Race and Culture in Psychotherapy Literature Review

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Abstract

Psychosocial adaptation and mental health are crucial aspects of overall health. Just as the concept of health extends beyond the absence of disease to a "positive concept of wellbeing" (Bryant & Worrall, 2020), the etic definition of mental health expands beyond the absence of severe dysfunction. However, underserved populations face cultural and social barriers to programs and resources that support mental health (Shochet, et al., 2020). For example, African Americans are underrepresented in outpatient mental healthcare, but overrepresented in inpatient populations (Hamilton, et al., 2015). Disparity and intercultural misalignment solidify the need for race and culture in psychotherapy to remain a critical psychosocial adaptation and mental health research subtopic.

This paper will open with a broad overview of race and culture in psychotherapy. This paper will address racial and cultural challenges to successful psychotherapeutic alliance. A peer-reviewed article review on therapist microaggression will exemplify methods, results, evidence of bias, and conclusions in contemporary, culturally focused psychotherapy research. The author will provide a rationale for research article choices, as well as societal implications and opportunities for future research.

Keywords: African American, culture, microaggression, psychotherapy, racism

Contents

Race and Culture in Psychotherapy

Problem

African American race and culture present psychotherapeutic challenges. Contemporary research focuses on personalized, culturally competent psychological care (Norcross & Wampold, 2018) as well as the use of evidence-based practice (Beidas, et al., 2019). However, few studies specifically address African American psychotherapeutic needs.

Previous Research

The African American client's racial and cultural needs challenge the efficacy of longstanding psychotherapeutic practices. Nuanced barriers to quality care include cultural encapsulation, color-blind racial ideology [CBRI], and African American mental health service attitudes and stigmas.

Cultural Encapsulation

Racism's negative effects on the adaptation and functioning of African Americans were published as early as the 1950s and 1960s (Belgrave & Allison, 2019). Coined by Wrenn (1962), "cultural encapsulation" is a phrase that describes the culturally-bound beliefs, values, education and training that color a therapist's lens (Bergkamp & Ponsford, 2020). According to Suzuki et al. (2019), the key to decolonizing counseling psychology practice (thus discontinuing its entrenched Eurocentric, culturally encapsulated norms) is to draw from interdisciplinary work on economics, ethnography, and sociology.

Color-Blind Racial Ideology

Color-blind racial ideology theory is a complex topic that is applicable to the therapeutic alliance due to its possible effect on both therapists and clients. According to Neville, et al. (2013), CBRI is a multifaceted form of ultra-racism, consisting of four

sections: 1) denial of race, 2) blatant racial issues, 3) institutional racism, and 4) White privilege within intersecting themes of color-evasion and power-evasion. CBRI by Caucasians would be seen in the aforementioned areas, but CBRI by African Americans may manifest as perpetuation of the status quo as a form of internalized racism.

Gushue, Walker, & Brewster (2017) took the Color-blind Racial Attitudes Scale further, pairing it with intrinsic and extrinsic motivation to avoid prejudice, as well as self-deceptive enhancement and impression management. In their study of predominantly Northeastern, female, middle to middle-upper class Caucasian psychology graduate students, those who were rated as self-deceptive were positive correlated with color-blindness and a feeling that they had earned their successes. Additionally, these intrinsically-motivated participants were positively correlated "with greater awareness of the existence of blatant racism, institutional racism, and White racial privilege" (Gushue, Walker, & Brewster, 2017, pp. 82). However, those with extrinsic motivation were negatively correlated with attitudes supporting institutional racism.

African American Mental Health Service Attitudes and Stigmas

African Americans and other ethnic minorities face unique mental healthcare challenges. According to Belgrave and Allison (2019), barriers to healthcare may be physical (lack of funding, insurance, or transportation), or more abstract (cultural communication differences, distrust of the medical system, racism, stereotyping, and time orientation). By differentiating between attitudes and stigma, Fripp and Carlson (2017) found a weak positive correlation between help-seeking attitudes and counseling service participation (8% increased likelihood), as well as a weak negative correlation between care-seeking attitudes and stigma (20% attitude variability related to stigma). The 129 study participants were

predominantly male, southern, low-income, treatment naïve African American and Latino participants (70% were African American, and 88% had never received counseling services). Because lack of education about the benefits of mental health services and a limited perception of services may have been contributing factors (Fripp & Carlson, 2017), it is important for ethnic minorities who do seek care to have positive mental health service experiences.

The science of psychology has come far in identifying the issues of cultural encapsulation, CBRI, and African American mental health service attitudes and stigmas. However, as conspicuous problems are addressed with surface solutions, such as cultural competence training, subtler issues, such as microaggression, emerge.

Research Article One: An Experimental Test of Microaggression Detection in Psychotherapy: Therapist Multicultural Orientation

Racial differentiation is not inherently negative. Race theory can be defined by biological, social, or political criteria. Eliminativists focus on biological differences between African Americans and Caucasians in order to study genetics and target medical care to vulnerable populations. Political ontology leads to greater representation of African Americans in positions of power. Conservationalists create anti-discrimination laws and social policies, such as affirmative action (James, 2012). Though leaps have been made to combat system racism, institutional racism remains.

A therapist who wants to work with ethnic minority clients must examine and resolve his ingrained racial and social biases. Subconscious thoughts and assumptions make themselves known through microaggressive behaviors. Microaggression, which may be rooted in biological, political, or social ontological bases, disrupts the therapeutic process and

leads to less favorable treatment outcomes. This is elimination of personal bias is process that should begin in therapeutic training. An Experimental Test of Microaggression Detection in Psychotherapy: Therapist Multicultural Orientation (Owen et al., 2018) examines recognition of racial bias through the lens of microaggressive behaviors during therapeutic interactions.

Methods

Owen et al. (2018) chose a group of 78 burgeoning therapists to take part in the study. They varied in gender, race, and sexual orientation. Study participants varied in religious affiliation, including (from most to least represented): Agnostic (37.17%), Catholic (10.26%), Christian (23.08%), Other (12.82%), Atheist (8.97%), Jewish (5.13%), Buddhist (2.56%). Muslim (2.56%). Level of education ranged from Master's student (60.26%) to Doctoral student (38.90%), to Doctoral practitioner (3.84%). Most participants had completed one or more courses in cultural counseling or diversity.

After recruitment via Listservs and snowballing, participants were randomly assigned to control or microaggression groups. Participants viewed vignettes of simulated therapy sessions that were either neutral or contained microaggressions performed by the therapist. The microaggressions displayed were minimization of cultural identity, culturally insensitive treatment suggestion, and microinsult (Owen et al., 2018). Participants pressed a different key to indicate their interpretation of content as sensitive or insensitive.

Three scales, the 5-point Counselor Comfort Scale, Cultural Humility Scale, and Cultural Missed Opportunities Measure, were adapted to gauge vignette therapist performance as multicultural orientation measures (Owen et al., 2018). Participants were rated with the Color-Blind Racial Attitudes Scale.

Results

Participant responses were recorded and underwent multivariate analysis to determine the validity of three hypotheses: 1) Microaggressions in the form of insensitive comments would be noticed by participants, 2) Therapists demonstrating microaggressions would be rated lower in areas of cultural comfort, humility, and cultural opportunity utilization, and 3) Participants who scored themselves higher on the color-blind scale would interpret microaggressive behavior higher in the areas outlined in the second hypothesis. The first and second hypotheses were supported, but the third was not. This is consistent with the aforementioned findings of Gushue, Walker, and Brewster (2017; see Color-Blind Racial Ideology, *above*) in that participants demonstrating high self-ratings in color-blindness would be expected to call attention to several forms of perceived racism.

Evidence of Bias

Multi-cultural experts examined study content in order to assure accurate representation of microaggressions and realistic therapeutic conversations. Owen et al. (2018) took the appropriate steps to ensure an unbiased research study.

Owen et al. (2018) may have a study limitation that considered a form of bias in the slight underrepresentation of African American study participants. Four of the 78 participants were African American and six were biracial. Assuming some or all of the biracial participants identified as African American, 5.12- 12.82% of participants were African American, which is not consistent with the average number of African American psychologists (see *Societal Implications*, below). Furthermore, the number of African American psychologist participants is too few to represent the national African American population who are 13.3% African American alone or 2.9% biracial (Belgrave & Allison, 2019). [If we consider biracial and

African Americans together, they would comprise 16.2% of the United States population, which far exceeds Owen et al.'s (2018) possible total by 3.38%.] Though new software is capable of correcting for biased data sets, i.e. participant falsehoods, within studies processed for meta-analyses (Oberlader, et al., 2021), limitations in cross-cultural studies such as this piece by Owen et al. (2018) demonstrate the pervasiveness of lack of representation awareness that exists in psychological research.

