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Racial Microaggressions, Whiteness, and Feminist Therapy

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Over the last decade, several authors have described the role of racial microaggressions in the lives of historically marginalized populations. However, the exact mechanisms in which racial microaggressions manifest in psychotherapy remain an area in need of further exploration. Drawing from research and scholarship on Feminist therapy and microaggressions, we use a case vignette of a 40-year-old African-American woman in treatment for depression with a White female therapist to demonstrate how microaggressions may unwittingly occur in a clinician–client dyad. We underscore the challenges that White therapists may encounter and provide suggestions and recommendations for culturally responsive therapy.

KEYWORDS *discrimination, ethnicity, microaggressions, racism, therapy*

Numerous initiatives, ethical standards and guidelines have been implemented over the past several decades to ensure mental health therapists provide culturally sensitive services inclusive of client worldviews and historical-political realities. Research shows that treatment services devoid of contextual racial-cultural factors explain poor treatment engagement (Chow, Jaffee, & Snowden, 2003), failed appointments (Atdjian & Vega, 2005), cultural mistrust (Bell & Tracey, 2006), and high rates of premature termination (Sue & Sue, 2012). Practitioners of all backgrounds are socialized within historical, political and social-cultural systems (e.g., cultural group, ethnic group, racial group, etc.), and therefore hold values, assumptions and beliefs about themselves, the therapeutic relationship and psychological wellbeing

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(American Psychological Association, 2002; Carter, 1995; Mazzula & Rangel, 2011).

In recognition of understanding the context in which human behaviors occur, the American Psychological Association (2002) *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* outlined skills and knowledge needed for the field to competently service diverse populations in the United States. These included the importance of having knowledge about ethnically and racially diverse individuals and clinical skills that are culturally congruent with diverse clients. The importance of culturally appropriate practice was recently highlighted with the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*'s inclusion of a cultural formulation interview guide providing clinicians with the tools to assess to cultural, historical and cultural contexts that may impact treatment and service (American Psychiatric Association, 2014).

However, perhaps the most challenging aspect of culturally sensitive treatment is the call for mental health practitioners to provide culturally appropriate treatment for their clients, while also recognizing their cultural selves in context. APA guidelines encourage psychologists to "... recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (American Psychological Association, 2002, p. 17). The notion that we, as psychologists, may hold attitudes and beliefs that are detrimental to our clients may be, for many, inconsistent with knowing our "self" as an agent of change. This may be particularly relevant for feminist therapists who are inherently committed to social justice and client empowerment (Hurtado & Stewart, 2004).

From a feminist theoretical framework, practitioners understand that mental health problems may develop as a result of negative systemic discrimination and subsequent socialized experiences- including encounters with discrimination, gender role conflicts, social class issues, or struggles with sexual orientation identity development (Enns, 2004; Worrell & Remer, 2002). As a result, feminist therapists are encouraged to conceptualize their clients through this lens, while guiding their clients toward empowerment, collaboration and shared-power (Worrell & Remer, 2002). Feminist therapists, female or male, are also encouraged to explore how they themselves have been socialized, which may influence their worldviews, their everyday problems, and their own mental health. As a result, feminist therapists are encouraged to engage in this level of self-reflection, particularly in exploring how power and privilege may influence their everyday lives, as well as their therapeutic relationships with clients. While feminist therapists may be more able to understand how their lives are affected by identities in which they have less power and privilege (e.g., a female therapist may be very cognizant of how sexism influences her life), at times they may also be less able to

recognize ways that their lives are affected by identities in which they have more power or privilege (e.g., a White therapist may not recognize how her race affords her benefits and advantages in her life).

Perhaps one of the primary reasons why it may be difficult to recognize power and privilege is because of the invisibility of Whiteness (Hurtado & Stewart, 2004; McIntosh, 2003; Smith & Redington, 2010). In a seminal article in the *American Psychologist*, Sue (2004) describes how White individuals may not view themselves as White and rather declare themselves to be colorblind; as a result, many may develop the worldview that the world is fair and just and that racism no longer exists in our society. Sue continues to describe how American society is embedded in a subtle, often invisible, ethnocentric monoculturalism or “the strong belief in the superiority of one group’s cultural heritage, history, values, language, beliefs, religion, traditions, and arts and crafts” (Sue, 2004, p. 764). Because Whites are the historically dominant group in the U.S., they have the power to establish the cultural norms, standards, beliefs and practices in the US; however, because racism has become socially unacceptable in the U.S., Whites may not admit that the U.S. is an ethnocentric country, nor that they may have power and privilege that is afforded as a result (Sue, 2004).

