DISSERTATION

MICROAGGRESSIONS AND THE EXPERIENCES OF MULTIRACIAL CLIENTS IN

PSYCHOTHERAPY: A QUALITATIVE INVESTIGATION

Submitted by

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ABSTRACT

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Although the importance of cultural competence for mental health professionals is widely

agreed upon, it is often difficult to evaluate how this occurs in practice. The present study used a

qualitative methodology to investigate the experiences of multiracial individuals in therapy with

a particular focus on how race was addressed within the therapy relationships. Researchers

investigated: 1) which, if any, microaggressions came up during psychotherapy, 2) how

multiracial individuals made sense of microaggressions in therapy, and 3) what contributed to

more positive experiences of discussing race in therapy. Thirteen multiracial individuals from

various racial backgrounds were interviewed about their experiences in psychotherapy. Analyses

revealed three major themes that occurred in all 13 interviews: therapist microaggressions,

helpful therapist behaviors around race, and the impact of microaggressions in therapy.

Multiracial microaggressions in the present study included: avoiding/minimizing race in therapy;

denial of multiracial reality; stereotypical assumptions based on race; second-class status and

treatment of multiracial people. Microaggressions negatively impacted the therapy experience

such that many clients who experienced microaggressions felt worse, struggled with the dilemma

of whether or not to confront microaggressions, became more guarded, felt therapy was not

helpful, and ended therapy early. In addition to the themes of microaggressions in therapy, the

present study also highlighted a number of positive ways that therapists addressed race with their

multiracial clients. Results from the present study highlight both challenges and opportunities of

doing culturally sensitive work with multiracial individuals.

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KEYWORDS

Keywords: psychotherapy with biracial and multiracial individuals, microaggressions in psychotherapy, culturally sensitive psychotherapy

INTRODUCTION

Psychotherapists have an ethical and professional mandate to provide culturally sensitive care to individuals from historically oppressed and marginalized social groups. Although the importance of cultural competence for mental health professionals is widely agreed upon, it is often difficult to evaluate how this occurs in practice (Sehgal et al., 2011). In order to understand both successful interventions and barriers to success in psychotherapy with people of color, there is a need for research on the experiences of individuals from specific cultural groups in psychotherapy (Constantine, 2007; Shelton & Delgado-Romero, 2011; Thompson, Cole, & Nitzarim, 2012). Studying the experiences of individuals from particular racial and ethnic groups allows for a richer and more contextualized understanding of how cultural dynamics impact clients' experiences in psychotherapy (e.g., Chang & Berk, 2009). The present study focused specifically on the experiences of individuals who identify as multiracial in psychotherapy.

It is difficult to know what percentage of the population identifies as multiracial, in part because it was not until 2000 that U.S. Census respondents were able to mark more than one racial category. Nonetheless, data suggest that multiracial individuals represent a growing group in the United States. In 2010, more than nine million people marked two or more racial categories on the U.S. Census, a 32% increase from just 10 years earlier (Humes, Jones, & Ramirez, 2011). The existence of individuals with parents from two or more separate racial groups is not a new phenomenon; what has changed is the increasing recognition of biracial and multiracial identities as legitimate categories and increasing social movement toward a common multiracial identity for people from various backgrounds (Rockquemore & Brunsma, 2002). As more individuals in the United States identify as multiracial, it is important that mental health

professionals gain awareness of cultural issues that may arise when individuals from these backgrounds seek psychotherapy.

Microaggressions in Therapy

One of the issues that have been explored in research on psychotherapy with individuals from marginalized backgrounds is the occurrence of therapist microaggressions (Constantine, 2007; Shelton & Delgado-Romero, 2011). First coined by Pierce (1970), the term *microaggression* conveys that discrimination often occurs in subtle and covert forms as part of the everyday experience of people from marginalized social groups. Microaggressions have been described as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional" that communicate insulting, hostile, or negative messages to individuals from historically oppressed backgrounds (Sue et al., 2007, p. 273). Microaggressions are often unconscious and are perpetrated by those who deny any prejudice. This includes mental health professionals, who experience the same social conditioning as other human beings, and may therefore unintentionally perpetrate microaggressions during their work with clients who identify as members of marginalized social groups (Sue et al., 2007).

Microaggressions can be categorized into three main types: microassaults, microinsults, and microinvalidations. Microassaults are the most overt form – explicit verbal or nonverbal attacks that are meant to hurt the intended victim (Sue et al., 2007). An example would be using a racial slur to refer to a person of color. Microinsults are typically unconscious remarks that convey insensitivity and derision based on race, gender, sexual orientation, or other social identities. These may even be disguised as positive statement or compliments – for instance, a lesbian client being told by her therapist that she was "too pretty to be gay" (Shelton & Delgado-Romero, 2012, p. 216). Microinvalidations also occur at the unconscious level, and are

statements or behaviors that exclude or deny the experiences of socially devalued groups. One pervasive illustration of this would be "colorblindness" – assertions of "not seeing color" or statements that racial-cultural differences do not matter. Microinvalidations may also be present at the systemic or institutional level – heteronormative intake forms in a psychotherapy office or the absence of therapists of color in a community agency that serves a diverse client base. These "colorblind" perspectives deny the importance of power and privilege in the lived experiences of people of color, and contribute to a sense of invisibility (Sue et al., 2007).

Initial research has supported Sue et al.'s (2007) hypothesis that cultural ruptures in therapy could be explained in part by therapist microaggressions (Constantine, 2007; Shelton & Delgado-Romero, 2011). In studies of microaggressions in psychotherapy, participants had strong, emotional reactions to these incidents and reported feeling uncomfortable, powerless, and invalidated. In some cases, therapist microaggressions led LGBQ clients to question the efficacy of therapy altogether (Shelton & Delgado-Romero, 2011). Additionally, more reported microaggressions predicted lower counseling satisfaction and a worse perception of the therapeutic working alliance for African Americans (Constantine, 2007) and for women in psychotherapy (Owen, Tao, & Rodolfa, 2010). Nonetheless, similar studies have identified the importance of therapists' willingness to acknowledge cultural missteps and repair ruptures in the working alliance (Chang & Berk, 2009; Thompson, et al., 2012). Thus, preliminary results suggest that microaggressions do occur in psychotherapy and that understanding clients' perceptions of these incidents is useful for mental health professionals.

Multiracial Identity and Microaggressions

With regard to microaggressions in the everyday lives of multiracial individuals, six major themes have been identified based on common experiences in the literature (Johnston &

Nadal, 2010; Nadal, et al., 2011). First, exclusion or isolation microaggressions occurred when multiracial individuals are forced to choose a single race (i.e., on a form) or were rejected by certain groups based on their multiracial status. Second, exoticization and objectification microaggressions occurred when multiracial individuals were dehumanized and objectified (e.g., being heralded as the poster child for a post-racial society or being sexualized on the basis of their racial identity). A third type of microaggression was the assumption of monoracial identity or mistaken identity. For example, multiracial individuals have reported that others share racist jokes or comments not recognizing the possibility that they were speaking with a member of that racial group (Buchanan & Acevedo, 2004). The fourth microaggression was the denial of multiracial reality, exhibited when multiracial individuals were attacked or criticized based on their racial self-identification. Fifth, pathologizing of identity and experience was a microaggression exemplified by the "tragic mulatto" stereotype in which Black/White mixed race people were viewed as hopeless based solely on their racial backgrounds (Johnston & Nadal, 2010). The last category was microaggressions based on racial stereotypes, in which multiracial individual were stereotyped based on one of their racial groups – for example, an Asian/White American woman being treated as a foreigner in her own country, a common microaggression targeted toward Asian/Asian American individuals (Nadal et al., 2011).

In addition to the themes identified above, researchers have also found that multiracial individuals experience prejudicial and hurtful comments from monoracial members of their own racial groups (Brackett, Marcus, McKenzie, Mullins, Tang, & Allen, 2006; Nishimura, 1998). Based on similar findings across studies (Brackett et al., 2006; Buchanan & Acevedo, 2004; Nishimura, 1998), researchers have theorized that multiracial people may be more likely to

experience racism, and that multiracial individuals may be more aware of these incidents of discrimination due to their unique social context as members of multiple social groups.