Conclusions

In sixth century BCE, Lau Tzu advised, "To learn, one accumulates day by day. To study Tao, one reduces day by day" (Chang, 2014, p. 11). The goal of unlearning that which we consider knowledge is to further reduce one's ideas about the world until a "state of non-interference and spontaneity" (Chang, 2014, p. 11) is reached. With regards to microaggression, the ridges of societal thumbprint contributing to therapist bias must be sloughed off until only the furrows of humanity exist. The therapist can then learn from African American psychologists and clients to develop a new thumbprint that reflects a fresh appreciation and understanding of the African American condition.

Article Choice Rationale

This article was chosen because it overtly exemplifies underlying challenges to interracial therapeutic interaction. While not ostensibly problematic, subtle expressed bias has an effect on the therapeutic relationship.

Of equal importance to the study of cultural competence is the idea that researchers assumed participants identifying as color-blind would not recognize microaggressive behaviors. Indeed, the aforementioned work by Neville et al. (2013) couples color-blind behaviors with denial of institutional racism and goes as far as to label color-blind ideas

"ultra-modern racism." However, in practice, study participants who rated themselves higher on the color-blind scale recognized microaggressions and did not dismiss the therapist's behaviors as anything to be negatively attributed to the client (such as reaction to the client's personal attributes, as opposed to a discriminatory or racist issue with the therapist).

Applicability to Belgrave and Allison

Availability heuristics may alter the effectiveness of the therapeutic alliance and resulting treatment efficacy, but according to Belgrave and Allison (2019), solutions have been posed by several psychologists. With the addition of African American centric attributes, such as biological, extended, and kinship members. Boyd-Franklin's (1989) approach can be likened to an extended family therapy. The therapist exhibiting microaggressions may need to grow his personal definition of the word "family." Thus, perhaps the therapist can understand the importance a distant family member or "unrelated" friend has to the client.

Societal Implications

As the United States becomes increasingly diversified, therapists are tasked with the moral imperative to provide the highest quality of care they can to each client, regardless of race or socioeconomic status. Recent psychologist demographic reports exemplify provider diversity disparities. Though African Americans comprise 11.6% of the general population, they only account for 6.26% of psychologists. Non-Hispanic whites make up 62.5% of the general population, but 79.9% of psychologists (Psychologists, n.d.). This gives African Americans a coefficient of 0.54 and non-Hispanic whites a coefficient of 1.28— 2.37 times as many per capita. Psychologist positions, in particular, are projected to continue to

experience average growth (Bureau of Labor Statistics, 2020) and it's important to educate and hire more minorities in order to even the distribution curve.

Though affirmative action and preferential higher educational practices strive to close the gap, there is a wide disparity between the availability of trained counseling and clinical psychologists (as well as other therapists) and the general population. Until the distribution of therapists more closely matches the client base, existing therapists should be encouraged to develop not only cultural awareness, but truly culturally competent care.

Drawing on the aforementioned idea of interprofessionalism, therapists can reach out to members of neighboring disciplines in order to strengthen their culturally-sensitive practices. For example, sociologists are now developing empowerment and social justice frameworks (Suzuki et al., 2019) that can help psychologists identify with their clients' chronic stressors. Through nursing, psychologists can move from individualistic cognitive empathy to develop collective compassionate empathy skills. Though it has been traditionally linked to the calling of nursing (Bivins, Tierney, & Seers, 2017), compassion is inexorably linked with other metrics (such as HCAHPS and Healthgrades reviews) that affect the organization's bottom line. Social responsibility aside, it is in the therapists' and organizations' best interests to remove any lingering bias and move toward a culturally competent care model.

Future Research Opportunities

A person develops lasting change through intrinsic motivation, introspection, and concentrated effort. Because Caucasian therapists vastly outnumber their ethnically diverse colleagues, it is important to not only teach therapists how to adapt their attitudes and resulting behaviors to fit the needs of their clientele, but to measure outcomes as well. Future

research should be aimed at developing introspective anti-bias frameworks for intrinsically motivated individual practice, as well as tools to measure change in microaggressive behaviors.

The aforementioned idea of availability heuristics dictates that judgments may be formed using the most recent or salient information (Baddeley, 2015), as opposed to nuanced or even strongest evidence. Culturally appropriate frameworks have been established with regards to conducting randomized controlled trials in low-income Latino communities (Rangel & Valdez, 2017). Researchers may look at the techniques utilized in these types of studies to develop buy-in among ethnic minority providers and reverse engineer a multicultural psychotherapeutic training framework.

Conclusion

This paper addressed race and culture in psychotherapy. This paper provided an overview of race and culture in psychotherapy. A peer-reviewed article review on the topic of therapist microaggression exemplified methods, results, evidence of bias, and conclusions in contemporary, culturally focused psychotherapy research. The author provided research article choice rationales, as well as societal implications and opportunities for future research.

References

Baddeley, Michelle. (2015). Herding, social influences and behavioural bias in scientific research: Simple awareness of the hidden pressures and beliefs that influence our thinking can help to preserve objectivity. *EMBO Reports, 16*(8), 902-905.

Beidas, R. S., Williams, N. J., Becker-Haimes, E. M., Aarons, G. A., Barg, F. K., Evans, A. C., . . . Mandell, D. S. (2019). A repeated cross-sectional study of clinicians' use of psychotherapy techniques during 5 years of a system-wide effort to implement evidence-based practices in Philadelphia. *Implementation Science : IS, 14*(1), 67.

Belgrave, F. Z., & Allison, K. W. (2019). *African American psychology: From Africa to America* (4th ed.). Sage.

Bergkamp, J., & Ponsford, M. (2020). Cultural Encapsulation. In *The Wiley Encyclopedia of Personality and Individual Differences* (pp. 239-241). Chichester, UK: John Wiley & Sons.

Bivins, R., Tierney, S., & Seers, K. (2017). Compassionate care: Not easy, not free, not only nurses. *BMJ Quality & Safety, 26*(12), 1023-1026.

Bryant, G., Scott, I., & Worrall, A. (2000). Is norethisterone a lifestyle drug? Health is not merely the absence of disease. *British Medical Journal [BMJ](Clinical Research Ed.), 320*(7249), 1605.

Bureau of Labor Statistics. (2020, September 1). Psychologists. *Occupational Outlook Handbook*. Retrieved from https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm

Chang, C. (2014). *Tao, a new way of thinking: A translation of the tao teaching with an introduction and commentaries*. Jessica Kingsley Publishers.

Fripp, J. A., & Carlson, R. G. (2017). Exploring the influence of attitude and stigma on participation of African American and Latino populations in mental health services. *Journal of Multicultural Counseling and Development, 45*(2), 80-94.

Gushue, G. V., Walker, A. D., & Brewster, M. E. (2017). Motivation and color-blind racial attitudes among white psychology trainees. *Training and Education in Professional Psychology, 11*(2), 78-85.

Hamilton, J. E., Heads, A. M., Cho, R. Y., Lane, S. D., & Soares, J. C. (2015). Racial disparities during admission to an academic psychiatric hospital in a large urban area. *Comprehensive Psychiatry, 63*, 113-122.

James, M. (2012). The political ontology of race. *Polity, 44*(1), 106-134.

Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color-blind racial ideology. *The American Psychologist, 68*(6), 455-466.

Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence‐based relationships and responsiveness. *Journal of Clinical Psychology, 74*(11), 1889-1906.

Oberlader, V. A., Quinten, L., Banse, R., Volbert, R., Schmidt, A. F., & Schönbrodt, F. D. (2021). Validity of content-based techniques for credibility assessment-- How telling is an extended meta-analysis, taking research bias into account? *Applied Cognitive Psychology, 35*(2), 393-410.

Owen, J., Drinane, J. M., Tao, K. W., DasGupta, D. R., Zhang, Y. S. D., & Adelson, J. (2018). An Experimental Test of Microaggression Detection in Psychotherapy: Therapist Multicultural Orientation. *Professional Psychology, Research and Practice, 49*(1), 9-21.

Psychologists. (n.d.). Data USA. Retrieved January 18, 2021, from https://datausa.io/profile/soc/psychologists#demographics

Shochet, I. M., Orr, J. A., Kelly, R. L., Wurfl, A. M., Saggers, B. R., & Carrington, S. B. (2020). Psychosocial resources developed and trialled for Indigenous people with autism spectrum disorder and their caregivers: A systematic review and catalogue. *International Journal for Equity in Health, 19*(1), 1-134.