There has been increasing scholarship and studies on Whiteness as access to resources and power beyond that which is granted to other groups (McIntosh, 2003; Smith & Redington, 2010). From a social justice framework, Whiteness is a component of dominance characterized by unearned power to define normalcy, which in turn hides under invisibility. Whiteness has received considerable attention in colorblindness research (e.g., Neville, Lilly, Duran, Lee, & Browne, 2000). Given the invisibility of Whiteness, scholars have noted the lack of attention to issues of race among White Americans (see McIntosh; Smith & Redington). Mainly because, as Gill Tuckwell noted in *Racial Identity, White Counsellors and Therapists* Tuckwell (2002)

The dominant group seldom needs to speak its name: it is defined in contrast to the more explicit naming of marginal and subordinated subjects. Historically the silence about white representation and white identity was part of the internalised assumption that white values, customs, traditions and characteristics were the exclusive standards against which other peoples and world orders must be evaluated and perceived. (p. 71)

This lack of attention to Whiteness and White people was addressed by Janet Helm’s seminal work on white racial identity development (1990); the psychological process that White individuals undertake in developing a non-racist identity. In recent years, scholars have initiated research on White antiracists—or White individuals who are committed to combatting racism in their everyday lives. In one qualitative study, participants noted the difficulties that may arise in being White antiracists (Smith & Redington, 2010). One

commonly reported theme was “Interpersonal conflicts”; White participants described that when they became committed to issues of racial advocacy, both their personal and public relationships were affected. The study also found the importance of continuing self-reflection and awareness of racism. One participant, for example, noted that irrespective of their personal commitment to antiracism “I still forget I’m White” (p. 564). Smith and Redington’s study supports the first, and perhaps most important, guideline of the APA Multicultural Guidelines (2002)—the importance of continuing self-awareness, particularly in working with clients that are racially or culturally different.

White Feminist therapists must uncover, and fights against, deep seeded biases engendered within such social structure and history. Uncovering personal biases and prejudices can generate difficult and conflicting feelings for all therapists (Mazzula & Rangel, 2011), particularly when called to challenge power and privilege (Smith & Redington, 2010). Yet, deliberate self-discovery and awareness of social power and status are perhaps the main methods to ensure we prevent manifesting oppressive acts in treatment (Jacobs, 2000). Relatively little, however, has focused on managing race-based power and privilege in psychotherapy. Yet, given that U.S. culture has been historically organized around notions of inferior and superior peoples based on the social construction of race, power differentials within the treatment room are likely to occur (Carter, 1995).

Historical and current events of discrimination also engender feelings of mistrust and discomfort (Shim, Compton, Rust, Druss, & Kaslow, 2009) among marginalized populations engaging in treatment with clinicians whose characteristics may resemble that of those who have historically been the oppressor (e.g., male or White). In studies examining perceptions of psychotherapists, Thompson, Bazile, and Akbar (2004) found that African-American clients described perceptions of therapists as older, male, and White who were uncaring, unavailable, and out of touch with the reality of African-American communities to provide competent treatment. Others have found that African-American clients may fear misdiagnosis or “brainwashing” (Thompson, Bazile, & Akbar) and may mistrust mental health services (Bell & Tracey, 2006). Perceived discrimination based on sexism and racism has also shown to impact help-seeking behaviors and treatment engagement (Gary, 2005). Similar trends have also been found for lesbian, gay, bisexual, and transgender (LGBT) people of color who may mistrust clinicians due to the historical mistreatment and discrimination of both LGBT people and people of color (Greene, 1997; Nadal, 2013).

Recent studies on treatment engagement also show that racial and ethnic minorities are not as unwilling to seek mental health treatment as previously thought. For example, Shim et al. (2009) found that African Americans were more likely than both Hispanics and non-Hispanic Whites to indicate they would engage in services and were also less likely to feel embarrassed about

their help-seeking. Among immigrant Hispanic women, Nadeem and colleagues (2007) also found that Hispanics were more likely to want mental health services compared with U.S.-born White women. The findings of both Nadeem and colleagues and Shim and colleagues contradict the notion that racial-ethnic minorities are less likely to want professional help. Instead, these studies highlight the potential role of perceived discrimination or mistrust in therapists' ability to fully engage and understand the experiences of racial-ethnic minority clients.

Over the last decade, there has been an increasing attention to the unique role of experiences with microaggressions in the lives of marginalized communities (Nadal, 2011, 2013; Nadal, Mazzula, Rivera, & Fujii-Doe, 2014; Sue et al., 2007). Racial microaggressions are "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., p. 273). These insidious acts of discrimination have been found to be pervasive in the lives of marginalized communities, particularly in the lives of Latinas/os, Asian Americans, and African Americans (Nadal, 2011; Nadal, Escobar, Prado, David, & Haynes, 2012; Rivera, Forquer, & Rangel, 2010; Sue, Bucceri, Lin, Nadal, & Torino, 2010; Sue et al., 2008). Microaggressions have been found to influence negative mental health symptoms (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014), binge drinking (Blume, Lovato, Thyken, & Denny, 2012), and negative emotional intensity (Wang, Leu, & Shoda, 2011).

Despite this increase in literature, the exact mechanisms in which racial microaggressions may manifest in treatment remain an area in need of further exploration. Given racial microaggressions are brief exchanges that, while sending denigrating messages, may be out of the perpetrator's awareness (Nadal, Griffin, et al., 2014) it becomes of grave importance for therapists to be self-aware and able to identify their own race-based biases, assumptions and prejudices. Self-awareness of microaggressive acts are particularly important when racial microaggressions transpire in the context of power differentials – in this case that of a client and of a therapist. Although processing issues of race may create feelings of discomfort in therapists, creating a safe environment in which these can be discussed is essential for clients of color who continue to experience racist encounters that cause psychological distress, at times rising to levels of trauma (Carter et al., 2013).