Psychotherapy with Multiracial Individuals

Although a number of articles have been published on multiracial and biracial individuals in psychotherapy, these articles have relied on clinical vignettes and case studies (Aldarondo, 2001; Buchanan & Acevedo, 2004), or applications of theory to clinical practice (Pedrotti, Edwards, & Lopez, 2008). Studies that have used empirical methodology (Miville et al., 2005; Rockquemore & Brunsma, 2004) have focused on general racial identity development and not specifically on experiences in psychotherapy. There remains a need for empirical research that directly examines the subjective experiences of multiracial individuals in therapy.

In summary, microaggressions are likely to occur within the counseling relationship and can have a powerful impact on clients' perceptions of their therapists and their attitude toward therapy altogether (Constantine, 2007; Shelton & Delgado-Romero, 2011). Prior studies have focused on the experiences of members of specific cultural groups in therapy; yet no empirical studies to date have focused on the experiences of multiracial individuals. Given that multiracial individuals represent a rapidly growing cultural group, understanding their experiences in psychotherapy within the context of microaggression literature represents an essential and valuable contribution to the literature on culturally-responsive psychotherapy.

Purpose of the Present Study

The purpose of the present study was to expand the research on microaggressions in psychotherapy by focusing on the subjective experiences of multiracial individuals. The term *multiracial* was used to represent the researcher's inclusive focus on individuals with heritage from two or more separate racial groups. Additionally, this study aimed to extend the work of

prior microaggression studies (e.g., Shelton & Delgado-Romero, 2011) by asking about both positive and negative experiences. Researchers were interested in exploring: 1) which, if any, microaggressions came up during psychotherapy, 2) how multiracial individuals made sense of these microaggressions in the context of therapy, and 3) what contributed to more positive experiences in therapy with regard to race.

METHOD

Rationale for Qualitative Design

In this qualitative study, researchers used interpretative phenomenological analysis (IPA) to capture a nuanced description of a complex and subjective experience. IPA acknowledges the impossibility of truly inhabiting another person's worldview and rather focuses on making explicit and visible the biases and beliefs that influence the perspectives of the researcher and the participants (Smith, Flowers, & Larkin, 2009; Willig, 2001). In this case, a phenomenological approach was used to understand and analyze clients' subjective experience of microaggressions in psychotherapy as well as how they made sense of these incidents in the larger context of their overall positive and negative experiences in therapy.

Researchers' Backgrounds, Experiences, and Biases

Reflexivity in qualitative research requires that the researcher acknowledge biases and personal identities as part of the analytic process. By making explicit the impact of personal beliefs and experiences, researchers are able to bracket the "taken-for-granted" world in order to focus intentionally on perceptions of the phenomenon in question (Smith et al., 2009). Accordingly, information about the researcher's background and biases is presented below. The primary researcher was a self-identified biracial Black/White heterosexual woman in her late 20s. The data for this study was collected while the primary investigator was a doctoral candidate and was used for her dissertation. Professionally, the researcher has clinical experience working as a psychotherapist with multiracial individuals and identifies as a social justice advocate. Personal interest in this topic stems from the researcher's experiences growing up in a multiracial family. The primary researcher identified several expectations prior to beginning the study: 1)

that therapists would make comments invalidating the experiences of multiracial individuals, 2) that microaggressions would have an impact on multiracial individuals in psychotherapy, and 3) that multiracial individuals would also have positive experiences of discussing race with their therapists. The primary researcher also recognized a bias in expecting that therapists of color would be more supportive and less likely to perpetrate microaggressions than White therapists.

Participants

Thirteen self-identified multiracial individuals from a variety of racial and ethnic backgrounds participated in this study. Information about participant demographics with pseudonyms is presented in Table 1. Eight participants reported having heritage from two distinct racial backgrounds (e.g., Black/White, Asian/White) and five participants identified with three or more distinct racial groups (e.g., Black/White/Native). Ten participants were women and three were men. Participants ranged in age from 21 to 52, with an average age of 32.31 ($SD =$ 9.04). Participants were generally highly educated; four participants had some college education, one had a bachelor's degree, and eight participants had completed advanced degrees (e.g., Master's, Ph.D., etc.). Most participants (9 out of 13) described their current financial situation as average, with three self-identifying as "below average" and one identifying as "pretty well off." Ten participants identified as heterosexual, one self-identified as lesbian, one as gay, and one as bisexual.

All participants reported that they had attended at least one psychotherapy session within the past five years. Experiences in therapy varied greatly, with the number of therapists seen ranging from 1 to 15. Most participants had experiences with multiple psychotherapists within the five-year time limit of the study. The 13 participants talked about their experiences with 23

therapists; of those 23 therapists, 18 were identified by participants as White, three as Black/African American, one as Asian, and one as Biracial.

Participants were asked to rate the helpfulness of therapy on a scale of 0-6 where 0 indicated "not at all helpful," 3 indicated a "neutral" experience and 6 indicated "extremely helpful." The results are presented in Table 1 and indicate a generally positive view of therapy for most participants, with only one participant rating their experience with a "6" and one participant rating their therapy with a "2."

Procedure

This study drew participants from various geographic regions in the United States using purposive sampling strategies. Recruitment efforts targeted multiracial college student groups and professional networks using flyers, email postings, and online links posted on social network sites (e.g., facebook.com; see Appendix A). To be included in the study, research participants had to identify as multiracial, biracial, and/or mixed, had to have attended at least one 45-60 minute session of individual therapy with a mental health professional within the past five years, and had to be age 18 or older. Participants were screened by phone or email to confirm that they met study requirements and then scheduled for an interview. Six interviews took place in person and seven took place by phone. Each participant received monetary inducement of $10 after completing the interview.

Data Collection

Participants were read an informed consent script regarding potential benefits and risks to their participation as well as audiorecording of interviews. Consistent with IPA, data was collected using a semi-structured interview format in order to allow participants to describe their experience of the phenomenon in their own words (Brocki & Wearden, 2006). Participants

completed a brief demographic form (see Appendix B), which was linked with their interview data via a numerical code in order to maintain participants' anonymity. The semi-structured interview schedule (see Appendix C) was developed based on prior research on microaggressions in psychotherapy and on multiracial identity. Interview questions were broad and open-ended; minimal prompts were used to ensure that sufficient detail was collected for a meaningful analysis.

Saturation

In qualitative research, data saturation occurs when each additional participant or interview generates no additional insight or themes, and the data becomes redundant (Bowen, 2008). Small sample sizes are often preferred in IPA because large sample sizes may make it difficult to capture subtle yet meaningful data in the analyses (Brocki & Wearden, 2006). Data analysis was completed after an initial round of data collection. In the present study, saturation was identified using broad theme categories and comparing the new information added by participants to existing data categories (Morrow, 2005). Data saturation focused on whether or not any major themes were added and saturation was achieved after the 11th interview and two additional interviews were conducted, adding no additional themes.

Establishing Trustworthiness

Trustworthiness in qualitative research refers to the methodological rigor and credibility of the study design and analysis (Morrow, 2005). Multiple strategies were used to establish and maintain trustworthiness throughout the process of data collection and analysis.

Peer review. The first strategy used was peer review, using an external check during study design, data collection, and analysis to monitor accuracy and to encourage awareness of biases (Creswell, 2013). Primary analyses were completed by the first author, a biracial

Black/White women and doctoral candidate in counseling psychology. All analyses were validated by a second reviewer, a 26-year-old Black/African American doctoral candidate in social psychology who was knowledgeable in microaggression research and qualitative methodologies. After the first author completed preliminary analyses, the second reviewer selected two transcripts at random and coded them independently. Preliminary codes were compared and discussed until consensus was achieved regarding the accuracy of theme titles. In a few cases, researchers agreed that data were ambiguous or could be interpreted multiple ways; in these situations, researchers agreed to code these theme titles as ambiguous or underdeveloped. After consensus was reached about major theme titles, the second researcher provided an audit of the remaining transcripts to ensure consistency and accuracy of coding.

Member checking. The second strategy that was used was member checking, which both provides a strategy for verifying the accuracy of data and encourages a more egalitarian approach that empowers participants to be more active contributors to the research process. In the present study, the researcher invited participants to review their transcribed individual interviews and solicited feedback to ensure that the interview data is accurately reflected in the transcript. Of the 13 participants, nine responded to the request for member checking; seven confirmed that they felt that their transcripts accurately reflected their experiences and two participants made minor changes to protect their anonymity. Four participants did not respond to the request.