Suzuki, L. A., O'Shaughnessy, T. A., Roysircar, G., Ponterotto, J. G., & Carter, R. T. (2019). Counseling psychology and the amelioration of oppression: Translating our knowledge into action. *The Counseling Psychologist, 47*(6), 826-872.

Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32*(4), 444–449.

Appendix A:

An experimental Test of Microaggression Detection in Psychotherapy:

Therapist Multicultural Orientation

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An Experimental Test of Microaggression Detection in Psychotherapy: Therapist Multicultural Orientation

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Previous studies have documented a relatively high rate of racial–ethnic microaggressions in therapy (e.g., 53% to 81% of clients have reported at least 1 microaggression). In addition, clients who perceive racial–ethnic microaggressions from their therapist have reported lower working alliances and worse therapy outcomes. In one study, over 75% of microaggressions went unaddressed in psychotherapy, and the reason for this is not fully understood. It could be that therapists do not recognize racial–ethnic microaggressions when they occur or feel anxiety about the process of addressing them. A 1st step is to determine whether therapists are able to recognize racial–ethnic microaggressions. The current study included 78 therapists who were randomly assigned to one of 2 conditions: (1) a video vignette of therapy session with 3 racial–ethnic microaggressions (i.e., microaggression condition) and (2) a video vignette of a therapy session with no microaggressions (i.e., neutral condition). The results demonstrated that when compared to those in the neutral condition, participants in the microaggression condition rated the therapist as less sensitive overall, less culturally comfortable, and less culturally humble and as having missed more cultural opportunities. Within the microaggression condition, 38% to 52% of therapists accurately identified one of the 3 microaggressions.

Public Significance Statement
This study demonstrates that therapists might be at risk for not observing microaggressions. Additionally, performance recognition tasks might be a useful assessment approach for testing therapists' multicultural orientation.

Keywords: microaggressions, therapist, detection, multicultural competencies, multicultural orientation

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9

Deepta R. DasGupta received her MA in counseling psychology from the University of Denver and is currently working toward completion of her PhD from the same program. Her areas of professional interest include diversity issues in counseling, disparities in access to care, and trauma.

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Minority stress theory asserts that racial–ethnic minorities' (R-EMs[1]) experience of being discriminated against on a chronic basis can negatively affect their psychological well-being and ability to cope with other life stressors (Meyer, 2003). Indeed, many of the overt discriminatory and racist actions of the past have shifted into more covert and subtle forms, commonly entitled *microaggressions* (Sue, 2010; Sue et al., 2007). Sue et al. (2007) outlined three overarching forms of microaggressions: (1) *microinsults* (e.g., stating R-EM individuals are a credit to their race or pathologizing cultural values–beliefs, such as how R-EM individuals communicate), (2) *microinvalidations* (e.g., color-blind attitudes, such as not seeing race or assuming R-EM individuals are being too sensitive to racial–ethnic comments), and (3) *microassaults* (e.g., use of blatant racism but not in the presence of anyone from that race; Pierce, Carew, Pierce-Gonzalez, & Willis, 1978; Sue et al., 2007). The associated effects of microaggressions on R-EMs include lower levels of psychological well-being and selfesteem and increased psychological distress (e.g., Blume, Lovato, Thyken, & Denny, 2012; Mercer, Zeigler-Hill, Wallace, & Hayes, 2011; Nadal et al., 2015; Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; Pieterse, Todd, Neville, & Carter, 2012; Schoulte, Schultz, & Altmaier, 2011; Wang, Leu, & Shoda, 2011).

Although psychotherapy sessions are purportedly safe, they are not necessarily free of microaggressions. Current estimates of R-EM clients who report experiencing at least one microaggression from their therapist range from 53% to 81%, and these frequencies do not vary by clients' racial–ethnic status (e.g., Hook et al., 2016; Owen et al., 2017). Hook et al. (2016) examined microaggressions with 2,212 R-EM clients, and they found the most commonly experienced microaggressions involved therapists' avoidance of or minimization of cultural issues, as well as therapists' subtle expression of cultural stereotypes. These experiences can negatively affect clients' therapeutic experience and outcomes. In particular, there are six known studies that have examined clients' experiences of racial–ethnic microaggessions in relation to psychotherapy processes and/or outcomes in university counseling centers as well as community-based settings (Constantine, 2007; Crawford, 2011; Hook et al., 2016; Morton, 2011; Owen et al., 2011, 2017).[2] These studies have shown that client perceptions of racial–ethnic microaggressions were associated with lower quality working alliances and worse therapy outcomes (Constantine, 2007; Hook et al., 2016; Morton, 2011; Owen et al., 2017, 2011).

In many ways, microaggressions are a special case of ruptures– strains that are common to therapy (Eubanks-Carter, Gorman, & Muran, 2012; Safran & Muran, 2000). For instance, if a therapist does not remember a client's partner's name or aspects of the client's life history, that could result in a therapeutic misstep or rupture. Additionally, if a therapist is late to a session or misses a session, then the client could experience a strain in the therapeutic relationship. In contrast, if a therapist suggests that a client is being too sensitive and should not attribute racial–ethnic bias from others when that is what the client is describing, then that would constitute a microaggression. Alternatively, if a therapist does not account for racial–ethnic differences (i.e., color-blind attitudes; Neville, Lilly, Duran, Lee, & Browne, 2000), assuming all clients have equal opportunities to resources, then again that would constitute a microaggression (see Constantine, 2007; Sue, 2010). Given that ruptures and microaggressions can negatively impact the therapeutic relationship and therapy outcomes when not addressed, it is important for therapists to be able to address these situations.

Recently, Owen et al. (2017) examined whether R-EM clients experienced racial–ethnic microaggressions. Participants who reported microaggressions were also asked whether these cultural transgressions were addressed in therapy. In a sample of 120 R-EM clients, 53% of clients reported experiencing at least one racial–ethnic microaggression over the course of therapy. Of those clients who experienced a racial–ethnic microaggression, 76% reported it was not addressed. Within the 24% of clients wherein the microaggression was addressed, all but one noted the microaggression was resolved (Owen et al., 2017). Additionally, clients who experienced a

[1] Racial–ethnic minorities include individuals who come from historically marginalized backgrounds (e.g., African American–Black, Hispanic– Latino/a, Asian American–Asian, Native American).

[2] There are only two other known studies examining microaggressions against women and lesbian, gay, bisexual, queer clients in therapy (Owen, Tao, & Rodolfa, 2010; Shelton & Delgado-Romero, 2011).

microaggression that was not addressed reported lower working alliance compared to clients where no microaggression occurred and to clients with whom microaggressions were discussed and resolved (Owen et al., 2017). This study highlights two main issues: (1) the majority of microaggressions in Owen et al. that were addressed led to a repair in the alliance and (2) they found a large number of therapists who did not process microaggressions.

For therapists to be able to repair the rupture to the therapeutic relationship in the aftermath of a microaggression they need to (a) recognize a microaggression occurred and (b) then adequately respond. Yet, it may be the case that some therapists have a difficult time identifying microaggressions. For example, Katz and Hoyt (2014) found the association between therapists' implicit biased attitudes and self-reported multicultural competencies was small and not significant (r .06). Consistently, in a therapy dyad study, Fuertes et al. (2006) found that clients' and therapists' perceptions of therapists' multicultural competencies were not aligned (r .02), which suggests that therapists and clients could be interpreting therapeutic interactions differently when it comes to cultural topics. Collectively, these studies suggest a potential disconnection between therapist self-report of multicultural competencies and other task-based assessments or client assessments for multicultural processes. At the same time, all therapists have biases, and being able to identify and adequately respond is an important skill. Extending from these prior studies, in the current study we test whether therapists' ability to detect microaggressions is associated with their color-blind ideology or believing that racial–ethnic differences should not or do not exist (Neville et al., 2000; Neville, Spanierman, & Doan, 2006). That is, we contend that therapists who are more likely to endorse these beliefs would be more likely to miss the presence of microaggressions.

Detecting Microaggressions

There are two main ways in which therapists can detect microaggressions. First, they may explicitly recognize a microaggression comment–action as it occurs. Second, therapists' recognition of a microaggression may be more indirect (e.g., noticing other indicators of cultural incongruence between client and therapist). The present study assesses therapists' direct recognition of microaggression comments as well as their ratings of a therapist's multicultural orientation (MCO).