RACIAL MICROAGGRESSIONS AND WHITE FEMINIST THERAPISTS

Given the previous literature on racial microaggressions, as well as our overview of how Whiteness may manifest in feminist therapy, we propose that there are several types of racial microaggressions that may occur in dynamics

between White Feminist therapists and clients of color. Although there is a dearth of research concerning this specific topic, we draw from theoretical works on racial microaggressions (Sue et al., 2007), as well as qualitative and quantitative research regarding microaggressions and people of color (Nadal et al., 2012; Nadal, Mazzula, et al., 2014; Rivera et al., 2010; Sue et al., 2010; Sue, Bucceri, Lin, Nadal, & Torino, 2010; Watkins, LaBarrie, & Appio, 2010). We also conceptualize our research from the few known studies that examine racial microaggressions in therapy (Owen, Tao, Leach, & Rodolfa, 2011) and sexual orientation microaggressions in therapy (Shelton & Delgado-Romero, 2011).

In this section, we will provide four types of racial microaggressions that may occur in therapy with White, feminist therapists: (a) Assumptions of White Cultural Values, (b) Colorblindness/ Unwillingness to Discuss Race, (c) Denial of Individual Racism, and (d) Assumptions of Stereotypes. To assist in illustrating these themes, we discuss examples from previous literature, while also using a case vignette as way to demonstrate how these microaggressions may unwittingly occur in a therapist–client relationship.

Assumptions of White Cultural Values

Because of the invisible nature of Whiteness (McIntosh, 2003), many therapists may not recognize the ways that race may manifest in therapeutic dyads. For White feminist therapists specifically, Whiteness may be even more difficult to recognize or address for two main reasons. First, because the therapist is committed to feminism and social justice issues, she/he may believe that she/he is incapable of discriminating against her/his clients on any level. Second, because the therapist may be committed to empowerment of her/his clients, she or he may not recognize how her/his own racial biases may influence how or when she/he empowers her/his clients, and how these instances may be based on her or his own White cultural values.

There are many ways that therapists may inadvertently promote White cultural values in therapy sessions. First, a therapist who is not aware of her/his biases may assume that her or his experiences and worldviews are normalized and that all others are incorrect. For instance, if a therapist insists that all of her/his clients communicate in a certain way, she/he is not considering the various cultural communication styles that may exist. One way that this can manifest is if a therapist were to strongly encourage an Asian-American client to be more assertive and confrontational with her parents. While well intentioned, the therapist may not recognize that some Asian-American clients may be uncomfortable with direct communication, or that being assertive is not acceptable in many Asian-American families (Sue et al., 2010). Second, a therapist may view certain behaviors that are exhibited by her/his clients of color as being pathological or deviant. For instance, if a therapist diagnoses an African-American client with paranoia

for always thinking of race, she/he may not realize that to be conscious of race on a daily basis is actually considered a healthy behavior (Sue et al., 2008). Fear of misdiagnosis in treatment has been noted among African-American clients (Sanders Thompson et al., 2004) and also shown to cause mistrust in mental health services (Bell & Tracey, 2006). Yet, according to Hansen et al. (2006), psychologists rarely incorporate racial or cultural issues in their clinical formulations. Given most theories of psychology are grounded within Western White cultural values, without a deliberate commitment to understanding clients' own cultural worldviews therapists may inadvertently promote them in therapy sessions.

Color-Blindness/Unwillingness to Discuss Race

In general, theories on racism purport that people often present themselves as unbiased and fair (Dovidio & Gaertner, 1986; Sue, 2004) and therefore may endorse color-blindness as a way to ensure, albeit potentially harmful, that all clients are treated equally. Sue et al. (2007) define color-blindness microaggressions as "statements that indicate that a White person does not want to acknowledge race" (p. 276). While therapists who claim to be color-blind have good intentions (i.e., they purport that they view everyone as equals), they may leave clients to feel misunderstood or invalidated. That is, the client is essentially told that her or his race does not matter. Furthermore, researchers have suggested that it is very unlikely for individuals to be color-blind, due to the inherent nature of stereotyping, racial socialization, and racism (Carter, 1995; Dovidio & Gaertner, 1986; Neville et al., 2000). So, while therapists may desire to be color-blind (and inform clients of this wish), it is not only invalidating to a client but is also based on a false belief. Given that all individuals are socialized within a racist society (Carter, 1995), it is virtually impossible to hold no biases or prejudices. Owning that we may have such biases is the first step toward competent feminist therapy.

There are several ways that color-blindness may manifest in therapy. Sue and colleagues (2007) share an example of a therapist telling a client: "I think you are being too paranoid. We should emphasize similarities, not people's differences" (p. 282). In this instance, a covert message is communicated that (a) race and culture are not salient aspects of people's lives and (b) clients who think about racial issues are overly sensitive or unreasonable. Another example of color-blindness may include a client of color who brings up a race-related stressor in a therapy session and continues to describe how race affects her everyday life; after listening to her story, the therapist interjects with, "It's interesting that you experience all of this, because when I see you, I don't see color." In this case, an indirect message is communicated that the client's perceptions about race are not valid. Although the therapist may have attempted to purport that she was not racist, the therapist may have inadvertently damaged their therapeutic rapport.