Researcher's journal. The third strategy of trustworthiness employed in their study was using a researcher's journal. In IPA, researchers acknowledge and bracket their biases and expectations based on the understanding the inherent subjectivity in this approach (Creswell, 2013). The researcher's journal was used to document notes, reactions, hypotheses, and experiences related to data collection and analysis. The researcher also recorded personal

thoughts, feelings, and experiences in order to maintain openness and awareness of potential bias. The researcher's journal was also used to organize initial hypotheses and master theme titles throughout the data analysis.

Thick description. Fourth, thick description was used to allow readers to judge the credibility of the analyses. In qualitative research, sampling is designed for information richness rather than to represent a particular population. Dense, information rich descriptions were used to provide readers with sufficient information to evaluate the transferability of results to other populations (Morrow, 2005). For the present study, the researcher included anonymized demographic information, direct quotes, and detailed descriptions of interview data. In order to ensure that the content and meaning of the interview was reflected in the analysis, interview data was transcribed verbatim and significant non-verbal utterances (e.g., pauses, sighs) were noted as well (Creswell, 2013).

Data Analyses

Interview data were analyzed, according to IPA, in a multi-step, recursive process of interpreting and coding data (Smith, Jarman, & Osborn, 1999). In phenomenological research, the goal of analysis is to identify common patterns in the experience of a phenomenon and to reduce individual experiences into a description of the "universal essence," including both the "what" and the "how" of the participants' experiences (Creswell, 2013, p. 76). In IPA, data collection and data analysis often occur simultaneously; even while conducting interviews, the researcher used the journal to note ideas of about theme titles. In the present study, formal data analyses began after the 8th interview and occurred simultaneously with the final stages of data collection. In the present study, the following stages of data analysis were completed by hand:

Stage 1. First, each interview was transcribed verbatim and read several times in order to ascertain a general sense of the meaning. The researcher made notes regarding preliminary interpretations, themes, and associations that arose when examining and analyzing the data (Willig, 2001).

Stage 2. Second, theme titles were identified as they emerged from the preliminary analysis of individual interview data (Smith et al., 1999). At this stage, the goal was to identify conceptual themes that represent the "essential" nature of the transcribed interview data (Willig, 2001).

Stage 3. In the third stage, the researcher began to identify connections between emerging themes (Smith et al., 1999). Themes were clustered together in order to identify a hierarchical nature of the themes (e.g., whether some terms are superordinate and other themes can be categorized beneath them).

Stage 4. In the fourth stage of analysis, a master list of themes was created; the researcher recursively compared the master list with the original data. In this stage, previously identified themes were organized into a meaningful structure. With each major theme, the researcher went back to the original transcript data to ensure that each theme was well represented in the participants' own words.

RESULTS

Study results support common experiences among the 13 multiracial participants with regard to their experiences in psychotherapy. Three major themes were identified: therapist microaggressions, helpful therapist behaviors around race, and the impact of microaggressions in therapy. Within these major themes, subthemes are identified as well (see Table 2 for a full list of themes and subthemes). The major themes were evident in all thirteen participants; subthemes were present in approximately half of the transcripts (6 out of 13). These themes and their subthemes are described below and quotes from interview narratives are included to illustrate the findings using pseudonyms to ensure the anonymity of participants.

Therapist Microaggressions

All participants reported experiencing at least one microaggression related to their racial identity in psychotherapy. Below are the four microaggression subthemes that were present across three or more participant interviews. To provide more insight into therapist microaggressions, this subtheme is also presented in Table 3 with examples of microaggressions reported by participants as well as the messages that participants felt the microaggressions communicated.

    Microaggression Subtheme 1: Avoidance and minimization of race in therapy. The most common microaggression subtheme was the avoidance and minimization of race in therapy. Most participants felt that the importance of race was understated and that issues related to their racial and ethnic heritage were not explored enough in therapy. This subtheme played out in therapy with clients introducing the topic of their multiracial identities and feeling that their therapists had nothing to say in response. Interviewees interpreted this unresponsiveness as a

sign of their therapist's discomfort, lack of knowledge, and/or inability to relate. One participant worked with multiple therapists and described going through a familiar process each time:

> I would have to explain to people, "No, I'm of mixed race." And that conversation would have to go to a whole 'nother deal -- it was almost as if, "Okay well I don't have any tools in my toolbox to deal with that one so let's move on." You know what I'm saying? It was like, "oh we have to ask it for demographic purposes, but we're not going to get deep into that mess." (Harry)

Many participants perceived nonverbal cues of their therapist's discomfort with race, which was communicated nonverbally – interviewees recalled their therapists suddenly shifting their body posture, becoming flushed, and even breathing differently when the topic of race came up. One participant recalled self-identifying as multiracial in an early session with a new therapist and her therapist responding with laughter:

> I think she laughed. She laughed. "That's cool," and laughed. Yeah. Something like that…. I don't know, I feel like it's what people do with their shame and their discomfort when they can't put me into a box. (Erica)

Part of participants' frustration came from the fact that therapists would explore other issues with care and concern, yet avoided the topic of their multiracial backgrounds. Rather than asking follow-up questions, exploring the issue, or displaying empathy, participants recalled their therapists abruptly changing the subject and ignoring disclosures about race. Seeing their therapists become uncomfortable and then avoid the subject of race left participants feeling that race was off-limits as a topic for therapy.

At other times, therapists did respond to client disclosures about race, but interviewees felt that their therapists used "textbook" responses as a way to avoid really engaging with the

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topic of race. They noticed their therapists using generic statements like "that sounds hard," rather than responding to their specific concerns around racial identity, discrimination, and family dynamics complicated by cultural clashes and systemic racism. For participants, these comments indicated a lack of comfort and knowledge around issues specific to multiracial identity. One participant described the experience of disclosing her racial background and having her therapist treat the information as unimportant:

> I can't remember her specifically acknowledging any of it, more than beyond like saying, "yeah," or verbal cues that she's listening…. "Just, an inability to even recognize that race may impact my life, I'm guessing she saw me as similar, she saw me as part Caucasian and that was the part she identified with and sort of based her therapy and her interaction with me on, is what I would guess." (Brooke)

Similarly, participants felt frustrated when their therapists moved too fast on issues of race, not taking care to establish safety or to recognize the emotional intensity of talking about complex issues of identity. Candace described feeling like questions about her racial identity were approached too quickly during her first two therapy sessions. Even though racial identity was in fact central to the issues bringing her to therapy, she felt overwhelmed by the pressure to talk about this private and painful experience with a therapist she did not yet trust and never returned to therapy:

> Like, "whoa!" I don't know… I'm just not open with you, like I have to be comfortable before I start telling you stuff…. You can't just assume, that just because I'm different racially that I'm going to have problems with it. I mean I was having problems with it, but since she like put it out, I was just like goddamn, I did not want to talk about this today. (Candace)

Microaggression 2. Denial of multiracial reality. In addition to avoiding race as a topic in therapy, many participants also felt that their therapists made suggestions and comments that denied their racial realities as multiracial individuals. Participants endorsed a common experience of therapists failing to acknowledge the difficult reality of their clients' struggle to find their place in a social context that privileges monoracial identities. Participants described a profound sense of social isolation and a pervasive experience of their racial identities as a "no man's land" – occupying a social space in which their authenticity was constantly challenged and questioned and social acceptance based on race felt precarious. This experience was present for interviewees at school, at work, in romantic relationships, and even within their families; yet, talking about their experience with therapists was often met with minimization and skepticism. One Black/White biracial participant reported that her therapist encouraged her to spend more time with her Black peers, but never empathized with her about her difficulty in navigating that task as a biracial woman.

> She was trying – she would try to push me outside my comfort zone. But everyone was pushing me back. She was like, "Oh yeah you need to go do this. But you didn't, so oh well, guess you're stuck with the White people." And so I didn't really feel like I should – *[long pause]* that I was working with her. (Denise)

Participants experienced this questioning of their racial realities as invalidating and were left struggling to convey how deeply imbedded issues of race were in their social relationships. In another example, Amy talked about her therapist encouraging her to believe that she had "the best of both worlds." In the context of their therapy work, this comment was experienced as particularly insensitive to the complicated racial dynamics of being a Black/White multiracial woman trying to navigate an estranged relationship with her White father.