Multicultural orientation is a concept used to examine three dimensions of therapists' interactions with their clients, which include, cultural humility, cultural opportunities, and cultural comfort (Owen, 2013). *Cultural humility* relates to the therapists' ability to maintain an other-oriented approach marked by curiosity as well as a nonsuperior approach to addressing cultural differences (Hook, Davis, Owen, Worthington, & Utsey, 2013). In multiple studies, clients' perceptions of their therapists' cultural humility have been positively related to therapy outcomes and negatively associated with microaggressions (Hook et al., 2013, 2016; Owen et al., 2014, 2016). *Cultural opportunities* are those moments during a therapy session when cultural content is presented and has the potential to be explored in more depth (Owen, 2013). For instance, Owen et al. (2016) found that clients had better therapy outcomes when they felt that their therapist attended to their cultural heritage. Last, an MCO approach asserts therapists must demonstrate *cultural comfort* (e.g., ease, calmness) in culturally salient therapeutic interactions. For example, Owen et al. (2017) found therapists' cultural comfort partially accounted for racial–ethnic therapy outcome disparities within their caseloads. Accordingly, these three components of the MCO framework have some initial empirical support and could be a useful way of evaluating a therapist's actions–reactions in session.

Commonly a first step in therapists' training and development is ability to recognize therapeutic actions in others prior to examining one's own behaviors. For instance, therapists frequently observe videos or role-plays from instructors with the intention to help translate those skills into action. Accordingly, the current study examined therapists' recognition of racial–ethnic microaggressions. We developed two conditions depicting therapy dyads in action: one in which there were three notable microaggressions and the other (deemed a neutral condition) in which the therapist engaged in basic helping skills techniques (e.g., nonverbal affirmations, open-ended questions, reflections). The following hypotheses drove this study:

Hypothesis 1: Participants in the microaggression condition will recognize more insensitive comments made by the therapist compared to participants in the neutral condition.

Hypothesis 2: Participants will rate the therapist in the microaggression condition as demonstrating lower levels of cultural humility, cultural comfort, and ability to utilize cultural opportunities compared to the therapist in the neutral condition.

Hypothesis 3: Participants in the microaggression condition who scored higher on self-reported color-blind attitudes will be less likely to identify microaggressions (Hypothesis 3a) and more likely to rate the therapist as culturally comfortable, culturally humble, and adequately attended to cultural opportunities (Hypothesis 3b).

Method

Participants

Seventy-eight therapists completed the online study (we excluded eight participants who did not complete the study in full; i.e., the rating of the session). Of which, 15 identified as

cis-gender male,[3] 61 identified as cis-gender female, and two identified as transgender–genderqueer. Forty-eight participants were White– Caucasian, 19 were a racial–ethnic minority (six identified as Asian American, four identified as African American, three identified as Hispanic, and six identified as biracial–ethnic), and nine did not indicate their race or ethnicity. The mean age was 30 years (*SD* 9). Fifty-three participants identified as heterosexual; 16 as lesbian, bisexual, gay, questioning, fluid, or queer; and nine did not indicate their sexual orientation. Twenty-nine participants identified as agnostic–atheist–none, two as Buddhist, eight as Catholic, 18 as Christian (several different denominations), four as Jewish, two as Muslim, seven as having no specific religious affiliation, and 10 as having other affiliations (e.g., spiritual, deist). Forty-four participants were Democrat–liberal, two were Republican, 14 were independent (or a mix of liberal and conservative), one was Socialist, 14 indicated no affiliation, and four did not respond.

In terms of training, 37 participants indicated a background in counseling–clinical psychology, 10 in clinical mental health, 21 in marriage and family therapy, three in school psychology, and one in rehabilitation counseling; six did not respond to this question. Twenty-eight participants were in doctoral programs (27 in PhD programs, one PsyD), three had finished their doctoral degree, and 47 were in master's-level programs. Three participants indicated that they have not had a class on multicultural counseling– diversity (3.9%). The remaining participants had completed either one course (47.4%), two courses (15.8%), three courses (11.8%), four courses (7.9%), or more than four courses (2.6%) in multicultural counseling–diversity.

Measures

Microaggression detection task. We developed two video vignettes (approximately 11 min in length each) for the purposes of this study. We opted for microaggression versus neutral comparison (compared to a vignette where there were other types of ruptures) to first establish whether therapists could identify these comments such that they were not reacting to potentially poorquality therapy. This approach is also consistent with other experimental approaches, wherein the experimental condition is first tested against a neutral or control condition prior to testing against more active comparisons (Heppner, Kivlighan, & Wampold, 1992). Additionally, in comparison to the case with traditional analogue research, it was difficult and disingenuous to just change one or two statements in both conditions, because the client and therapist responses evolve from the ongoing dialogue. That is, it is difficult to remove microaggression statements while having a logical flow for the session.[4] Our approach mirrors randomized clinical trial studies, where adherence is measured but there is not an expectation that two therapies (even of the same theoretical orientation or from the same therapist) are delivered in the same manner. Indeed, empirical evidence has suggested that there is significant variation in how therapies are delivered across sessions, clients, and therapists (Boswell et al., 2013; Imel et al., 2011; Owen & Hilsenroth, 2014). We ensured that the two conditions were notably different from one another, which was verified by a panel of expert researchers–therapists. Thus, our comparison was commensurate with how we understood the efficacy of psychotherapy as a field.

In both vignettes, we hired actors (the same two actors for both vignettes) to play the therapist (White, cis-gender female, mid to late 30s) and the client (Hispanic, cis-gender male, late 20s to early 30s). These actors were semiprofessionals recruited from local actor organizations. We auditioned nine actors for the two roles, and the authors of this article determined who would be best for the roles. Additionally, we hired cinematographers to record and edit the videos.

In the first vignette (microaggression condition), we included three racial–ethnic microaggressions (minimization of cultural identity, culturally insensitive treatment suggestion, and microinsult). In the neutral condition, the therapist utilized explorationhelping skills (e.g., open-ended questions, reflection of feelings) to ensure that the vignette was notably different from the microaggression condition. The content of these videos is provided in the Appendix. The scripts for the two vignettes were initially vetted by the lead author's research lab (23 master's- and doctoral-level students in counseling psychology). Next, we enlisted four multicultural counseling content experts to review the scripts. These four experts were doctoral-level researchers–therapists who had multiple peer-reviewed publications on multicultural issues in psychotherapy. The experts were charged to ensure (a) the vignettes reflected racial–ethnic microaggressions, (b) the sessions were representative of actual therapy sessions, and (c) the two scripts were notably different. The four experts offered some wording changes, but all agreed that the conditions were notably distinct and the microaggressions were appropriate.

Additionally, we discussed within our research team as well as with the expert reviewers the prompts for endorsing a microaggression. The possibility of various words for the keystrokes (e.g., *therapeutic* vs. *nontherapeutic, discriminatory* vs. *nondiscriminatory, helpful* vs. *unhelpful*) were vetted. We decided to utilize the terms *sensitive* and *insensitive* to be applicable to both conditions without priming participants to look for microaggressions.

Given the requirements for our study, we developed an online platform where participants watched the video vignettes. They were instructed to press the *Z* key on the keyboard if they noticed the therapist being particularly sensitive in their

[3] The term *cis* means that the participants' gender identity is consistent with their gender expression.

[4] Our expert reviewers noted that not addressing cultural issues when explicitly stated by a client could be seen as an avoidance of cultural issues.

comments or actions. Additionally, they were instructed to press the *X* key on the keyboard if they noted the therapist being particularly insensitive. The software was programmed such that when participants pressed either key, a time stamp would be logged in the database.

We calculated three scores for the microaggression detection task. First, a total number of *X* responses or insensitive comments– actions identified was summed. This number reflected all insensi-

tive comments identified by participants, regardless of when participants pushed the *X* key. Second, we divided the total number of *X* responses by the total number of keystrokes. This score accounts for participants' responses to any stimuli. Third, we counted whether the participant identified the microaggression specific comments as being marked as insensitive within 5 s of the microaggression comments.

Multicultural orientation measures. We adjusted instructions to the client-rated measures of therapists' multicultural orientation. The only substantive change in the instructions was to evaluate an observed session versus an actual experience in session with a therapist. Given the paucity of cultural psychotherapy process measures, coupled with the psychometric support of the original scales, we believe this approach was the best option.

Counselor Comfort Scale (CCS; Slone & Owen, 2015). The CCS was designed to assess how clients view the degree of comfort the counselor appeared to exhibit in counseling sessions. We adapted this measure to be an external rating measure. The CCS has 10 items, which are rated on a 5-point scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). The instructions were as follows: "Overall, how comfortable did therapist appear to you in the session as it relates to dialogue around the client's cultural identity or cultural issues?" and sample items included "Comfortable," "Awkward," "Nervous," and "Calm." The client-rated version of the CCS has demonstrated strong internal consistency (Cronbach's alpha .94; Slone & Owen, 2015). For the clientrated version, the items loaded on one factor, explaining 61.6% of the variance, and all items had factor loadings of .60 or higher (exploratory factor analysis was conducted with principle axis extraction and oblique rotation; Owen et al., 2016). Moreover, it has been positively related to the working alliance, alliance behaviors, and therapy outcomes (Slone & Owen, 2015). This measure was also utilized. In the current study, the Cronbach's alpha was .93.