Denial of Individual Racism

Sue and colleagues (2007) define racial microaggressions that fit under the category “Denial of Individual Racism” as “A statement made when Whites renounce their racial biases” (p. 276). These types of microaggressions can manifest in therapy in a couple of ways. First, a client can confront her/his therapist on a microaggression that may have occurred in therapy; in response, the therapist might tell the client that she or he is not racist or may vehemently deny that the interaction was a microaggression. Second, a therapist may preemptively describe her or himself as a non-racist person, perhaps in an attempt to connect with the client or present her or himself as someone fair and unbiased (Dovidio & Gaertner, 1986; Sue, 2004). However, in doing so, the client may view the therapist as insincere and incapable of recognizing her or his racial biases. These types of microaggressions are likely well intentioned, in that the therapist truly believes that they are incapable of committing racially biased acts. However, in not being able to own her or his potential prejudice or bias, clients may feel an array of emotions, including frustration, doubt, or mistrust.

There are many ways that microaggressions based on denial of individual racism may occur in therapy settings. For instance, a client of color may bring up that she feels uncomfortable talking about race with her therapist because she is White, in which the therapist replies, “race does not affect the way I treat you.” Again, while well intentioned, the therapist invalidates the racial reality of the client who may have difficulty in discussing race with White people. Scholars have shown that clients of color may have previous experiences with discrimination that create general feelings of mistrust when in treatment with therapists that represent those that have been oppressive, whether historically or in their day-to-day lives (Shim et al., 2009). Therefore, it is likely that clients may feel discomfort talking about race and therefore important for the therapist to validate the client’s experience. This leads to a second way in which “Denial of Individual Racism” microaggressions may occur in therapy; a therapist failing to acknowledge that there may indeed be a racial dynamic that is affecting the client’s experience in therapy. Finally, the therapist’s claim that race doesn’t affect her/his treatment of the client negates any individual responsibility, but instead places the fault or responsibility on the client.

Another way in which a therapist may deny any potential racism in a therapy session may be when she or he turns to another marginalized identity to either negate the client’s experience or in an attempt to bond with the client. For example, Sue and colleagues (2007) describe a situation in which a male client of color expresses uncertainty in discussing racial issues with his White female therapist; in response, she states, “I understand. As a woman, I face discrimination also” (Sue et al., 2007, p. 282). In this case, the therapist has the best intentions and perhaps wants to relate to the client

in some way; however, the client may actually have the opposite response and may be offended or upset by her attempts. First, in bringing up her experiences with sexism, the therapist is equating racism and sexism, while claiming to understand how her male client experiences racism in the world. Despite this, she, as a White woman, would never fully understand what it means for him to be a man of color in this country. In fact, in making such a statement, she is also communicating that she does not recognize how her Whiteness affords her power and privilege. While sexism is still rampant on systemic, institutional, and interpersonal levels, the therapist's White identity places her into the dominant group, which has historically defined the cultural norms, standards, and beliefs in the U.S. (Bennett & Stewart, 2005).

When an individual is oppressed in one identity but privileged in another, it may be even more difficult for them to recognize the advantages and privileges that they do have (Nadal, 2013). For instance, imagine a White gay male therapist who experiences discrimination regularly, based on his sexual orientation. As a result of these experiences, he may become very cognizant of the many ways that heterosexism has negatively impacted his life (e.g., he recognizes homophobic language, he notices when people stare at him if he holds his husband's hand, etc.). However, it may be challenging for him to identify the ways that he has privilege because of his race or his gender. As a result, he may operate in subtly racist and sexist ways because he does not believe that he could possibly discriminate against others in the same ways that he has been. If a client confronted him on the ways that he may have racial or gender biases, he may be defensive and incapable of hearing or validating the client's reality. As a result, it would be crucial for him (and others) to recognize how power and privilege manifest in all of their identities.

Assumptions of Stereotypes

All individuals, including therapists, have been socialized in an environment in which stereotypes are formed about certain groups. The psychological study of race suggests that racial attitudes, biases, and prejudices are subconscious processes (see Carter, 1995; Helms, 1990) and that implicit biases often result in racial stereotyping (Amodio & Devine, 2006). Therefore, it is possible for stereotypes to result in microaggressions in therapy without conscious malicious intent from therapists. For instance, Sue and colleagues (2007) share an example of a Black client who is accused of stealing from work, and how her therapist does not believe her. Because the therapist would have no reason to believe that the client would engage in such behavior, such an assumption could be interpreted as being based on the therapist's racial biases against African Americans. In studies with African Americans (e.g., Sue et al., 2008), participants describe an array of microaggressions including "Assumptions of Criminal Status" (i.e., microaggressions

in which African Americans are presumed to be violent, deviant, or likely to engage in illegal behaviors) and “Assumptions of Inferiority” (i.e., microaggressions in which African Americans are presumed to be less intellectual). For example, if a therapist presumed that an African American would be less intelligent (e.g., assuming a client did not go to college or that she did not have a high-status job), the therapist would be committing a microaggression based on her/his own stereotypes.