Participants were especially frustrated by the denial of their racial realities when they brought up experiences of discrimination and ended up feeling that their therapists blamed or judged them. Felicia described trying to talk to her therapist about racism and having it always redirected it back to suggest that Felicia herself was the problem. This communicated a familiar message to her that her experiences were not valid and that she was being too sensitive:

> If I say that at work that I feel like I'm not safe then, it's been about: *[in soft voice]* "Oh well, when else have you not felt safe?" or like, "When did you get that message growing up?" But not around race. Like a clear shift of focus from that. Like that's not really what it's about, you know? (Felicia)

Therapists' neglect and dismissiveness of their participants' racial realities brought up intense emotions for participants during the interview. The topics that interviewees brought into their therapy were often deeply vulnerable and painful experiences, and they felt that their therapists lacked empathy and sensitivity in their responses. In the interview, they expressed frustration, sadness, and disappointment that therapy became another place in which the authenticity of their racial realities was called into question.

Microaggression 3: Stereotypical assumptions based on race. A common theme emerged of therapists making stereotypic assumptions based on participants' appearance and perceived racial identity. These were not stereotypes based on multiraciality but rather stereotypes based on the racial group with which participants were most frequently identified. Hence, participants who reported being typically perceived as Black experienced assumptions of criminality, ascription of inferior intelligence, and assumptions of hypersexuality whereas a participant who was perceived as Asian was stereotyped as being religious on the basis of her

race. Therapists, likely unintentionally and unconsciously, communicated these beliefs through their questions, comments, facial expressions, and their behaviors.

An example from one participant demonstrated how these stereotypic assumptions played out in the context of the therapeutic relationship. Lance recalled being treated like a criminal on the basis of his Black identity: "When he was leaving the office, he had to go to the front, he left the door open. I was like, 'Oh so what are you saying, Black people steal? All Black people steal?'" To make matters worse, his therapist denied that there was a racial element to this event by responding with "Oh, you're overthinking it, calm down. That's not what I was doing." This incident highlights the way that microaggressions are often communicated – because the communication was subtle and indirect, Lance's attempt to confront his therapist led to further stereotyped accusations of hypersensitivity to their racially charged conflict.

These stereotypes were often hard to confront because of the ambiguity of the way they were expressed and the fact that participants often felt that these messages were communicated with positive intent. In one example, a therapist said: "I relate to Indian culture" after Felicia self-identified as biracial Native American and White. In the interview, Felicia's description of her experience highlights her internal struggle between understanding her therapist's desire to connect yet also recognizing the stereotypical beliefs underlying this comment:

> I felt the discomfort of not really knowing what to do. Yeah, I get the sense like she wanted me to feel like she understood something about me, but it was just very stereotypical. There's a huge variance from tribe to tribe. (Felicia)

Participants who experienced these microaggressions reported that the stereotypes endorsed by their therapists were the same that they heard from people in their everyday lives, and were often related to racial phenotype and racialized characteristics, such as skin color, hair

texture, and dialect. Participants explained that although these microaggressions were "typical," they were surprised and disappointed to hear them from therapists.

Microaggression 4: Second-class status and treatment of multiracial people. Several participants endorsed experiencing microaggressions that communicated their second-class status on an environmental and institutional level. Participants who attended counseling through university mental health centers and community mental health clinics commented on the lack of diversity of counselors and staff and remarked that the environment felt like a "White" space. Further, a few participants reported hostile interactions with some staff members based on their racial appearance. In one particularly powerful example, Lance reported being harassed by the building security guard every time he entered the building for his therapy appointment. He described his experience:

> I feel comfortable in my therapist's office, but I don't feel comfortable going in that building because of the security guard. Because he gives me a hard time each and every time. For the past number of years that I have been going, each and every time, he gives me a hard time. So, it's a very uncomfortable, I have to, as I'm walking off the subway to the building, I have to talk myself into it. Like, "okay, just deal with it, you just have to get by him." And this is each and every time, this is not like one time and I would imagine, I mean I would think that, you know, over the course of the years that he has seen me entering and leaving the building, you know, I haven't lived up to the stereotype that, you know, that he seems to have, I think he would loosen his grip a bit, but he hasn't. If anything, he makes it tighter every time. (Lance)

Lance explained that his attempts to address this harassment with his therapist have only led to further invalidation:

And when I'm explaining it to [my therapist], sometimes he doesn't grasp what I'm trying to convey, that this man is racist, he really doesn't want me in the building. [My therapist] said, "Oh, the security guard? He's not going to bother you! He's a nice guy." It's frustrating sometimes, totally frustrating and then to explain it to your therapist and he kind of brushes it off. (Lance)

On an institutional level, most participants felt that overall, therapy did not seem like the place to talk about issues of racial identity, racial discrimination, and particularly about their multiracial identities. This was conveyed through the superficial way it was addressed during initial appointments as well as what one participant described as the "framing" of therapy in the larger culture. Some participants commented during the interview that they were struggling to answer the questions because they had never taken the time to consider how being multiracial might be important to their therapy experiences. Many participants endorsed wishing that they had known while they were in therapy that they could have spoken more about race. Amy described coming to realize that race was relevant to other issues she brought to therapy and wishing that she had gotten that message earlier:

At the same time I wasn't really prompted to think about race in my session. Except for when, you know, the conversation around my dad happened. But like there are so many things that I didn't really tell my counselor about race, about my experience with race. So even if I would have had a conversation, then it would have been more a part of our sessions. And I think also a lot of time why we talk about the importance of counseling is around topics of stress and wanting to have someone listen. And it's rare, even in my work [at a university], where I've talked to students like "you know if you're having experiences about, around race maybe you should go talk to a counselor." (Amy)

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Like Amy, many interviewees wished that their therapists had addressed these issues directly by asking about race and creating space for participants to make connections between their presenting issues and their racial backgrounds.

Helpful Therapist Behaviors Around Race

Although interviews illuminated microaggressions that occurred in therapy, several participants also had positive experiences of discussing race with therapists. As noted in Table 1, several participants had experiences with two or more therapists and in the interviews, they highlighted differences between times when race was avoided or ignored and times that it was addressed successfully. The following subthemes highlight some of the ways that therapists created an atmosphere that facilitated deeper exploration of their clients' multiracial backgrounds.

Therapists addressed race directly. Participants felt validated and heard when therapists asked directly about race and continued the conversation by asking follow up questions and appearing genuinely interested in hearing about their clients' experiences. While this approach may seem simplistic, this occurred relatively infrequently for participants of the present study. Although most participants were asked about their identities or self-disclosed spontaneously early in therapy, few participants had the experience of being asked to really talk about their identities and what it meant to them, and those who had that experience appreciated it immensely. James, the one participant to work with a biracial therapist, struggled to explain what helped him to feel comfortable talking about race: "The fact that she could sympathize, but that was maybe just circumstantial. *[Deep breath]* I don't know, she was just, she was just genuinely interested."

The "genuine interest" described by several participants seemed to be most often conveyed through nonverbal behaviors – participants noticed when their therapists appeared comfortable with race because their nonverbals remained unchanged after the topic of race was introduced and because they continued to pursue the topic. Another effective strategy of addressing race in therapy was incorporating exploration of participants' multiracial identities into understanding the issues that brought them into therapy. Iris talked about the importance of her therapist's comfort and willingness to discuss race in helping her to address her presenting concern of dissatisfaction with her graduate program. Ultimately, it was her therapist's ability to validate and explore both issues of multiracial identity and experiences with racism that helped her to get through a difficult period in her life:

> I think it was one, that he was listening to what I was saying and it didn't appear to make him uncomfortable, even though he was White, and then two, it was like he was kind of affirming what I was saying, and then three, he was – said, "okay, well this is what you can do." And "why don't you try this," or "is there this office, is there something you can…." He was proposing solutions of ways that I could kind of work through my frustrations beyond just kind of like venting to him and talking about it. So I think that that was really the – the positive experience that I had. (Iris)

Therapists tried to understand race. Even for those participants who ultimately felt that race was not explored enough in their therapy, several participants appreciated what they felt were attempts from their therapists to "get it." This desire to understand was demonstrated through asking questions and opening up the conversation in spite of the therapist's perceived discomfort or lack of knowledge about multiracial experiences. For Amy, one of the most

powerful moments in therapy came when she was able to recognize the importance of race in her strained relationship with her White father:

> I noticed that when I was sharing and when I made the connection about – specifically with my dad, she closed her eyes for a second and I could tell that she was just like soaking it all in. And then she took some deep breaths and kind of just let it sit in the room for a second before responding. Which, when I saw that, I respected that she kind of took some time to respond before just jumping in and having a response. It was clear that she wanted to like process the information before she said anything next. Then she also said something along the lines of like *[slows speech]* "Wow that seems like a lot to carry." (Amy)

This was an important moment for Amy, and the fact that she witnessed her therapist give it the appropriate amount of emotional weight was significant in what she gained in therapy. In addition to these non-verbal cues that conveyed therapists working to understand, participants appreciated hearing about therapist's own cultural backgrounds and gaining an understanding on where they stood with regard to race.