Cultural Humility Scale (CHS; Hook et al., 2013). The CHS consists of 12 items, seven reflecting positive cultural humility and five reflecting negative cultural humility. The CHS was originally a client-rated measure; however, for the purposes of this study we had the participants rate the therapist. The instructions were as follows:

> In this next section, we would like for you to rate the therapist based on the following items. These items reflect therapist's cultural humility. As above, it is important to keep in mind the interactions specific to cultural issues in session (as opposed to general interactions). As a reminder, cultural humility is an other-oriented mind-frame that is open to explore and understand the other's worldview and a mind frame that does not assume superiority or expertise. However, this stance does not mean that the therapist is completely deferent to the client's view, but rather invites the dialogue.

Example items included "is respectful," "acts superior" (reversedcoded), and "is genuinely interested in learning more." Participants rated the items on a 5-point scale ranging from 1 (*Strongly disagree*) to 5 (*Strongly agree*). The CHS was developed after screening the items with content experts and then through exploratory and confirmatory factor analyses with several diverse therapeutic samples (see Hook et al., 2013). The internal consistency of the CHS has been good in previous studies (Cronbach's alphas ranged from .86 to .93; Hook et al., 2013; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). Moreover, the client-rated version of the CHS has been significantly associated with other measures of therapists' multicultural competencies, general competencies, working alliance, and therapy outcomes (Hook et al., 2013, 2016; Owen et al., 2016, 2014). Additionally, clients' perceptions of their therapist's cultural humility have been associated with fewer perceived microaggressions from their therapist (Hook et al., 2016). We used the total score, and the Cronbach's alpha was .95.

Cultural Missed Opportunities Measure (Owen et al., 2016). Similar to the case with the other measures, we adapted this measure to be externally rated. The instructions were as follows:

> Please rate the degree to which the therapist in the video addressed (e.g., responded to or elicited) cultural issues within the session. In many cases, there are times where clients and therapists have the opportunity to discuss certain cultural issues more in depth (e.g., a client could mention in passing that their distress has shaken their faith in God, or that they feel empowered via a local social justice group around gay rights). These opportunities come and go. Sometimes they are important and other times, they are not. Please rate the following items regarding these cultural opportunities.

Sample items included "The therapist missed opportunities to discuss the client's cultural background," "The therapist avoided topics related to the client's cultural background," and "There were many chances to have deeper discussions about the client's cultural background that never happened." These items were rated on a 5-point scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), with higher scores indicating more missed cultural opportunities. The client-rated version of this measure has demonstrated a one-factor solution via an exploratory factor analysis, and the internal consistency was strong (Cronbach's alpha .86). For validity, the missed opportunities measure has been related to other cultural humility (*r* .58). Additionally, it has been significantly associated with therapy outcomes (*b* .13), after controlling for cultural humility, and number of sessions (Owen et al., 2016). In this study, the Cronbach's alpha was .83.

Therapist-rated measure.

Color-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000). The CoBRAS is a 20-item self-reported measure of

colorblind attitudes. The items are rated on a scale of 1 (*strongly disagree*) to 6 (*strongly agree*), with higher scores indicating more color-blind attitudes. An example item is "White people in the U.S. have certain advantages because of the color of their skin." The CoBRAS has been used in several studies, with associations in the predicted direction with other measures of racial attitudes, therapists' self-reported multicultural competencies, and therapists' racial identity (e.g., Gushue & Constantine, 2007; Neville et al., 2000; Neville et al., 2006). In this study, the Cronbach's alpha was .88.

Procedure

Participants were recruited via professional counseling, counseling psychology, psychotherapy, and clinical psychology Listservs as well as by snowball sampling (e.g., sending the announcement to other individuals who might qualify to participate). Upon clicking on the survey, participants were presented with the informed consent form, and if they endorsed wanting to continue, then they were randomized to the microaggression condition or the neutral condition. We contracted with a computer programmer to develop the platform for our videos and survey (blinded for review). This online platform allowed us to upload multiple videos and have participants indicate time-specific responses based on keystrokes. Additionally, this platform allowed for randomization to video conditions based on a random number algorithm, and we were able to link to another website for completion of the measures. Accordingly, after watching the video the participants clicked on a link to another survey platform to respond to the counselor comfort scale, cultural humility scale, cultural missed opportunity scale, and other culturally related items–demographics. We connected participants' responses between the two systems based on a unique identification system. Participants were eligible to enter a raffle for $50 at the completion of the study. All procedures were approved by a university institutional review board.

Results

We initially tested whether the two conditions differed based on overall insensitive comments–actions identified by the participants. The results were statistically significant, $t(74)$ 2.12, p .04, d .49. That is, the participants in the microaggression condition reported more insensitive comments–actions (M 7.89, SD 9.18) compared to those in the neutral condition (M 3.69, SD 8.06). Additionally, after accounting for the total number of responses, participants in the microaggression condition reported more insensitive comments–actions compared to those in the neutral condition, $t(74)$ 2.54, p .01, d .57. These results support Hypothesis 1. Table 1 reflects participants' accuracy in identifying microaggressions (range 38% to 51%), with less than a quarter of participants identifying multiple microaggressions. Next, we conducted a multivariate analysis of variance to assess whether participants' perceptions of the therapists in the two conditions varied on the outcome variables (i.e., cultural comfort, cultural humility, and cultural missed opportunities). The results demonstrated a significant effect for condition (Wilks's lambda .36), $F(3, 75)$ 42.22, p .001. As seen in Table 2, the between-conditions differences were all statistically significant (p .01) for all outcome variables. The effect size difference between the groups ranged from large to very large. These results support Hypothesis 2.

Last, for participants in the microaggression condition, we correlated their CoBRAS scores with their identification of microaggressions as well as their ratings of the therapist on cultural comfort, cultural humility, and cultural opportunities. As seen in Table 3, participants' CoBRAS scores were not statistically associated with identification of microaggressions. Additionally, their CoBRAS scores were not statistically significantly associated with their ratings of cultural comfort, cultural humility, or cultural missed opportunities. These results do not support Hypothesis 3a or 3b.

Table 1
Detection of Microaggressions

Microaggression	% identified (*n*)
Microaggression 1	40.5 (15)
Microaggression 2	37.8 (14)
Microaggression 3	51.4 (19)
Two out of three	24.3 (9)
All three	21.6 (8)

Note. Microaggression 1 Those who identified the first microaggression within the condition; Microaggression 2 Those who identified the second microaggression within the condition; Microaggression 3 Those who identified the third microaggression within the condition.

Table 2
Means, Standard Deviations, and Effect Sizes for MCO Variables by Condition

Measure	Microaggression: *M* (*SD*)	Neutral: *M* (*SD*)	Difference (Cohen's *d*)
Cultural comfort	3.22 (.91)	3.85 (.87)	.70
Cultural humility	1.86 (.67)	3.61 (.82)	2.34
Cultural missed opportunities	4.51 (.75)	3.84 (.74)	.91

Note. Microaggression condition n 37; neutral condition n 39. MCO multicultural orientation.
p .05. p .01. p .001.

Discussion

The current study is the only known study to test therapists' ability to recognize racial–ethnic microaggressions, and the results highlight several important issues. Racial–ethnic microaggressions in therapy can be discerned from more benign or neutral therapy interactions. The condition with microaggressions was differentiated from the neutral

condition in terms of the total number of insensitive comments therapists identified upon witnessing the interactions and also in terms of therapists' perceptions of multicultural orientation occurring in the session they watched. Indeed, the differentials between conditions on ratings of cultural humility, missed opportunities, and cultural comfort were notable (large effects). Consistently, all three predictors have been associated with therapy outcomes in studies where clients provided ratings of the therapists they worked with on these variables (e.g., Hook et al., 2013, 2016; Owen et al., 2016). Additionally, these results provide support for the multicultural orientation framework because the therapists watching could discern a culturally sensitive session from a culturally insensitive session where the tenets of MCO are in fact far from optimal.