Microaggressions towards Latinas/os or Asian Americans may result from stereotypes as well. For instance, in studies with Latinas/os (Rivera et al., 2010) and Asian Americans (Sue et al., 2010), participants describe being treated as perpetual foreigners or “Aliens in their own Land” (i.e., individuals assume that they would not be American-born or would not speak English well). These types of microaggressions can be especially daunting for individuals who were raised in the United States or whose families have been in the United States for generations. When individuals commit these types of microaggressions, they indirectly communicate that Latina/os or Asian Americans are not “American enough,” primarily because they equate “American” with being “Anglo-White.” Other scholars have found microaggressions manifest differently when considering within group factors. For example, a recent study found Puerto Ricans are more likely to be treated as criminals (i.e., perceived to be deviant or prone to crime) or as “Second-Class Citizens” (i.e., receive subordinate treatment) compared to other Latino sub-ethnic groups (Nadal, Mazzula, et al., 2014). Similarly, Filipino Americans were found to experience microaggressions that were similar to those experienced by other Asian Americans (e.g., being exoticized or viewed as “perpetual foreigners”), but they also encountered microaggressions that were not as typical for other Asian Americans (e.g., being viewed as criminal or intellectually inferior; Nadal et al., 2012).

In a therapy session, assumptions of stereotypes can occur in an array of ways. For instance, in an intake session, a therapist may ask a male Asian American client “Where you from?” and when the client answers “New Jersey,” the therapist may ask further clarification by asking “I mean, where are you *really* from?” Although the therapist may have been well intentioned in an effort to gather background information, the client may feel offended as an individual who was born and raised in New Jersey. If the therapist is interested in knowing about the client’s ethnic heritage, microaggressions based on stereotypes can be prevented, for example, by asking more direct questions (e.g., “How do you identify ethnically? What is your family’s ethnic background?” or “What is your family’s immigration history?”).

Microaggressions based on stereotypes can also manifest through clinical diagnoses. For instance, Sue and colleagues (2007) describe an instance in which a therapist takes great care to ask substance abuse questions during an intake with a Native American client, and is skeptical of the client’s absent history with substances (Sue et al., 2007). Similar types of overgeneralizations

can be made for non-diagnostic clinical conceptualizations. For example, therapists may assume that all Latino male clients are macho and would be incapable of expressing emotion; that all Black women clients are aggressive or have anger issues; or that all Asian male clients are emotionally inept or exhibit symptoms of alexithymia.

Finally, stereotypes may result in microaggressions when therapists make presumptions that race would be a central factor in every aspect of a client's life. In Shelton and Delgado-Romero's (2011) study with lesbian, gay, and bisexual (LGB) clients' experiences of microaggressions, one common theme was therapists' assumption that sexual orientation was the cause of all of their presenting issues. Although it is important for therapists to recognize how individuals' identities and experiences can be salient and integral parts of their lives, it is also important to recognize that such identities may not be central in every case. Sometimes, making these assumptions may be due to therapists' desires, whether conscious or subconscious, to overidentify with a client or compensate for their recognition of social injustices in the world. Recent studies show that, for some minority clients, cultural issues are not an integral part of psychotherapy (Chang & Berk, 2009). Therefore, making broad generalizations can also be viewed as microaggressions because clients are not viewed as individuals, but rather treated based on preconceived stereotypes, which may or may not reflect the client's life or life experiences.

CASE STUDY

Drawing from feminist theory and research on racial microaggressions, we present the case of a 40-year-old African-American woman who is in treatment for depression. We demonstrate how challenging it may be to note racial microaggressions in the moment, the reality of their existence, and the importance of validating client's experiences and engaging in meaningful discussions. The conceptualization of the client's problem and engagement in treatment is contextualized within microaggressions scholarship (Sue et al., 2007) and studies with people of color (Nadal et al., 2012; Rivera et al., 2010; Sue et al., 2008), as well as our own clinical experiences in working diverse clients.

The Case of Nicole

Nicole is a 40-year-old African-American woman who seeks therapy to help overcome her symptoms of depression. While she has worked as an attorney for the past 10 years, she has overcome a spectrum of difficulties in recent years—including a tumultuous divorce, work stressors, and obstacles in raising her 8-year-old daughter, Sophia. Because Nicole has been experiencing chronic feelings of sadness, hopelessness, and worthlessness, one of her close

friends suggested that she seek therapy at a local community mental health agency. The agency is in the heart of a predominantly working-class Black and Latino neighborhood in a Northeastern metropolitan city. Most of the agency's clients (including Nicole and her daughter) live in the community.

Two weeks after signing up for therapy, Nicole was assigned to Linda, a fifth-year psychology intern from a local clinical doctoral program. Linda is a 28-year-old White American, who identifies as middle-class. She has completed most of her coursework and has worked at the agency for the past year. Linda grew up in a small rural town, several thousand miles away, and moved to the metropolitan city as a result of her doctoral program. She views herself as "a liberal feminist" and reports that she "does not see race and treats everyone the same."

When Nicole attends her first meeting, she is a "bit" surprised when she sees that Linda would be her therapist. Having grown up in the neighborhood (and knowing that many of the agency's clients were people of color), Nicole falsely assumed that the clinicians would be mostly people of color too. Nicole wanted to work with a person of color, particularly a woman of color, because she thought it would be easier to relate. However, she decided that she wanted to remain open-minded in her first meeting with Linda.

At their first meeting, Nicole perceived Linda to be a warm therapist. She was friendly, pleasant and comforting as Nicole started to talk about the various issues in her life. Nicole discussed how she felt "stressed out" about being a single mother most of the time (i.e., her ex-husband had custody every other weekend) and about how hard it was to pay bills and keep the household afloat. The first meeting was a good "venting session" for Nicole, and after a few similar sessions, Nicole was optimistic that therapy could actually be helpful for her.