Many interviewees recognized how important it was for therapists to remain authentic, and felt it would have been more hurtful if their therapists had been disingenuous about their cultural expertise in an effort to connect. Karen explained that despite her disappointment that her therapist could not fully understand the way that culture shaped the issues that brought her to therapy, she appreciated that her therapist never made statements that were untrue or inauthentic:

> I appreciated that she never tried to tell me, "I understand that experience." But she really tried to connect with the emotions of the situation being difficult, which kind of made it

okay. I think had she said, I totally get where you're talking about I probably would have just been really angry and just terminated therapy. (Karen)

It was generally good therapy. Finally, most participants emphasized the importance of feeling that their therapist was skilled, professional, and caring in their experience of therapy. They felt that their therapists helped them to understand themselves, to learn better coping strategies, and to work toward the goals that brought them to therapy:

But he spoke to my situation with words of true, I think, experience and perspective. And I was amazed at the difference his presence made. I felt like he cared, I didn't feel like I was just a – another person, I didn't feel like I was just another number, you know, coming through and filling out a quota. (Harry)

The connections that were built in early sessions helped participants to feel supported and cared about and laid important groundwork for talking about race:

By that time, we had already – and it was still early in our sessions, probably within the first three to four sessions it came up, but I was seeing her regularly, I was seeing her every week, and things were going really well and I felt very safe sharing anything with her. So, saying something about race wasn't a big deal to me. (Margaret)

Impact of Microaggressions in Therapy

Interviews revealed that microaggressions had a significant impact on multiracial clients in therapy. Participants experienced emotional reactions, became guarded and withdrawn, used familiar strategies to navigate race with their therapists, and many eventually ended therapy.

Felt worse. When microaggressions occurred in therapy, participants often had intense emotional reactions including feeling hurt, disappointed, guilty, confused. Participants explained that they were surprised to experience microaggressions in a space that they had hoped would be

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safe. As they struggled to make sense of ambiguous interactions, participants recalled leaving their therapy sessions feeling unheard, blamed, criticized, and alone.

> I became much more – I became much more reclusive I would say, like I kind of spent most of my time by myself. I started journaling a lot more, but I was doing the kind of – like taking it into my own hands of ways to kind of get all of my thoughts and emotions out, because I didn't really have anybody to talk to about it. (Iris)

These interactions had ongoing effects that participants struggled to reconcile during the interview. Denise's reflection on her first therapy experience highlights her lingering ambivalence and confusion about how to make sense of a therapist who she believed was skilled and caring, yet who communicated invalidating and stereotyped messages about race:

> I felt like it was good, but it wasn't all that helpful because I felt like she was condescending. She made me feel guilty about my actions and my personal life. And it was helpful because I learned different things. I also got the technique and tools to be able to overcome – certain things. But in the end I felt like she, like she helped but she didn't help me. (Denise)

Dilemma of confrontation. Despite having intense emotional reactions, participants felt unable to directly confront their therapists about microaggressions in therapy. Because microaggressions were often subtle and indirect, interviewees often did not recognize that they had been slighted until after the fact, struggled with whether or not they had accurately perceived what happened, worried about hurting their therapists' feelings by confronting, and felt acutely aware of the power differential in therapy. Further, participants feared that if they confronted their therapist's hurtful comments directly, they would be confirming negative stereotypes of

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people of color as hypersensitive, aggressive, or overly focused on race. One participant explained her dilemma:

> I don't want people to think I'm a bad person. Just when I get defensive, I get really upset and I'll start cursing or something. That's how you know when I'm upset, I just don't like bringing that side out. Because it – I don't know, sometimes it reminds me of my mom and like, her African American side. People, I just don't want them to call me ghetto or something. (Candace)

Increased guardedness around race. As a result of microaggressions in therapy, participants were wary of how they discussed race with their therapists. They attended to their therapist's racial backgrounds, looked for cues and indicators of whether or not they would be understood, and responded to microaggressions that occurred by withdrawing and engaging in coping strategies to maintain their safety. Harry described how he reacted to his therapists' evident discomfort in talking about race:

> Standoffish. Attitude problems. It's like, "whatever man, get this over with," type of situation. Like, "yeah, you don't understand, just keep it moving." Being, um, surface-oriented, a little less deep, a little less open. A lot less open. (Harry)

When they otherwise liked their therapists and believed that they could benefit from therapy, clients worked to navigate around race with their therapists. They "compartmentalized" race in therapy by focusing exclusively on mental health issues (e.g., depression, anxiety, grief) and leaving out issues of race that they thought their therapist would not understand. Interviewees also endorsed using this strategy in order to avoid providing the therapist with any opportunity to say something offensive. Karen very bluntly described her decision to limit her discussions of her racial identity:

It's your counselor so you don't think, "Oh this person is going to be racist or inappropriate." But why open that door for another opportunity? I don't want to walk into a situation where I might experience some kind of microaggression from my therapist. (Karen)

Participants also shifted in their presentation of their racial identity by emphasizing that parts of their identity that would allow their therapists to feel comfortable. For most participants, this seemed to occur with subtle shifts in language and generally involved bringing up less racial content. However, Harry, a Black/White man engaged in a more conscious process of shifting his racial identity when he worked with a Black psychologist:

I have a Black side. Because I have that overcompensating Black person in me, I'm able to – when I sit down with a psychologist, I almost feel like I'm giving them therapy. And it's – *[laughs]* – you know, it can be frustrating, but I'm giving you an ability to feel comfortable about who you are in talking to me. Yeah, dude. I have my White voice and I have my Black voice. I mean it's like I'm a fucking chameleon sometimes. (Harry)

Limited helpfulness of therapy. Many participants felt that their therapists' discomfort with race got in the way of therapy being as effective as they would have hoped. They felt that they had to sacrifice their own need to talk about race in order to ensure that their therapists felt comfortable. As Erica explained: "And so it felt like the – even the meaning and the depth of the therapy was – it felt superficial to me, it felt like this is… this is for them." Other participants made strikingly similar comments conveying their disappointment with what felt like a lost opportunity to explore their multiracial identities in therapy:

And it's so important too, you know, I just felt like many times I was left – okay, I'll go with you on whatever you wanna go with, dude, you know, I just need help, you know

what I'm saying? I'm not trying to get the whole kit and caboodle from you, I'll get it

from somewhere else, but I certainly, yeah, felt like, man you guys should be more

equipped in dealing with racial identity, ethnicity, how it affects the dynamics of

everyday living (Harry)

Ended therapy. Finally, participants described reaching a breaking point in which they

left therapy. Denise explained that after feeling judged and shamed by her therapist, she

eventually started avoiding their appointments:

And so I stopped going to her. I started giving her excuses like 'Oh, no I need to study I

can't come to your meetings.' When in reality I'm walking past the building… Canceling

my appointment like, 'I'm sorry I can't make it, I'm studying right now, I'm swamped'

or 'I'm sick.' And in reality I was just walking by the building. (Denise)

Nearly all participants endorsed feeling more hesitant to seek therapy again after negative

experiences. Racial microaggressions had a lasting and generalized negative impact on

multiracial interviewees such that they questioned whether any therapist would be able to fully

empathize with their experiences.

DISCUSSION

The present study identified several multiracial microaggressions that occurred in psychotherapy. This was true across all clients from a wide variety of racial backgrounds and occurred regardless of therapist race or ethnicity. As is often the case with racial microaggressions, these cultural ruptures often occurred in subtle ways and without any evidence of therapists intentionally communicating racial biases. Rather it seemed that discomfort, lack of knowledge about multiracial identities, and unexamined beliefs about race led to cultural ruptures that interfered with the effectiveness of therapy and in some cases, contributed to the premature termination of therapy. In addition to the emerging themes of microaggressions in therapy, participants in the present study also highlighted a number of positive experiences of addressing issues of race with their therapists, again, regardless of therapist race or ethnicity. Multiracial clients appreciated when race was talked about at length, when therapists conveyed comfort and willingness to engage with complex racial identities, and when issues of identity were incorporated into the therapeutic work. In this section, the experiences of participants are explored within a larger context in order to draw out implications for working with multiracial clients in therapy.