Although therapists were able to differentiate between the two conditions, those assigned to watch the microaggression condition were, for the most part, not able to identify all of the expressed insensitive comments (i.e., microaggressions) as they were expressed (i.e., within 5 s). Approximately half of the participants identified at least one of the three microaggressions. However, it is noteworthy that less than a quarter of the therapists in the microaggression condition successfully identified two or three of the microaggressions. This raises an important question: Why were these microaggressions missed in the moment? It could be that recognition on behalf of therapists is based upon other observable cues from clients (e.g., facial expressions or changes in body posture) or that it is inhibited by some underlying assumption or bias held by the observer. Alternatively, it could be that the instructions to focus on sensitive and insensitive comments led to sustained inattentional blindness. For instance, Drew, Võ, and Wolfe (2013) found 83% of radiologists missed the insertion of a gorilla in a lung nodule detection task, even though the gorilla was 48 times larger than a typical nodule. Accordingly, it could be that focused attention could be inhibitory to natural processing.

Additionally, this study highlights that some therapists may be more astute in being able to identify these important and salient cultural transgressions in the moment. The variance in the ability to do so may be the result of therapist factors such as cultural awareness or mindfulness, for example. It is to be expected that some therapists perform better than do others. However, on a topic that is so inextricably related to client identity and important to therapy outcomes, the reasons for this must be uncovered. The one measure utilized to assess the observing therapists' color-blind attitudes was not significantly associated with detection ability or identification of multicultural orientation. This finding is consistent with findings of prior research examining therapists' multicultural competency measures and other non-self-report measures, insofar as the two methods tending not to be associated (e.g., Fuertes et al., 2006; Katz & Hoyt, 2014). As such, further research should be conducted to identify variables at the therapist level that may be influencing such processes.

Strengths and Limitations

The present study offers an important contribution to the field related to microaggression detection; however, the results must be interpreted within the context of the methodological strengths and weaknesses. The study utilized random assignment, whereby clinicians received either the neutral or the microaggression condition. Doing so allowed for a between-groups comparison whereby it could be asserted that detection of insensitive comments could be attributed to perceiving actual microaggressions as opposed to clicking at random. In a related vein, content experts were consulted so that the microaggressions depicted would represent realworld examples that clients might encounter and pick up on during a routine session. Yet, we do not know whether this paradigm will generalize to actual therapy practice. Ideally, we would have recorded microaggressions in actual therapy sessions. In doing so, it would be important to gauge the degree to which therapists and clients could identify a shift in the interpersonal dynamic.

Table 3
Correlations Between CoBRAS, Microaggression Identification, and MCO Variables for Microaggression Condition

	CoBRAS	
Measure	*r*	*p*
Total insensitive	.08	.67
Insensitive/ratio	.07	.69
Microaggression		
Microaggression 1	.03	.85
Microaggression 2	.13	.45
Microaggression 3	.01	.96
Two out of three microaggressions	.13	.46
All three microaggressions	.14	.44
Measure		
Cultural comfort	.25	.15
Cultural humility	.30	.08
Cultural missed opportunities	.23	.19

Note. Microaggression condition *n* 37. CoBRAS Color-Blind Racial Attitudes Scale; MCO multicultural orientation.

Moreover, the two vignettes differed on more than just the microaggression statements (e.g., number of interventions, type of interventions). This was done intentionally because the flow of the session would have been disjointed if we only removed the therapists' microaggression statements. Additionally, if the therapist ignored the client's cultural statements, then this inaction could have been interpreted as a minimization or avoidance of cultural issues, which is a microaggression.

We also utilized just one microaggression condition, which may limit the generalizability to other microaggressions, especially as related to other cultural identities (e.g., gender, sexual orientation). In many ways, this is a first step to a new generation of multicultural measures that are not reliant on client or therapist self-report. Additionally, there is a trade-off

on the length of the assessment (the videos were 11 min long) and wanting multiple assessment points. The use of multiple briefer video tasks might be needed to do a broader cultural assessment.

The clinicians in the study were not themselves being assessed as it relates to their multicultural orientation. They were observing the scenarios and rating their perceptions of the therapist in the video. Further, the sample of therapists who participated in this study was relatively small (*n* 79), and the vast majority of them were still in training. As such, this study is somewhat limited in its generalizability and should be replicated in a larger group with diverse cultural backgrounds and levels of training and also from diverse clinical sites.

Implications

The current study also highlights implications for training and practice of psychotherapists. For some reason, aspiring clinicians, who oftentimes enter the field to "help others," struggle to see examples of racial injustice being perpetrated right in front of them. This study emphasizes that at least in part, the reason that microaggressions go unanswered is because they go undetected. This is important to note and must be addressed in future research, so that training programs and educators can work to identify trainees who may miss the mark on cultural issues and make effort to improve their skills. Culture defines clients and therapists alike, and it is essential to determine what may interfere with therapists' objectivity regarding their perceptions in and about therapy sessions.

This study has begun to answer the first question about processing microaggressions. In part, the reason microaggressions are not discussed is because many therapists may not know they occur. Future studies should build upon this one to identify therapist-level variables that may predict detection ability. In addition, it is still not known why the therapists who do detect microaggressions do not process them. This may relate to anxiety surrounding the conversation or ambiguity about the impact that a statement has on a client. However, the thought processes of the therapists in these moments are not known. Further investigation of these domains will assist in the process of determining where to place emphasis and responsibility (i.e., teaching therapists to recognize the issue in the moment or teaching therapists to follow up and process the situation).

References

Blume, A. W., Lovato, L. V., Thyken, B. N., & Denny, N. (2012). The relationship of microaggressions with alcohol use and anxiety among ethnic minority college students in a historically White institution. *Cultural Diversity and Ethnic Minority Psychology, 18,* 45–54. http:// dx.doi.org/10.1037/a0025457

Boswell, J. F., Gallagher, M. W., Sauer-Zavala, S. E., Bullis, J., Gorman, J. M., Shear, M. K., . . . Barlow, D. H. (2013). Patient characteristics and variability in adherence and competence in cognitive-behavioral therapy for panic disorder. *Journal of Consulting and Clinical Psychology, 81,* 443–454. http://dx.doi.org/10.1037/a0031437

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54,* 1–16. http://dx.doi.org/10.1037/0022-0167.54.1.1

Crawford, E. P. (2011). *Stigma, racial microaggressions, and acculturation strategies as predictors of likelihood to seek counseling among Black college students* (Unpublished doctoral dissertation). Oklahoma State University—Stillwater, Oklahoma.

Drew, T., Võ, M. L. H., & Wolfe, J. M. (2013). The invisible gorilla strikes again: Sustained inattentional blindness in expert observers. *Psychological Science, 24,* 1848–1853. http://dx.doi.org/10.1177/0956797613 479386

Eubanks-Carter, C., Gorman, B. S., & Muran, J. C. (2012). Quantitative naturalistic methods for detecting change points in psychotherapy research: An illustration with alliance ruptures. *Psychotherapy Research, 22,* 621–637. http://dx.doi.org/10.1080/10503307.2012.693772

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, 43,* 480–490. http://dx.doi.org/10.1037/0033-3204.43.4.480

Gushue, G. V., & Constantine, M. G. (2007). Color-blind racial attitudes and white racial identity attitudes in psychology trainees. *Professional Psychology: Research and Practice, 38,* 321–328. http://dx.doi.org/10 .1037/0735-7028.38.3.321

Heppner, P. P., Kivlighan, D. J., & Wampold, B. E. (1992). *Research design in counseling*. Belmont, CA: Thomson Brooks/Cole Publishing Co.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60,* 353–366. http://dx.doi .org/10.1037/a0032595

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63,* 269–277. http://dx .doi.org/10.1037/cou0000114

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology, 58,* 290–298.

Katz, A. D., & Hoyt, W. T. (2014). The influence of multicultural counseling competence and anti-Black prejudice on therapists' outcome expectancies. *Journal of Counseling Psychology, 61,* 299–305. http:// dx.doi.org/10.1037/a0036134

Mercer, S. H., Zeigler-Hill, V., Wallace, M., & Hayes, D. M. (2011). Development and initial validation of the Inventory of Microaggressions Against Black Individuals. *Journal of Counseling Psychology, 58,* 457– 469. http://dx.doi.org/10.1037/a0024937

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697. http://dx.doi.org/10.1037/00332909.129.5.674

Morton, E. (2011). *The incidence of racial microaggressions in the crossracial counseling dyad* (Unpublished doctoral dissertation). Saint Louis University, St. Louis.

Nadal, K. L., Davidoff, K. C., Davis, L. S., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: Influences of race, ethnicity, gender, sexuality, and religion. *Qualitative Psychology, 2,* 147–163. http://dx.doi.org/10.1037/qup0000026

Nadal, K. L., Wong, Y., Griffin, K. E., Davidoff, K., & Sriken, J. (2014). The adverse impact of racial microaggressions on college students' self-esteem. *Journal of College Student Development, 55,* 462–474.