In their fifth session together, Nicole decided to open up about her failed marriage with her ex-husband, David. She described how she and David had been together since college and how they married after dating for ten years because "it was the next logical step." She explained how they were married for an additional 10 years and how hard it was to divorce after being with someone for twenty years. When telling the story, Nicole noticed that Linda's facial expression was one of surprise; in fact, Linda even responded, "Oh, I didn't realize you had been together for that long. I just assumed that you..." Linda paused and then finished her statement with "Wait, let me just clarify... Did you get married before or after your daughter was born?" Nicole answered her but was very annoyed by this interaction; however, she was unsure what made her annoyed and decided to let it go.

When Nicole arrived to their sixth session, she appeared to be very rushed and anxious. She began to talk about some of the stressors at work including how she felt very overwhelmed because she perceived her colleagues to have high expectations for her. Nicole described how she felt even more burdened because she was the only Black woman in her office and felt

that she had to outperform everyone else. After realizing that she had never explicitly brought up race in the room, Nicole intently looked up to notice Linda's reaction. Although Linda seemed comfortable and empathic, Nicole recognized that Linda did not directly address the topic of race or validate Nicole's experiences of being the only Black woman in the office. Disappointed by this, Nicole continued the session, but was emotionally checked out for the rest of the session.

For their seventh session, Nicole decided that she needed to share how she felt about therapy. She began by sharing how disappointed she was with the previous session; she shared that she wanted to be comfortable in talking about the topic of race in her therapy sessions. Linda replied, "Why do you think you are fixated on race?" Nicole immediately became angry and hesitatingly replied: "Because it is an important of my life." Linda replied, "Well, maybe that is a problem. By fixating on race so much, you won't be able to recognize the potential you have." Nicole felt stunned, annoyed, and invalidated, but remained silent. She decided to not to return to therapy.

Case Study Discussion

In this vignette, we see many ways in which racial microaggressions manifested in the therapeutic dyad between Linda and Nicole. Let's begin with the four types of microaggressions that we highlighted (e.g., Assumptions of White Cultural Values, Colorblindness/ Unwillingness to Discuss Race, Denial of Individual Racism, and Assumptions of Stereotypes) and discuss how those materialized in the therapy sessions.

First, it was clear that Linda assumed many White cultural values that impeded her ability to work with Nicole. During the first meeting, Nicole discussed stressors related to single parenting, finances and maintaining her household. While seemingly innocuous, the value of balancing of multiple roles is a common trait for women of color; studies on African-American women show some women are expected, and expect of themselves, to have the ability to manage multiple roles (e.g., that of a mother, employee, etc.) on their own without asking others for help (see Speight, Isom, & Thomas, 2013). If Linda endorses White American cultural values of autonomy and democracy, she may (1) have a difficult time understanding that the management of multi-tasks for Nicole indicates a culturally sanctioned worldview that differs from her own, and (2) intervene at one point incorrectly assuming that Nicole is doing this on her own (e.g., pathologizing Nicole's need to hold this role as head of household). Second, from the outset, it was clear that Linda tried to maintain a color-blind attitude, as demonstrated by her belief that she "does not see race and treats everyone the same." However, race and racial dynamics will become evident in the therapeutic dyad whether or not the therapist is able to engage the conversation (Carter, 1995). For example, after meeting with

Linda several times, Nicole described feeling burdened by being the only Black woman in her office. While Linda was emphatic, she did not address Nicole's experience directly. She did not acknowledge that race is a salient part of Nicole's life or that racism (and sexism and other forms of discrimination) may be a regular experience in Nicole's life. Perhaps if Linda was aware of research studies that have demonstrated this phenomenon (see Carter et al., 2013), she may have recognized that Nicole's experiences were quite common.

Further, it appears that Linda had been somewhat successful in establishing a trusting relationship with Nicole, as indicated by the notion that Nicole did initially feel safe in discussing her experience as a Black woman. Yet, perhaps due to the invisibility of Whiteness, Linda was unable to see this as an opportunity to further engage the client around issues of race. It is possible that Linda was uncomfortable about issues of race or did not want to bring up race because she believes race to be a socially taboo topic. However, in doing so, she unintentionally dismissed the client's reality, as well as the opportunity to develop a stronger therapeutic bond. Scholars and researchers note clients' perceptions of their therapists' ability to value the salience of racial and cultural issues in clients lives are related to better therapeutic rapport and client-therapist relationship (see Owen et al., 2011).

When Nicole expressed disappointment with therapy, Linda's response was that Nicole was too focused on race. Statements, like these, that negate an individual's racial realities have been referred to as microinvalidations (Sue et al., 2007). In this case, Linda's statement dismissed the centrality of Nicole's racial experiences in her life and the possibility that Nicole's experiences with racism impacted her wellbeing. Linda's statement also demonstrated her lack of awareness of the many studies that support that people of color do indeed experience discrimination regularly in their lives (see Sue & Sue, 2012; Carter et al., 2013) and that these experiences of racial microaggressions, like the ones that Nicole describes, are related to mental health issues (see Nadal, Griffin, et al., 2014).