Invisibility and Dynamics of Microaggressions in Therapy

The microaggressions identified in the present study appear to fit within the microaggression taxonomy identified by Sue et al. (2007). Microassaults, explicit and intentional discriminatory behaviors based on racial bias, did not emerge in the present study. The microaggressions identified in the present study would be best categorized as either microinsults or microinvalidations. Microinsults, described by Sue et al. (2007) as subtle and demeaning

comments that convey underlying beliefs about the inferiority of people of color, occurred in the stereotypical assumptions microaggression subtheme and in the avoidance and minimization of race in therapy subtheme. These incidents fit under the microinsult category because, even as therapists were communicating stereotyped beliefs, their comments were often couched in seemingly good intentions. In one instance, a therapist suggested that a client apply to a "White" school so that he could get grants and scholarships. Out of context, this might seem like helpful advice, but for a multiracial Black man, this was interpreted as insulting for the underlying assumption that he could only succeed on the basis of affirmative action.

Microinvalidations, communications that ignore or nullify the thoughts, feelings, and realities or people of color, were very common in the present study. Microinvalidations occurred within the avoidance and minimization subtheme, the denial of multiracial reality subtheme, and the second-class status and treatment of multiracial individuals subtheme. Both comments from individual therapist and environmental cues contributed to an overwhelming invisibility and avoidance of multiraciality in therapy for many participants. Again, these messages were often communicated with what appeared to be positive intent. Taken at face value, some of the therapists' comments might seem to be supportive statement or appropriate therapeutic challenges intended to help clients – for example, a therapist using an irreverent approach to encourage a Black/White biracial woman to engage more with Black peers. However, placed within a larger sociocultural context, it becomes easier to see the way in which this intervention reinforced a problematic framing of multiracial people as needing to "get over" their experiences of social rejection and isolation on the basis or race. From that perspective, this irreverence can be better understood invalidating and insulting to the client who was describing a vulnerable and painful experience.

The unconscious and unintentional nature of multiracial microaggressions in therapy was consistent with dynamics described in the microaggression literature (Sue et al., 2007) and in similar studies of microaggressions in therapy (Constantine, 2007; Shelton & Delgado-Romero, 2011). Because microaggressions were often subtle and couched in good intentions, multiracial clients experienced psychological dilemmas when they attempted to make sense of the interactions with their therapists. Multiracial clients experienced uncertainty about how to respond to these incidents, were aware of the invisibility of the bias to the therapist, and were aware of the perceived minimal harm of the comments (Sue et al., 2007). Participants recalled their fear of hurting their therapist's feelings, of reinforcing negative stereotypes of people of color, or of being accused of hypersensitivity. Therapy seemed to be a particularly vulnerable space for multiracial individuals to navigate this psychological dilemma because of the inherent power of the therapist to validate their client's realities and because of the emotionally sensitive nature of the material being discussed.

For these reasons, microaggressions most often resulted in internal processing that multiracial clients did not reveal to their therapists. Therapists may have gone through an entire course of treatment with a multiracial client without ever realizing that there had been a cultural rupture. Part of what Miville et al. (2005) termed the "chameleon" experience for multiracial individuals is that they often become particularly adept at navigating hostile racial environments and shifting their racial identities to meet the demands of their environment (Buchanan & Acevedo, 2004). While this coping strategy is clearly adaptive in many contexts, it highlights an important need for therapists to be attuned to the context of race in the therapy room. Neither good intentions nor shared racial identities were sufficient in the present study to negate harmful effects of racial microaggressions.

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The Power of Discussing Multiracial Identities in Therapy

In addition to illuminating potential cultural ruptures and expressions of unexamined bias, the results of this study also highlight the opportunity for powerful therapeutic work when clients do feel safe to talk about their multiracial identities. Existing research has highlighted the complex and dynamic processes through which multiracial people make meaning out of their racial identities, negotiate racism and discrimination, and seek a sense of place and community in a highly racialized world (Miville et al., 2005; Pedrotti et al., 2008; Rockquemore & Brunsma, 2002). When therapy was a place for multiracial individuals to talk about these experiences, the impact was powerful and extremely beneficial for clients.

Several studies have revealed an important finding that multiracial individuals may hold a "private" identity that does not necessarily match their physical appearance and that may be different from the identity that they most often claim publicly (Brunsma, 2004; Buchanan & Acevedo, 2004; Miville et al., 2005). Multiracial identities are often socially contested and highly influenced by factors over which individuals have little control, such as physical appearance, geographical context, and family dynamics (Ahnallen, Suyemoto, & Carter, 2006; Pedrotti et al., 2008). Claiming certain identities publicly carries a risk of social rejection, has political implications, and may even feel like a betrayal of one's ethnic heritage (Buchanan & Acevedo, 2004; Rockquemore & Brunsma, 2004). Therefore, the private, confidential, and sensitive space that psychotherapy provides has the potential to be a crucially important and valuable space in which multiracial individuals can receive validation and support around the private identities that are difficult to discuss publicly. In the present study, therapists who asked questions about race and conveyed willingness and interest in hearing the answers provided

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clients with a unique experience to talk about a part of their lives that is often silenced or ignored in the dominant narrative of race.

Significantly, even when therapy was helpful, it was not necessarily free of any therapist expressions of bias or of invalidation of multiracial identity. As long as there was a therapeutic connection and a perception that the therapist was willing to try to understand race, multiracial individuals were forgiving of the occasional racial misstep. Additionally, the multiracial individuals in the present study sometimes ignored racial microaggressions either as a coping strategy or because the messages aligned with their own internalized racism and were therefore not seen as offensive. One potential pitfall for both multiracial clients and their therapists is in the idealization of multiracial individuals. The dominant sociocultural narrative sometimes positions multiracial individuals as superior to their monoracial counterparts on the basis of their mixed racial heritage, particularly when the multiracial individuals have a White parent (Johnston & Nadal, 2010; Nadal et al., 2011). Multiracial individuals may internalize this message without recognizing the implicit racism in this notion. Therapists may also reinforce this unexamined belief when they communicate beliefs that multiracial individuals represent "the future of America," are "beyond race," or have "the best of both worlds." Therapists may struggle to maintain a balance of highlighting the positive parts of having a multiracial identity without also communicating an implicit message that denigrates people of color.

Strengths and Limitations of the Study Design

As with any empirical study, strengths and weaknesses always exist and caution should be taken in considering the generalizability of these results. Readers should pay attention to the characteristics of the participants in this study when considering the transferability of results. Participants represented a broad range of racial and ethnic backgrounds, but most identified as

middle class, were highly educated, and the majority identified as heterosexual. Participants were recruited from across the United States, with many participants coming from the East or West coast. Geographical context is an important part of the experience of being multiracial and therapeutic experiences would certainly be influenced by the local sociocultural context. Further, the majority of the therapy experiences discussed in interviews were with therapists identified by participants as White. Caution should be taken in generalizing the impact of therapist race on the therapeutic experience.

In the present study, the primary researcher, a Black/White biracial woman, conducted all of the interviews and it is possible that participants' answers were influenced in some way by their assumptions about the interviewer's racial identity and experiences. As discussed by Mohan and Chambers (2010) the primary researcher's insider status as a multiracial individual was likely also a strength of the study; a few participants made comments that they would not have spoken in the same way to a White researcher and several indicated the importance of shared racial heritage in their comfort in answering personal questions.

Interview questions were developed based on existing literature and modeled after prior studies (Thompson et al., 2012; Shelton & Delgado-Romero, 2011). Therefore, themes from these interviews were shaped by the questions, rather than emerging purely from participant experience and this structure should be taken into consideration when interpreting study results. However, the empirical grounding of the methodology is also a strength of the study design that contextualizes the interviews within existing empirical findings. Another methodological consideration is that unlike past studies on racial microaggressions, individual interviews were used rather than focus groups. Although there were many common themes across interviews, it is possible that a focus group would have allowed for more depth of exploration as a result of

shared experiences. Future researchers may wish to use both individual interviews and focus groups for triangulation of data.

