs and legislation helpful to women” p168. Studies have found that sexism can have damaging effects such as exposure to greater violence and harassment, as well as decrease sense of self worth and affect psychological distress (Strickland, 1992; Lyness, K.S. & Thompson, 2000). Gender microaggressions manifest as microassaults, microinsults, and microinvalidations, similar to that of racial microaggressions, and through research, the following themes emerged: sexual objectification, second-class citizenship, use of sexist language, assumptions of inferiority, denial of the reality of sexism, traditional gender role assumptions, invisibility, denial of individual sexism, and sexist jokes (Sue & Capodilupo, 2008).

Model

The purpose of the study was to examine the reactions of second generation Asian and Latin American people of color when encountering racial microaggressions in the therapeutic dyad, its impact on the therapeutic encounter, the coping strategies utilized, how it affected perceptions of psychotherapy, and potential interventions that could have aided in repairing the therapeutic relationship. The dynamic process is represented as Figure 1 and consists of five constructs which are of the following: 1) types of racial microaggressions encountered in therapy, 2) influences of client’s reactions to racial microaggressions in therapy, 3) navigating the racially microaggressive experience in therapy, 4) the interaction with therapists, and 5) recommendations for practice. These factors are unified by the theme identifying and navigating racial microaggressions in therapy. When coming into the therapeutic setting, the participant brings her own beliefs

and perception of self, which includes her racial identification, self-identification, and cultural beliefs/perceptions about coping and support. In coming into the therapeutic space with a white clinician and being subjected to a racial microaggression, the participant became aware of the therapist's position and of how she was perceived, which included emerging themes of colorblindness, negotiation of multiple overlapping identities, ascription of intelligence, assumption of superiority, passing as part of the racial majority, and alien in one's own land, as well as experiencing a sense of Otherness. After the assessing the encounter, the participant then navigated the therapeutic relationship in a myriad of ways, including having dialogue with the clinician about the microaggression, not addressing the microaggressive encounter with the clinician, and censoring of thoughts and feelings in session. The outcomes included discontinuing or continuing with therapy. The model illustrates the uniqueness of second generation women of color's experience in traversing issues of racial/ethnic identity in the United States given the influences of their family of origin's culture and that of US White American culture. How those cultural, racial, ethnic influences then intersect with identity that is imposed by others, (namely those encountered in everyday life and by participants' White clinicians,) with that of the participants' own self-identification, demonstrates the complexity of negotiating identity, and speaks to the challenge participants encountered in being truly *seen* by therapists within the therapeutic setting.

Figure 1. Navigating Racial Microaggressions in the Therapeutic Encounter



Limitations of Study

While the aims of the study was to provide a qualitative analysis of the the racially microaggressive experience in the context of the cross racial dyad consisting of White clinician and clients who are second generation Asian Americans and Latina Americans, much research still needs to be conducted in this area as the scope of the current study was limited. A few limitations of the study are the generalizability of the results as the sample size is small and consists of participants from varying racial/ethnic backgrounds, and the retrospective reporting of participants inherent in the study design. The targeted sample size was that of 12 participants total, with 6 second generation Asian Americans and 6 second generation Latino/a Americans; however, recruitment yielded 6 Asian American women and 5 Latina Americans. Multiple attempts of outreach were made to professional organizations, anti-racist organizations, agencies, university counseling centers, and through various social justice list-serves; despite numerous attempts, the target sample size was not met. During the recruitment process, only women volunteered to participate in the study. Gender was not a specific focus in the development of the study; however, given that the respondents were all female, it presents an area for further investigation, namely that of experiences of individuals facing multiple oppressions, in this case in the areas of gender and race. It is also important to note that given the qualitative aspect of the research, it is not possible to generalize about the experiences of both second generation Asian Americans and second generation Latina Americans, especially since the participants represented several different geographic areas of the US and thus experiences of microaggressions may differ given this.

Retrospective reporting of participants as also noted as a limitation, particularly

due to the differing lapses of time between encounter and time of interview. Having to rely on the participant's recollection of the event versus immediate recall relatively close to the time of the interaction, likely impacted content of what was reported. In addition, the unfolding of the therapy process and relationship could not be as closely examined. There is a question as to whether the additional themes noted by other researchers studying microaggressions would have also emerged had it been possible to capture the content of the session more closely. Another point to consider was that the description of the encounter was solely from the client's perspective, based on retrospective recollection; speaking to the therapist about the encounter was not a possibility, and thus a limitation as well. The information provided by participants does serve as a major contribution to the literature though, as the racially microaggressive encounter in a cross-racial dyad in therapy remains a growing area of focus.