When telling the story about her 20-year relationship with her husband, Nicole noticed that Linda's facial expression was one of surprise, which was followed by Linda asking Nicole about whether her daughter was born before or after she married David. While a seemingly innocent question, it is likely that Linda's reactions are based on her stereotypes about Black women. Perhaps Linda has biases that Black women do not have long-term romantic relationships or that all Black children are born to single mothers. Linda merely continued the therapy session without addressing the impasse that occurred. Nicole was annoyed by the whole interaction, but did not address it. If she did, it is possible that Linda would have denied that she committed a microaggression. Because Linda is committed to feminism and social justice issues, she may believe that she is incapable

of discriminating against her clients; she may also be unaware of the biases she holds about other groups. As a result, the incident went unaddressed and Nicole continued to grow more disappointed in therapy. Given the previous studies that show a healthy client-therapy relationship and therapists' credibility are associated with their clients' perceptions that her or his therapist has the ability to work with issues of race and culture (Owen et al., 2011), it is likely that Linda's inability to discuss race may have led to Nicole's premature termination.

Another dynamic occurred in the therapeutic dyad that is worth noting. Nicole held assumptions about Linda that may have impacted her treatment. Nicole was surprised that her therapist was a White woman and had the preference of working with a person of color, particularly a woman of color. Here, we see potential underlying issues of mistrust, which could have been addressed right away. Given previous studies on some African Americans' perceptions of White therapists as "detached" and unlikely to be able to relate to their experience (Thompson et al., 2004), it would have been worthwhile for Linda to engage Nicole in a conversation in one of their first sessions. However, because Linda is in a place where she "does not see race," it did not occur and the cultural mistrust grew throughout their work together.

CONCLUSION

Racial microaggressions have been documented to be pervasive in the lives of marginalized groups (Nadal, 2011, 2013; Nadal, Mazzula, et al., 2014). Although relatively little has been documented on the manifestation of racial microaggressions in treatment (Owen et al., 2011), we discussed several types of racial microaggressions that could occur between White feminist therapists and clients of color. While APA's *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (2002) encourage psychologists to examine their own biases, assumptions, and worldview, we understand self-awareness is challenging, and more so in the context of racial microaggressions for White therapists due to the invisibility of Whiteness. Exploring personal biases, prejudices, and assumptions requires therapists to engage in thoughtful and deliberate self-reflection on their dominant social status and how their assumptions and worldviews influence interactions with clients.

The process of discovering our own biases and assumptions is a lifelong journey and commitment that transcends a prescribed set of skills (Mazzula & Rangel, 2011). For White trainees, who are just beginning to engage in feminist work, it is important for them to understand the lifelong nature of discovering and owning racist biases and assumptions; as well as the importance for a support system given the difficulties and challenges that

may arise when engaging in this work (Smith & Redington, 2010). Increasing self-awareness and preventing racial microaggressions from occurring in the therapy room are critical when working with Clients of Color who have been documented to continue to encounter race-based experiences of discrimination on a daily basis (Carter, Forsyth, Mazzula, & Williams, 2005; Nadal, 2011). Providing a “safe space” for clients to discuss their own experiences with racial microaggressions can assist in building a healthy client-therapist alliance and break down cultural mistrust of system that has been historically oppressive to marginalized populations (Sue & Sue, 2012).

REFERENCES

- American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: American Psychological Association.
- American Psychiatric Association. (2014). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Amodio, D. M., & Devine, P. G. (2006). Stereotyping and evaluation in implicit race bias: Evidence for independent constructs and unique effects on behavior. *Journal of Personality and Social Psychology, 91*(4), 652–661. doi:10.1037/0022-3514.91.4.652
- Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in the U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services, 56*(12), 1600–1602. doi:10.1176/appi.ps.56.12.1600
- Bell, T. J., & Tracey, T. J. G. (2006). The relation of cultural mistrust and psychological health. *Journal of Multicultural Counseling and Development, 34*(1), 2–14. doi:10.1002/j.2161-1912.2006.tb00022.x
- Bennett, M. J., & Stewart, E. C. (2005). *American cultural patterns: A cross-cultural perspective* (2nd ed.). Boston, MA: Intercultural Press.
- 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*(1), 45–54. doi:10.1037/a0025457
- Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy*. New York, NY: Wiley & Sons, Inc.
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105. doi:10.1177/0011000006292033
- Carter, R. T., Forsyth, J., Mazzula, S. L., & Williams, B. (2005). Racial discrimination and race-based traumatic stress. In R. T. Carter (Vol. Ed.), *Handbook of racial-cultural psychology and counseling: Practice and training* (Vol. 2, pp. 447–476). New York: Wiley & Sons, Inc.
- Carter, R. T., Mazzula, S., Victoria, R., Vazquez, R., Hall, S., Smith, S., . . . Williams, B. (2013). Initial development of the race-based traumatic stress symptom scale: Assessing the emotional impact of racism. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(1), 1–9. doi:10.1037/a0025911

- Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*, 521–536. doi:10.1037/a0016905
- Chow, J. C.-C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*, 792–797. doi:10.2105/ajph.93.5.792
- Dovidio, J. F., & Gaertner, S. L. (1986). Prejudice, discrimination, and racism: Historical trends and contemporary approaches. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination and racism* (pp. 1–34). Orlando, FL: Academic Press.
- Enns, C. (2004). *Feminist theories and feminist psychotherapies: Origins, themes, and diversity* (2nd ed.). New York: Haworth Press.
- Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*, 979–999. doi:10.1080/01612840500280638
- Greene, B. (1997). Ethnic minority lesbians and gay men: Mental health and treatment issues. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 216–239). Thousand Oaks, CA: Sage.
- Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., . . . Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*(1), 66–74. doi:10.1037/0735-7028.37.1.66
- Helms, J. E. (1990). *Black and White racial identity attitudes: Theory, research, and practice*. Westport, CT: Greenwood Press.
- Hurtado, A., & Stewart, A. J. (2004). Through the looking glass: Implications for studying whiteness for feminist methods. In M. Fine, L. Weis, L. P. Pruitt, & A. Burns (Eds.), *Off White: Readings on power, privilege, and resistance* (pp. 315–330). New York: Routledge.
- Jacobs, L. (2000). For Whites only. *British Gestalt Journal 9*(1), 3–14.
- Mazzula, S. L., & Rangel, B. (2011). Cultural consideration for mental health treatment with women of color. In P. Lundberg-Love, K. Nadal, & M. Paludi (Eds.), *Women and mental disorders: Treatments and research* (Vol. 4, pp. 75–91). Santa Barbara, CA: Praeger.
- McIntosh, P. (2003). White privilege: Unpacking the invisible knapsack. In S. Plous (Ed.), *Understanding prejudice and discrimination* (pp. 191–196). New York: McGraw-Hill.
- Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS): Construction, reliability, and validity. *Journal of Counseling Psychology, 58*, 470–480. doi:10.1037/a0025193
- Nadal, K. L. (2013). *That's so gay! microaggressions and the lesbian, gay, bisexual, and transgender community*. Washington, DC: American Psychological Association.
- Nadal, K. L., Escobar, K. M. V., Prado, G. T., David, E. J. R., & Haynes, K. (2012). Racial microaggressions and the Filipino American Experience: Recommendations for counseling and development. *Journal of Multicultural Counseling and Development, 40*, 156–173. doi:10.1002/j.2161-1912.2012.00015.x
- Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The Impact of Racial microaggressions on mental health: Counseling Implications for clients of color. *Journal of Counseling & Development, 92*(1), 57–66. doi:10.1002/j.1556-6676.2014.00130.x

- Nadal, K. L., Mazzula, S. L., Rivera, D. P., & Fujii-Doe, W. (2014). *Journal of Latina/o Psychology*, 2(2), 67–78. doi:10.1037/lat0000013
- Nadeem, E., Lange, J. M., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and US-born Black and Latina women from seeking mental health care? *Psychiatric Services*, 58, 1547–1554. doi:10.1176/appi.ps.58.12.1547
- 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. doi:10.1037//0022-0167.47.1.59
- Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, 48(3), 274–282. doi:10.1037/a0022065
- Rivera, D. P., Forquer, E. E., & Rangel, R. (2010). Microaggressions and the life experience of Latina/o Americans. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 59–84). New York: Wiley & Sons.
- 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(2), 210–221. doi:10.1037/a0022251
- Shim, R. S., Compton, M. T., Rust, G., Druss, B. G., & Kaslow, N. J. (2009). Race-ethnicity as a predictor of attitudes toward mental health treatment seeking. *Psychiatric Services*, 60(10), 1336–1341. doi:10.1176/appi.ps.60.10.1336
- Smith, L., & Redington, R. M. (2010). Lessons from the experiences of White antiracist activists. *Professional Psychology: Research and Practice*, 41, 541–549. doi:10.1037/a0021793
- Speight, S. L., Isom, D. A., & Thomas, A. J. (2013). From Hottentot to Superwoman: Issues of identity and mental health for African American women. In C. Z. Enns & E. N. Williams (Eds.), *The Oxford handbook of feminist multicultural counseling psychology* (pp. 115–130). New York: Oxford University Press.
- Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the “invisible” visible. *American Psychologist*, 59, 759–769. doi:10.1037/0003-066x.59.8.761
- Sue, D. W., Bucceri, J., Lin, A. I., Nadal, K. L., & Torino, G. C. (2010). Racial microaggressions and the Asian American experience. *Asian American Journal of Psychology*, 5(1), 88–101. doi:10.1037/1948-1985.S.1.88
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for counseling. *The American Psychologist*, 62(4), 271–286. doi:10.1037/0003-066x.62.4.271
- Sue, D. W., Nadal, K. L., Capodilupo, C. M., Lin, A. I., Torino, G. C., & Rivera, D. P. (2008). Racial Microaggressions against Black Americans: Implications for counseling. *Journal of Counseling & Development*, 86(3), 330–338. doi:10.1002/j.1556-6678.2008.tb00517.x
- Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse* (6th ed.). New York: John Wiley & Sons, Inc.

- Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African-Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35(1), 19–26. doi:10.1037/0735-7028.35.1.19
- Tuckwell, G. (2002). *Racial identity, White counsellors and therapists*. Buckingham, UK: Open University Press.
- Wang, J., Leu, J., & Shoda, Y. (2011). When the seemingly innocuous “stings”: Racial microaggressions and their emotional consequences. *Personality and Social Psychology Bulletin*, 37(12), 1666–1678. doi:10.1177/0146167211416130
- Watkins, N. L., LaBarrie, T. L., & Appio, L. M. (2010). Black undergraduates experience with perceived racial microaggressions in predominantly White colleges and universities. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 25–58). New York: Wiley & Sons.
- Worrell, J., & Remer, P. (2002). *Feminist perspectives in therapy: Empowering diverse women*. New York: Wiley.