Additionally, this study relied on retrospective accounts of their experiences in therapy and it is impossible to ascertain the veracity of client recollections of their experiences. Given that the present study focused on the meaning that participants made of their experience of their past experiences, the retrospective design was appropriate for the research questions. However, future investigators may consider alternative research designs that explore ongoing or more recent therapy experiences. Further, some participants brought up experiences in therapy that were outside the scope of this study – childhood experiences in psychotherapy, couples counseling, and therapy that occurred outside of the five year time limit. These experiences were excluded from the present study, but may be an area for further research.

Directions for Future Research

There are several findings from the present study that merit further examination in empirical research. This introductory qualitative investigation provided compelling evidence that multiracial microaggressions occurred in therapy, that these microaggressions often negatively impacted clients' experience of therapy, and that there were also strategies that therapists used to effectively negotiate and explore issues of race with their multiracial clients. In keeping with the goal of increasing therapist's cultural awareness and sensitivity, future studies should continue to examine what factors contribute to more effective work with multiracial clients. For example, researchers could evaluate whether or not multicultural training leads to better outcomes in therapist's work with multiracial clients.

Further, although therapist race was not directly related to the helpfulness of therapy in the present study, future investigators may wish to further investigate the way that various

combinations of racial dyads impact the therapy process for multiracial individuals. For example, whereas some multiracial individuals may endorse preferences for work with therapists of color on the basis of shared experience, for others, working with a therapist of color may bring up fears around questioning of racial authenticity and social rejection. These dynamics merit further empirical exploration. The present study also provides an interesting introductory findings with regard to strategies that multiracial individuals used to cope with microaggressions, including compartmentalizing their racial identities as separate from other issues or by shifting how they identified (for example, referring to oneself as Black rather than biracial when discussing a particularly hurtful comment). Future studies should continue to explore these coping strategies that multiracial individuals cope with microaggressions and to explore whether these are the same strategies used by monoracial individuals or if they are unique to the multiracial experience. Additionally, participants in the present study seemed to be struggling at times with internalized racism about one or more or the racial groups that made up their multiracial identity. This area has been touched on indirectly through studies of multiracial identity (e.g., Miville et al., 2005; Pedrotti, et al., 2008); however, it may be useful to examine this phenomenon directly as it has implications for understanding how therapists might facilitate exploration and healing for their multiracial clients.

Finally, quantitative research should be employed to ascertain the generalizability of these findings. There are increasingly validated quantitative measures that assess multiracial microaggressions (Nadal et al., 2011) and experiences of microaggressions in therapy (e.g., Constantine, 2007, Owen et al. 2010). Future studies could examine the relationship between therapeutic alliance, racial microaggressions, and therapy outcomes.

Implications for Clinical Work

Multiracial identities are diverse, complex, and multifaceted, and it is impossible to make sweeping generalizations that will apply equally to all individuals who may identify as multiracial. Instead, this study highlights ways in which therapists' fear, inexperience, discomfort, and/or unexamined biases with regard to multiracial identity might inadvertently shut down potentially fruitful avenues of exploration in psychotherapy. While it is certainly important to be aware and attempt to avoid the microaggressions outlined in this study, there is also a deeper need for therapists to examine their own beliefs and biases about multiraciality and to be aware of their reactions when they are faced with clients who challenge the dominant narrative of racial identity. Additionally, education about the experiences of multiracial individuals is always recommended for therapists and there are a number of readings that provide useful and succinct information about clinically relevant issues for multiracial clients (see Buchanan & Acevedo, 2004; Johnston & Nadal, 2010; Miville et al., 2005; Nishimura, 1998, Pedrotti et al., 2008; Rockquemore & Brunsma, 2002, 2004).

This study also highlights the need to establish therapy as a safe space for multiracial clients to talk about their experiences. One important takeaway from the present study is that race is always part of the context of therapy for multiracial clients regardless of the racial background of the therapist. Even for therapists who are well trained in issues of cultural competence and/or who identify as people of color themselves, work with multiracial individuals can be complex and nuanced and creating sufficient safety can be challenging. In order to do culturally competent therapeutic work, therapists must be willing to acknowledge the existence of racial dynamics in the room and to be open to feedback from clients about the level of safety. Multiracial individuals have generally adapted to a lifetime of questions, challenges, and

assumptions about their racial identities and may be adept at shifting their style to make their therapists feel more comfortable. Therapists will likely be most effective with multiracial clients when they can attend to unspoken dynamics of race in the therapy room and when they convey a willingness to put the clients' needs first and engage in a deeper conversation about race.

One way to facilitate that depth may be to acknowledge microaggressions if and when they occur. Although the present study supported Sue et al.'s (2007) "catch-22" of responding to microaggressions, therapists have the ability to create a different experience for their clients by inviting clients to share any concerns and responding in a non-defensive and respectful manner if clients have felt hurt. Some have argued that this type of cultural rupture repair may lead to a "corrective cultural experience" that can be powerful for both client and therapist (Gaztambide, 2012, p.187). Therapists who are open to acknowledging their own biases, uncertainty, and mistakes and who are willing to reframe therapeutic ruptures as an opportunity for deeper client insight and connection could provide a uniquely supportive and potentially transformative experience for their multiracial clients.

TABLE 1

Participant Demographics

Pseudonym	Age	Sex	Racial Heritage	Therapists in Lifetime	# of Therapy Sessions	Helpfulness of Therapy
Amy	26	F	Black/White/Native American	2	10	4
Brooke	28	F	Persian/White	1	4	3
Candace	20	F	Asian/Black/White/Native American	4	65	3
Denise	21	F	Black/White	1	2	4
Erica	52	F	Latina/Filipino/Native American	5	35	5
Felicia	36	F	Native/White	4	400	3
Genevieve	38	F	Black/Hispanic/Chamorro	12	900	5
Harry	43	M	Black/White	15	50	2
Iris	24	F	Black/Native American/White	3	15	4
James	33	M	Black/White	4	9	5
Karen	35	F	Filipino/White	1	16	4
Lance	35	M	African American/West Indian	5+	30+	5
Margaret	29	F	Black/White	2	21	6

Note. N = 13. Participants ranked "helpfulness of therapy" on a 0-6 scale where 0 indicates "Not very helpful overall" and 6 indicates "very helpful overall."

TABLE 2

Multiracial Clients' Experiences of Addressing Race in Psychotherapy: Themes and Subthemes

Themes and Subthemes	Frequency
Therapist Microaggressions	13
Avoidance/minimization of race in therapy	10
Denial of multiracial reality	8
Stereotypical assumptions based on race	6
Second-class status and treatment of multiracial people	8
Helpful Therapist Behaviors Around Race	13
Therapists addressed race directly	8
Therapists tried to understand race	7
It was generally good therapy	10
Impact of Microaggressions in Therapy	13
Felt worse	10
Dilemma of confrontation	9
Increased guardedness around race	7
Limited helpfulness of therapy	10
Ended therapy	7

Note. $N = 13$. Categories that occurred in all 13 interviews are major themes; categories that appeared in 6 or more (approximately half) interviews are subthemes.