Neville, H. A., Lilly, R. L., Duran, G., Lee, R. M., & Browne, L. (2000). Construction and initial validation of the Color-Blind Racial Attitudes Scale (CoBRAS). *Journal of Counseling Psychology, 47,* 59–70. http:// dx.doi.org/10.1037/0022-0167.47.1.59

Neville, H., Spanierman, L., & Doan, B. T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 12,* 275–290. http://dx.doi.org/10.1037/1099-9809.12.2.275

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy: Theory, Research, Practice, 50,* 496–502. http://dx.doi.org/10.1037/a0034617

Owen, J., Drinane, J., Tao, K., Adelson, J., Hook, J., Davis, D., & Foo Kune, N. (2017). Racial-ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27,* 102–111. http://dx.doi.org/10.1080/10503307.2015.1078517 Owen, J., Imel, Z., Tao, K., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling & Psychotherapy Research, 11,* 204–212. http://dx.doi.org/ 10.1080/14733145.2010.491551

Owen, J., Tao, K., Drinane, J., Hook, J., Davis, D., & Foo Kune, N. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47,* 30–37. http://dx.doi.org/10.1037/pro0000046

Owen, J., & Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology, 61,* 280–288.

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice, 45,* 283–290. http://dx.doi.org/10 .1037/a0037420

Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions against women in short-term psychotherapy: Initial evidence. *Counseling Psychologist, 38,* 923–946. http://dx.doi.org/10.1177/0011000010376093

Pierce, C., Carew, J., Pierce-Gonzalez, D., & Willis, D. (1978). An experiment in racism: TV commercials. In C. Pierce (Ed.), *Television and education* (pp. 62–88). Beverly Hills, CA: SAGE.

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59,* 1–9. http:// dx.doi.org/10.1037/a0026208

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Schoulte, J., Schultz, J., & Altmaier, E. (2011). Forgiveness in response to cultural microaggressions. *Counselling Psychology Quarterly, 24,* 291– 300. http://dx.doi.org/10.1080/09515070.2011.634266

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58,* 210–221. http://dx.doi.org/10.1037/a0022251

Slone, N. C., & Owen, J. J. (2015). Therapist alliance activity, therapist comfort, and systemic alliance on individual psychotherapy outcome. *Journal of Psychotherapy Integration, 25,* 275–288. http://dx.doi.org/10 .1037/a0039562

Solórzano, D. E., Ceja, M., & Yosso, T. J. (2000). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education, 69,* 60–73.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62,* 271–286. http://dx.doi.org/10.1037/0003-066X.62.4 .271

Wang, J., Leu, J., & Shoda, Y. (2011). When the seemingly innocuous "stings": Racial microaggressions and their emotional consequences. *Personality and Social Psychology Bulletin, 37,* 1666–1678. http://dx .doi.org/10.1177/0146167211416130

Appendix
Vignette Scripts by Condition

Minutes 1–2—broad intro that will be displayed in all conditions.

Therapist: Hey, Diego, good seeing you again. How's it going?

Client: Going okay. I still feel a bit down, but I did get some feedback on the project that I told you about from work. My boss pointed out some small issues, but overall said it was great. I was pretty nervous before I turned it in for him to see, but his reaction helped me to see that I'm adjusting to the new tasks and that I'm doing okay at the things they are assigning for me.

Therapist: Aw, I'm so glad—that must be a real relief. I know you were stressed about how that would go—how you would be evaluated . . .

Client: Yeah—definitely. It was overwhelming at first, but I felt like our conversation last week really helped me to get through it. I thought about what you said, and I'm starting to feel a bit better about things—you know, not as down, and like counseling and talking with you can actually help me.

Therapist: I'm happy to hear that things are looking up and that you are feeling good about the work we are doing together.

Client: Yeah, me too. Definitely moving in the right direction, but still feel down a lot.

Therapist: Well, with that in mind, what would you like to start with today?

Client: Hmmm—I was thinking about that as I was driving here. I feel like I've been trying so hard to keep things together with my girlfriend and at work, so little things are building up. Even last night, I called my mom just to vent and share some of my stress with her. We have that kind of relationship, where I can let things out and she is supportive and knows the right advice to give me me.

But when we were talking last night, I got so overwhelmed that I started to tear up. Then it made her cry just knowing how bad things feel to me right now—even with little successes, it feels like an uphill battle . . .

Therapist: It sounds like things are adding up to make you feel overwhelmed and exhausted even . . . and your mom can sense that and connect with your experience. How did you feel after that conversation, knowing that it was so emotional for both of you?

Client: It just let me know how much I have to work on. Seeing my mom moved in that way by how hopeless I'm feeling—it let me know I needed to tell you about it.

Therapist: Sure. Well, let's explore that in here and see if we can get a better sense of what is underneath that—what is at the root of what is going on for you . . .

Condition: Microaggression

Client: Especially over this past week, I've been trying to stay upbeat and to keep myself motivated. These past few months have just sucked—I cannot kick these negative feelings. Even when I'm really putting in the effort, I go to work, push through the day, and [sigh] when I get home, I just have to unwind and reboot, and it doesn't feel like enough. It takes everything I've got just to tolerate my day, and then I just settle in in front of the TV, which makes my girlfriend upset, but I just do not want to deal with it. I cannot explain it to her, but all I want to do is veg out.

Therapist: Hmm. Yeah, it sounds like you are spending so much energy at work that you aren't able to take care of yourself when you get home. Does that sound right to you?

Client: Exactly. Work takes it out of me, and I do not have the motivation to put forth to work on my relationship or to spend time with my family, and that's what I really want to do. I miss them, and I miss feeling like myself.

Therapist: So you are in survival mode, just trying to make it through? Sounds hard to keep this up. What do you think is contributing to that?

Client: I think in part it has to do with my being the only Mexican man in my office. Like I feel so on edge without a feeling of community and connection with my colleagues, and it wears on me all the time. I'm on my own, and people aren't really reaching out. It's exhausting trying to make it all come together and being by myself.

Therapist: Well, after listening to you these past few sessions, I'm not really sure if you being Mexican has anything to do with it. . . . A lot of people experiencing depression like you are feel lonely and isolated. Do not be so hard on yourself.

Brief Pause …

Client: I mean, maybe, I guess so . . .

Therapist: How many days of the past week would you say that you were feeling depressed or down?

Client: Probably five. I start to feel better on the weekends, but it's always kind of there in the back of my head, so I feel like I'm using energy to not think about it. Once Sunday hits, I do not really feel like doing anything, because I know the week is about to start again.

Therapist: Yeah, that sounds like it must be really tough to feel down in that way, especially as often as you do. What do you think might help you to cope?

Client: I think I have to start to become more confident with what I'm doing. I care a lot about doing a good job—you know I've always excelled in my academics—honor roll, that kind of thing, played football in high school and college, always had internships, but I just worry that I will be negatively evaluated in this new environment.

Therapist: Have there been times in the past when you have been evaluated in this way?

Client: No, not really. I'm just afraid of what it might feel like to fail. My parents placed a lot of emphasis on me doing well, and I've always risen to the occasion. There have been a few times when I've struggled, and they were supportive, but I knew I was letting them down.

Therapist: I can sense that you are feeling a lot of pressure. What do you fear will happen if you let them down?

Client: I know they would understand. They know it's not because I'm lazy or anything. I think I'm more afraid of letting myself down really. I want to be able to take advantage of all these opportunities, and I do not want to struggle through them. I've worked hard, and I do not want my success to stop just because I doubt myself.

Therapist: I think I see. Can you tell me more about this self-doubt?

Client: I guess it's more of that I'm used to people valuing my being around, which has been true in almost every setting in the past. Regardless of what I was doing, I had people looking up to me—be it on the team or in my church group. And now, I just feel isolated and on my own in the office. I just do not have the same feeling of being a leader, and that makes me question if I'm valuable.

Therapist: It makes sense that you are struggling with this change—moving from situations where you felt comfortable to a place where you do not feel as seen for what you can contribute.

Client: Exactly, things are just so different at work right now, compared to how they have been in the past . . . I do not feel recognized for who I am. I do not want to give up, because I know I can be successful, like with the project I did. I have moments of clarity that remind me that I'm capable of doing really well.

Therapist: That's great that you can recognize when things turn out positively at work and be able to keep track of them. I'm wondering what barriers are still in your way.

Client: Well, I'm exhausted most days and do not really feel like I have the energy to tackle more than what I'm doing. During the interview, my boss spoke about the workspace being really inclusive and a place where everybody could contribute, but you can see from his actions that he plays favorites. Like even in the lunch room, he always sits with the same two guys, and I do not want to impose and join them. In meetings, he's always emphasizing everybody being treated the same, but I kinda feel like he wants everybody to be the same, which makes me feel invisible.