Implications

Through the exploration of the experiences of people of color within the therapeutic dyad, it was hoped that greater understanding can be fostered as to the impact and implications of racial microaggressions on the therapeutic encounter. Specifically these include the nuances of the lived experience, means of coping, and perceptions of psychotherapy and mental health treatment. The dissertation study can have direct implications on social work practice in that it highlights the dynamics within the cross-racial/ethnic therapy dyad and illustrates the internal experience for clients of color. Since most interracial encounters are prone to manifestations of racial microaggressions (Sue et al, 2007), it is even more pressing that the implications on clinical practice be highlighted. As current research of racial microaggressions is monoracial, not making

the distinction between first and second generation immigrants (Sue et al., 2008; Constantine, 2007; Constantine & Sue 2002; Knox et al 2003, Solarzano, 2000; Sue et al., 2008, Torres et al., 2010; Sue et al 2007, Wang et al, 2011a; Huynh & Fuligni, 2010; Rivera, Forquer, & Rangel, 2010), and it has been found that second generation immigrants have higher rates for mental disorders than their first generation counterparts, in part, due to issues related to ethnic subgroup, gender, English-language proficiency, years of living in the United States, and age at immigration (Williams, Haile, Gonzalez, Neighbors, Baser, and Jackson, 2007; Takeuchi, Zane, Hong, Chae, Gong, Gee, Walton, Sue, and Alegria, 2007, Alegria, Mulvaney-day, Torres, Polo, Cao, and Canino, 2007; Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegria, 2007), it becomes critical to intervene within the therapeutic encounter in effective ways that enhance rapport building and facilitate repair when a racial microaggression occurs. These interventions can then impact the trajectory of treatment. The findings illustrated the importance of clinicians 1) acknowledging the power differential inherent in a cross-racial/ethnic dyad with White clinician and client of color, 2) being aware of the racial, cultural, and communication differences between client and therapist that may arise due to cultural or linguistic incongruity, from lack of mutual trust or from racial discrimination (Saha et al, 1999), and 3) engaging in the therapeutic process in such a way that discussion with the client about differences/challenges can be facilitated in the service of collaboratively co-constructing a safe space, (Kelly & Greene, 2010; Dyche & Zayas, 2001), all of which will require self-reflection and curiosity by the clinician. Respectful curiosity” as described by Coleman (2000) entails fostering a nonjudgmental and supportive space for the client to share and discuss their cultural background,

enabling the relationship to grow and blossom. Improving awareness and identification of racial microaggressions in themselves and in others, as well as possessing understanding in how to repair ruptures in the therapeutic alliance, will enable clinicians to share space with the client in a more deeply authentic way that cultivates connection.

The findings highlighted the importance of continued research in various areas, including gender microaggressions, the nuanced microaggression experiences for different populations of color and additional factors involved in identity development, such as physical appearance and immigration history and status. A few of the themes noted by study interviewees overlap with the gender microaggression themes, specifically that of assumptions of inferiority and invisibility, leaving room for inquiry about the interplay among the factors of gender and race within the therapeutic dyad. An examination of the intersection of race and gender within a therapeutic context can be an area of future research, but it also can be used as a point of dialogue as how to better understand and honor the client's multiple overlapping identities. It would also be of importance to further investigate the theme of passing for racial majority; while it was only explicitly addressed with one Latina American participant, research has found that Latino/as may experience discrimination due to physical characteristics, specifically skin color (Araujo & Borrell, 2006). Most importantly, future research that will focus specifically on the impact of racial microaggressions among different populations of color could inform how clinicians could provide culturally sensitive treatment. With attention to these variables, therapeutic ruptures can be repaired, which would then affect the client's perceptions of the therapist and of therapy. Additionally, given that current research on racial microaggressions has not made the distinction between the experience

of first and second generation immigrants, it becomes even more pressing that more research be conducted, as it is documented that characteristics of nativity and the immigrant experience are associated with mental health issues (U.S. Dept of Health and Human Services, 2001).

Conclusion

The aim of the study was to provide a qualitative analysis on the experience of second generation Latina Americans and Asian Americans who have encountered racial microaggressions while working with a White clinician. The examination gave voice to the client's experience of the microaggression, its impact, and implications for practice. Interviewees discussed their personal perceptions of therapy, as well as how mental health is viewed by their family of origin's country of origin, exposing a tension between cultures and their identification with those cultures. In experiencing a racial microaggression in therapy, interviewees were confronted with questions about and challenges to their self-identification, an experience that mirrored their experiences in the world; it can be said then that the therapeutic space/relationship serves potentially as a microcosm of interviewee's experiences in cross-racial interactions. Numerous categories surfaced, namely the themes of pathologizing of cultural values and communication styles, invisibility, being perceived as foreigner, ascription of intelligence, for the Asian American participants and the themes of colorblindness, negotiation of multiple overlapping identities, ascription of intelligence, assumption of superiority, passing as part of the racial majority for the Latina American participants. Navigating multiple identities and navigating the racially microaggressive encounter in therapy were major tasks involved in managing, building, and repairing the therapeutic

relationship, which then affected the trajectory of treatment. Despite experiencing a racial microaggression within the context of therapy, participants generally held neutral to positive views of therapy. They did however advocate for therapists to engage in self reflection and awareness, exercise cultural humility, and display a willingness to collaborate with their clients of color, which may entail uncomfortable dialogue about difference and other points of tension. The findings of the study suggest that it is through these dialogues and explorations that change and progress occur, ultimately impacting existing disparities and treatment outcomes.