TABLE 3

Multiracial Microaggressions in Psychotherapy: Subthemes and Examples

Subtheme	Microaggression Examples	Message
Avoidance/ minimization of racial-cultural issues	Therapist becomes silent, shifts body posture, flushes, or laughs when participant brings up race	Your racial identity makes me uncomfortable
	Therapist changes the subject after participant self-identifies	Your racial identity is not important or relevant in therapy
	Therapist validates sexual harassment but not racial discrimination	Racial discrimination is less important than other types of discrimination
Denial of multiracial reality	Therapist rolls her eyes when Black/White participant talks about being rejected by Black male peers	Social rejection on the basis of your multiracial identity is unimportant
	Therapist refers to being multiracial as having "the best of both worlds"	Multiracial people don't experience real oppression
	Therapist says "that's cool" when participant self-identifies	You are an oddity; you represent a racialized ideal
	Therapist responds to participant's disclosure of racism by saying: "There are some assholes in this world."	Racism is not what matters, individual characteristics matter
	Therapist makes recommendation without exploring client's cultural background	Your race and culture are not relevant
	Therapist tells a Black/White client that it is okay that she has a prejudice against Black people	Your complicated feelings about your racial background are not worth exploring
Stereotypical assumptions based on race	A therapist says: "Well, I think you should apply to a White school because you can get all the grants and scholarships that you need."	You need affirmative action to succeed
	A therapist responds with surprise at a Black/White client's high GPA	People of your racial background are not intelligent
	A therapist assumes that an Asian/White client is highly religious based on her ethnic background	All people of your background are the same
	A therapist expresses inappropriate concern about a Black/White female client having sex	People of your racial background are overly promiscuous
Second-class status and treatment of multiracial individuals	A community agency that serves people of color is staffed by mostly White therapists	You do not belong here
	Agency staff (e.g., security guards and receptionists) are rude to Black/White individuals	You do not belong here; you are a second-class citizen
	Therapists ask about race on demographic forms and do not ask follow up questions	This is an institutional requirement, not an area of therapeutic concern

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APPENDIX A

Recruitment Materials

Dear Potential Participant:

My name is Amanda Foster, and I am a doctoral student in Counseling Psychology at Colorado State University. I am currently conducting a study under the guidance of Dr. Tammi Vacha-Haase.

The focus of this study is on the experiences of multiracial individuals in psychotherapy. In order to participate, you must: 1) **identify as multiracial, biracial, or mixed** (i.e., having mixed racial heritage, or having parents from two separate racial groups), 2) have attended **at least one 45-60 minute psychotherapy session** with a mental health professional (e.g., psychologist, licensed counselor, social worker, marriage and family therapist), 3) within **the past five years**, 4) be **at least 18 years old**.

The purpose of this research study is to gain a better understanding of how mental health professionals can best work with multiracial individuals. We are particularly interested in multiracial clients' experiences of discussing race and ethnicity in psychotherapy. We are interested in hearing from individuals with both positive and negative experiences. Your participation is essential to learning more about this issue and we hope that you will take part in our study.

This research project involves a **brief demographic survey (5 minutes) and a 60- to 90-minute phone interview about your experiences in psychotherapy**. The researchers may also contact participants for a brief follow-up interview (lasting no longer than 1 hour) for clarification or with additional questions. You are not required to answer every question and you may choose to discontinue your participation at any time. All interviews will be audiorecorded and transcribed by the researchers and each participant will be given the option to review his or her completed interview transcript for accuracy. For your participation in this study, you will receive $10 compensation.

Because this is a qualitative research project, interview data may be published as part of the results of the study. In order to maintain anonymity, identifying information will be concealed through pseudonyms in the final write-up of the study. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or from viewing unedited interview data. For example, your name will be kept separate from your research records and these two things will be stored in different places under lock and key.

The only identified risk of your participation in this study would be emotional difficulty that may arise from the discussion of negative experiences in psychotherapy. It is not possible to identify all potential risks in research procedures, but the researchers have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

Thank you very much in advance for your time! Please feel free to pass on information about this study to other people who might be eligible. If you have any questions about your rights as a volunteer in this research, contact Janell Barker, Human Research Administrator, at 970- 491-1655.

If you have any questions about this study, you can contact me at anfoster@gmail.com or 970-541-1123. We look forward to hearing from you!

Sincerely,
Tammi Vacha-Haase, Ph.D.   Amanda Foster, M.S.
Professor   Graduate Student

Multiracial Clients in Psychotherapy Study
Be part of a study on multiracial individuals' positive and negative experiences in psychotherapy

- Do you identify as **multiracial**, **biracial, or mixed** (i.e., having mixed racial heritage, or having parents from two separate racial groups)

- Have you attended **at least ONE** 45-60 minute **psychotherapy session** with a mental health professional (i.e., psychologist, licensed counselor, social worker, marriage and family therapist) **within the past 5 years?**

- Are you **at least 18 years old**?

If you answered YES to these questions, you may be eligible to participate in a research study!

The purpose of this research study is to gain a better understanding of how mental health professionals can best work with multiracial individuals. We are particularly interested in multiracial clients' experiences of discussing race and ethnicity in psychotherapy. We are interested in hearing from individuals with both positive and negative experiences. We hope to work towards the larger goal of the best possible mental health treatment for multiracial individuals. Your participation is essential to learning more about this issue and we hope that you will take part in our study.

This research project involves a brief demographic survey (5-10 minutes) and a 60- to 90-minute interview about your experiences in psychotherapy. You may be contacted for a brief follow-up after the initial interview. You are not required to answer every question and you may choose to discontinue your participation at any time. All interviews will be audiorecorded and transcribed by the researchers and each participant will be given the option to review his or her completed interview transcript for accuracy.

To express our appreciation for your time, you will be offered **$10 compensation.**

This study is being conducted at Department of Psychology, Colorado State University, Fort Collins, CO.

Please call Amanda Foster at (970) 541-1123 or email anfoster@gmail.com for more information

Demographic Form

Thank you for your willingness to participate in this study! Please answer every question to your best ability. If unknown, please write "unknown" or "not sure."

1. Age: _____
2. Sex (check one): ☐ *Female*   ☐ *Transgender*
                     ☐ *Male*   ☐ *Other*
3. What is your racial identity? How do you typically identify?
   _____
4. What is the racial/ethnic background of your biological mother?
   _____
5. What is the racial/ethnic background of your biological father?
   _____
6. How many therapists have you seen in your lifetime? _____
7. How many therapy sessions have you had in your lifetime (please estimate)? _____
8. With regard to the recent experience of psychotherapy that you are discussing in this study, please rate how helpful you found your overall experience in therapy. On a scale from 0 to 6, where 0 is "not at all helpful" and 6 is "very helpful," how would you rate your experience?

   | 0 ------1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 |
   Not at all helpful   Neutral   Very helpful

9. What is your highest level of education (check one):
   ☐ Some high school   ☐ High school degree or equivalent (GED)
   ☐ Some college   ☐ Associate's Degree
   ☐ Bachelor's Degree   ☐ Postgraduate Degree (e.g., Master's, J.D., Ph.D.)
10. What is your occupation?
_____

11. Which option best describes your sexual orientation? (check one)
    ☐ *Gay*   ☐ *Lesbian*   ☐ *Bisexual*   ☐ *Heterosexual*   ☐ *Queer*
    ☐ *Other:_____*   ☐ *Prefer not to answer*
12. How would you rate your financial situation during your childhood:
    Pretty well off   Average   Below Average / Poor
13. How would you rate your current financial situation:
    Pretty well off   Average   Below Average / Poor

14. What if any, is your religious preference? _____

APPENDIX C

Interview Protocol

1. What is your racial/ethnic background? How do you self-identify?
   (Prompt: How do other people usually perceive you? In what ways does your racial identity impact you?)

2. Give me an overview of your experiences in therapy. (Prompts: How old were you at the time? What issues brought you to therapy? What was the context and setting of therapy?)

3. Tell me about your more recent experience in therapy (within the last five years). What was it like? What were you expecting/hoping to get out of the experience?

4. To what extend did you discuss your racial identity with your therapist?

5. In what ways was your counselor different from or similar to you culturally? (Prompt: What was your counselor's racial/ethnic background? How do you know?)

6. What, if any, are some ways that your therapist supported you or validated your experiences as a _____ (*use participants' racial self-identification*) individual?

7. People of color often have experiences in which they are subtly invalidated, discriminated against, and made to feel uncomfortable because of their racial identity.

   a. Think of some stereotypes that exist about people of your racial background or backgrounds. Has a therapist ever expressed their stereotypical beliefs about you?

   b. Were there any experiences in therapy in which you felt that your therapist did not understand the impact of your racial or cultural background on the issues that brought you into therapy? Or overstated the impact?

   c. What, if anything, has a therapist said or done to validate or invalidate your experiences of being discriminated against?

   d. What, if anything, did you notice in the environment that made you feel welcome and accepted or that made your feel uncomfortable or unwelcome as a _____ (*use participants' racial self-identification*) person? (Prompt: For example, did you notice anything in the waiting room or in the way that your therapist's office was decorated?)

8. What are some ways that you dealt with these experiences of being invalidated or treated differently in psychotherapy?

9. On your demographic form you were asked to rate how helpful you found your experience in therapy; what contributed to that rating?

10. What, if any, recommendations do you have for therapists working with biracial and multiracial clients?

11. What else should I have asked you about your experiences in psychotherapy?