Therapist: Wow, that's really powerful. I'm having a reaction as you say the word *invisible.* You really want your boss to see you for you.

Client: Yeah, that's it. I really do.

Therapist: I wonder what would it be like for you to just be your personal self, and not your Mexican self when you are at work, so that you could see yourself as everybody else working there, ready to join the other lunch table?

Brief Silence…

Client: Um, I do not know. . . . I never really tried that before.

Therapist: What would it take you to try something differently?

Client: I'm just feeling exhausted most days, and I do not really feel like I have the energy to go above and beyond and reach out.

Therapist: Yeah, I can see how that would provoke a lot of anxiety for you. What do you think that would look like if you pushed yourself to connect with your colleagues? I wonder if we can try to envision that in here . . .

Client: To try looking at the office in a new way? Um, I guess just trying to maybe see what I might have in common with some of the guys who work there. It seems like I'm already in this outsider role. I'm sure I have lots of things I could connect with them on—politics, work, girlfriend, sports, beer. They are guys . . . but I also feel the differences between us, and that keeps me from opening up.

Therapist: Yeah, I get that.

Client: I do not know how much of it's me not being sure of how to approach them and how much of what I'm thinking is real. . . . Are they uncomfortable and distant because I'm new? Or is it that I'm Mexican? I get in my head and wonder if they are afraid of me—afraid to approach me, afraid to get to know me—or just if they are judging me. You know? What is it about me that gets in the way of them taking me in as one of the guys?

Therapist: I can see as you ask all these questions that it's on your mind a lot.

Client: It is. I went to a primarily White undergrad and master's program. I also developed plenty of great friendships, but what I see in my office is this hesitancy among my colleagues, and it makes me wary in return. They kind of have this offputting vibe about them, like they dress the same, and act the same, and they get pretty quiet when I get close. It makes it pretty hard to approach them.

Therapist: You know, it's easy to get pretty isolated when you are feeling depressed, so I wonder if that's playing a role in making it seem like they are unapproachable. I wonder if trying to engage them in conversation could be good for all of you, so all of you can be reminded of the fact that you are a really smart, well-educated, and hardworking Mexican man and that you do have things in common with them.

Client: I guess so.

Therapist: I know it can be hard to talk to people who are clearly an established group, so how do you think you might go about that?

Client: I guess I could just go sit down with them when we break for lunch. Or maybe ask a question about something for work to try to open up a conversation.

Therapist: Those sound like great ideas. I think this will get easier for you. I know that when you put yourself out there, these people will see all the great things and qualities that others have admired in the past.

Condition: Neutral

Therapist: You know, you mentioned earlier that you are feeling hopeless at work, but also that things might be looking up. I wonder how you are feeling about your work situation now.

Client: Well. I guess I am not feeling totally hopeless—getting a good review definitely helped a lot there—but I still feel this kind of sick feeling in my stomach when I think about going to work each week. I just do not know if it's the right place for me, and that worries me because I had to fight really hard to get here.

Therapist: How so?

Client: Well, this firm is really prestigious, so I had to work really hard to do well and land this spot. But it's more that this is kind of new for my family. Everyone in my family went into medicine, and I was headed that way until I hit college and I changed directions completely. I felt like my parents wanted to be supportive but they felt a little let down. I think they kind of saw it as me selling out but they didn't want to say it.

Therapist: Selling out?

Client: Yeah, well, it's always been really important to my family to do something that helps people, and with so many doctors and nurses in the family, that was kind of easy to do. I feel like they see me going to business school as me choosing money over people, and it's not like that. I really just thought this was what worked for me. In college, it all really seemed to click for me. It felt like this was what I was supposed to be doing. And it's not like choosing business means I'm going to go corporate and totally give up on my values, but I've never felt that they were totally convinced on that. So that makes it hard right now because I felt like I was constantly having to defend my decision to go to business school to them, and now I'm not happy with my job. I'm so afraid this was the wrong choice for me, and I do not feel like I can talk to them about it, because in their heads, they might be, like, well, yeah. And I'm so used to being able to talk to my parents about pretty much everything, especially my mom. She and I are so

Therapist: So you feel like you cannot even get support from the people you always go to because you might hear an "I told you so."

Client: Pretty much. And she probably wouldn't actually say it, but she would think it and she would feel bad, but this is also the only big thing we have ever disagreed on. She also totally loves my girlfriend, so she would not be cool with the fact that this huge choice I made that she doesn't really agree with is affecting my personal life, too. She tries not to push, but she is really hoping we get married and have kids soon so she can do the grandma thing. But I'm kind of just rambling now.

Therapist: I do not see it as rambling. It seems like you're really questioning everything right now, and it's affecting every part of your life.

Client: Yeah exactly. I feel bad saying it, but it's kind of like I cannot even think about the issues with my girlfriend right now. Part of it is just that I hope that if things get better at work, the stuff with her will just get better on its own. But a lot of it is also that it's just too much to deal with right now, and the work problems seem so much bigger. This is kind of my whole life I'm talking about, and I'm really afraid I made a wrong choice.

Therapist: Have there been other points where you have questioned this decision, going to business school?

Client: Um, I'm not really sure. Like, it was hard when I was in school, especially when I was getting the MBA, but I think it was mostly just that it was such a hard program and I felt like I had to defend it to my family all the time. I do not know if I really wondered about what I was actually doing so much as I felt like I couldn't get their support. And it was so different from everything my family was doing that I couldn't even explain it to them half the time, so it left me feeling kind of cut off from them. But I do not know if it was really that I didn't think I could do it, or I didn't think I would be good at it and happy with it. I just couldn't get them to get it.

erapist: So this fear that it's not the right place for you is pretty new.

ient: Yeah. Really new. I do not know if I really thought it might be a mistake until I said it just now.

erapist: That must be pretty scary for you.

ient: Yeah.

erapist: What makes you think this is a mistake?

ient: I'm not really sure. I guess maybe that I still keep coming back to feeling hopeless about it. When I left work the other day, I felt so good because I had that good review, and it felt like things might be looking up. But that night, I got that same sick feeling. I was just dreading going back. I couldn't hang on to the good feeling from doing something right. I fell right back into assuming I'm going to screw up again.

erapist: So what was the next day of work like for you?

ient: It felt pretty typical. I felt like I was making a lot of mistakes again. I tried to think about the success from the day before, but it was hard not to doubt myself. I guess that might be a lot of it. I doubt my abilities when I'm there.

erapist: How so?

ient: I just do not really trust myself. I know I know how to do the work —there was never a time that I just didn't know what was going on when I was in school. But putting it together in a real work environment, and being part of a team that's expecting me to be perfect, that's really stressful. I just do not know if I can do it.

erapist: It seems like that self-doubt keeps coming up when you are at work. Have there been other times you've felt like that?

ient: No.

erapist: Never?

ient: Maybe for really little things, but I cannot think of anything. I've always felt like a lot of things came pretty naturally for me, and if they didn't, I could get where I needed by working harder. I do not think there was ever a point that I really didn't know if I could get where I needed. It sounds kind of arrogant, now that I think of it—like I'm saying I'm great at everything.

Therapist: Do you feel you're arrogant?

Client: Maybe a little, but not really. My dad used to always tell us that it's not arrogant to know your skills, as long as you actually have them—basically that you do not do any good with fake modesty, that you need to know your weaknesses but also your strengths if you're going to improve on any of it. So I guess I have been really lucky up till now that I've been able to do well with everything. Or maybe I somehow picked things I would be good at. And this time I didn't.

Therapist: You know, it sounds to me like you are saying that the fact that you are doubting your abilities at work means you are just bad at it.

Client: Yeah, I guess.

Therapist: Is that true?

Client: I do not think I would be doubting myself if I was good at it. But I can see what you're getting at, that I'm making it pretty all-or-none in my head. I know I have been lucky to have not really struggled at things before, so how I've been feeling at work really threw me. Part of me feels like I need to get it together and just work harder, but it's hard to ignore that voice that's telling me it's a sign that I do not belong there, that I picked the wrong field.

Therapist: How will you know?

Client: I'm not sure. I have only been there for a few months, so maybe this is just part of the process of getting comfortable. Maybe the good review is a sign it's starting to get better and I'm missing it because I'm so focused on all the bad. It's a lot easier to say that when I'm here though, because I can think about it when I'm not right there in it and feeling crappy about myself. But I guess for now, all I can really do is keep going, try harder to focus on the wins and look at the mistakes as an opportunity for growth, like my father would tell me to.

Therapist: That sounds like a pretty good way of looking at things.