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Appendix A

Standardized text for recruitment

Dear Colleague,

I am writing in an attempt to recruit for a qualitative study I am conducting which will focus on exploring racial microaggressions within the therapeutic dyad. Please find enclosed the inclusion and exclusion criteria noted below. Participation will consist of an interview ranging from 1-2 two hours, which will be recorded and transcribed. Confidentiality will be maintained and all documents/tapes securely stored in locked files. Participants will be offered a \$50 Barnes and Noble or CVS gift card as incentive for participation. I am looking to recruit 12 participants total (6 second-generation Asian Americans and 6 second-generation Latino/a Americans) over the next 6 months. Please feel free to contact me if you have been able to identify any suitable candidates or if you should have any questions. Once you have obtained permission by the potential participants for contact, please forward me their names and contact information and I will reach out to them.

Thank you in advance for your time and support.

Warm regards,

Kristine Miranda, LCSW

Definition of Terms

Racial microaggressions can be understood as commonplace verbal, behavioral or environmental indignities, whether unintentional or intentional which communicate hostile, derogatory, or negative slights and insults to people from marginalized groups (Sue et al., 2007)

Therapeutic encounter is defined as the contact between at least two individuals designed to enhance the health of one or more of those engaged in the interaction (Jonas, 2005).

Inclusion Criteria

The interviewee should be

- self identified as a person of color,
- be second generation Asian American or Latino/a American,
- born and raised in the US ((born in the United States to a foreign-born parent or parents),
- be English speaking,
- have previously been in outpatient individual therapy (at minimum two sessions) in the past 5 years with a White clinician

Exclusion Criteria

- Individuals who identify as people of color but who are have newly immigrated to the US

Appendix B

Face sheet Data

Participant Number:

Date

Time

Location of interview

Racial identification

Ethnicity

Gender

Religion

Age

Where was the participant born and raised

Education history

History of outpatient individual psychotherapy (specifically setting, length and duration of treatment)

Racial/ethnic background of treatment provider(s)

Appendix C

Interview guide

As a participant in this study, you have self identified as a person of color, second generation American, were born and raised in the US ((born in the United States to a foreign-born parent or parents), are over age 18, English speaking, and have previously been in outpatient individual psychotherapy (at minimum 2 sessions) within the past year with a White clinician. The type of racism being explored within the context of this interview is that of racial microaggressions, which can be understood as commonplace verbal, behavioral or environmental indignities, whether unintentional or intentional which communicate hostile, derogatory, or negative slights and insults to people from marginalized groups, in this case, people of color.

An example is that of micro insults which are communications that demean a personal's racial heritage and convey rudeness, i.e. a White professor not calling on students of color in class.

Microinvalidations are also a form of microaggression in which the communication excludes or negates the psychological thoughts, feelings and experience of a person of color; an example may be an Asian American born and raised in the US being told they speak English well or that African Americans are overly sensitive about issues of race. The former communicates that Asian Americans are viewed as foreigners and the latter example demonstrates how the reality of African Americans experiences of racism are dismissed.

Another example may be microassaults or "old fashioned" racism in which there are blatant verbal or nonverbal attacks meant to hurt the victim or purposeful discrimination.

The interview will focus on the therapeutic relationship, the relationship between you and your clinician, and the manifestations and impact of racial microaggressions.

The areas of inquiry for the interview are the following:

- 1) How do you identify racially? How would you describe the demographics of your social group in terms of race, ethnicity, and culture? How active are you in terms of being involved with your racial group outside of your own immediate family? What are some messages you've received about your racial group? How do you feel about your own racial group?
- 2) What are your thoughts about psychotherapy and what prompted you to follow through with it? Can you speak to the setting and context in which you sought treatment?

- 3) As you know the aim of the study is to examine experiences of racism, specifically microaggressions, within psychotherapy. Were you familiar with the concept of racial microaggressions prior to this interview? What comes to mind as we discuss it?
- 4) Can you think of an example in therapy in which a microaggression occurred? What are your thoughts about it? How did the interaction affect you?
- 5) What was your sense of how you were perceived or understood? What stood out about that incident? What was your understanding of the incident? How did you feel? What reaction did you have in response? What thoughts came to mind in that moment?
- 6) What effect do you think experiences such as these had on your relationship with your clinician? How about on you? On your feelings about the therapy?
- 7) How did you manage or cope with your feelings? Was it discussed with your therapist? What was said? Was there anything said by your therapist which was or was not helpful? Can you speak to what would have been helpful to you when the microaggression occurred?
- 8) Are these experiences of racial microaggressions one that you have discussed before? If so, with who, and for what reason? If not, what are your thoughts about discussing it?
- 9) What are your thoughts about psychotherapy, in general and personally as a result of these experiences?
- 10) Debriefing question: What advice would you give to a person of color who finds him or herself in a similar situation having experienced a microaggression?
- 11) What advice would you give to a therapist?