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Microaggressions Against Ethnic Individuals From Minorities in Counseling

Joan Morton
Walden University

Walden University

College of Allied Health

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Joan B. Morton

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Review Committee
Dr. Peggy Samples, Committee Chairperson, Psychology Faculty
Dr. Arcella Trimble, Committee Member, Psychology Faculty
Dr. Megan Corley, University Reviewer, Psychology Faculty

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Sue Subocz, Ph.D.

Walden University
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Abstract

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Abstract

Even though the current literature addresses racial microaggressions among ethnic minority people and implications for counseling, no qualitative research that included the voices of ethnic minority individuals was found. Researchers have not fully addressed the prevalence of racial microaggressions in counseling sessions. The purpose of this qualitative narrative study was to explore the lived encounters of ethnic minorities concerning racial microaggressions in counseling. The study issue was analyzed through the lens of critical race theory. Four participants were recruited from the Walden University participation pool. Data were selected through semi-structure interviews and narrative analysis was used to analyze data to identify the main concepts and develop a narrative coding structure. Fourteen narrative themes emerged from the narrative codes and findings showed that participants encountered racial microaggressions in the form of bias, prejudice, false assumptions, and misinterpretations, which the clients' reported impacted their judgment and not trusting their instincts. This research may contribute to positive social change by helping leaders in the counseling profession to understand their multicultural and diverse environment. The counseling organization could also use this research as a basis for policy decisions that may enhance racial relations in this profession.

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Dedication

This dissertation is in honor to Jehovah God and his darling son Jesus who would not allow me to stop. Jesus gave me the incentive to go on when I wanted to throw up my hands and say I give up! It is with Jesus Christ's help that I am what I am today not a defeatist. But a go getter who sees a way out of no way. I remembered that God never gives you more than you can handle. I GIVE GOD ALL THE GLORY!!!

I would like to thank my children Iris, Nathaniel, Sr., Terrance, Andre, Aaron (twins) and my grandsons, Nathaniel, jr. and Donald, who never gave up on me and always had an encouraging word and continued to call me. Especially my son Andre, he called the most.

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I would also like to thank the four research participants who agreed to freely share their lived encounter of the research phenomenon, in spite of the sensitive nature of the research theme. May the Lord reward you greatly.

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Chapter 1: Introduction to the Study

Introduction

Despite the fact that the civil rights movement had a significant influence on modifying racial prejudice and discrimination in the United States, racism still persists and the effects are still pervasive on many different levels (Thompson & Neville, 1999). In fact, President Clinton's Race Advisory Board found the following:

> (a) racism is one of the most divisive forces in our society, (b) racial legacies of the past continue to haunt recent policies and practices that create unfair disparities between minority and majority cohorts, (c) racial inequities are so deeply ingrained in American society that they are nearly invisible, and (d) most White Americans are unaware of the advantages they enjoy in this society and of how their behaviors and actions unintentionally discriminate against persons of color (Advisory Board to the President's Initiative on Race, 1998 as cited by Sue et al., 2007).

The last point is particularly relevant in the health professions, where most health professionals in the United States are educated about service delivery in predominately White institutions of higher learning through the lens of the White Anglo-Saxon Protestant perspective (D. W. Sue & Sue, 2003). With this in mind, the present research will specifically focus on White therapist-client of color communications as it relates to racial microaggressions (Sue et al., 2007).

White therapists are not inoculated from the racial prejudices of their ancestors (Burkard & Knox, 2004; D. W. Sue, 2005), and can become inadvertent victims of subconscious cultural learning that fosters biases and injustices. This conditioning can

happen in many ways such as through the media, through education systems, and through social norms and values (Abelson et al. 1998; Banaji et al. 1993), fostering discriminative tendencies toward clients of color (Sue et al., 2007). Development and education related to cultural competence in therapists has been a major focus for several years in the mental health profession (American Psychological Association, 2003; D. W. Sue et al. 1992), and two therapeutic characteristics, in particular, have been identified as integral to the delivery of culturally competent care to racial/ethnic minority (R/EM) clients: "(a) perception of oneself as a racial/cultural being and of the prejudices, typecast, and conjectures that impact worldviews and (b) perception of the worldviews of culturally diverse clients" (Sue et al., 2007, p.1).

The two goals are not possible to achieve since they have been closed; nevertheless, when White clinicians are unable to comprehend that these issues of race are an important factor in therapy procedures and what significance it plays in racism delivery of services to clients of color (Richardson & Molinaro, 1996). Counselors who are used to having these biases as part of their culture become unintentionally ignorant that this is not acceptable by the ethnic minority cultures. Therefore, they end up with untimely terminations from counseling by ethnic minorities clients (Burkard & Knox, 2004; Kearney et al., 2005). Sue et al. (2007) described how racial microaggressions has been implemented into the counseling sessions unnoticed by the counselor(s) intentional or unintentionally. Therefore, it is essential that counselors be educated on the proper protocol when approaching clients from ethnic cultures and more studies need to be conducted on counseling/therapy procedures to explain how racial microaggressions can

impair the therapeutic alliance. To date, no conceptual or theoretical model of racial microaggressions has been proposed to explain their influence on the therapeutic process (Sue et al., 2007).

A culturally competent psychologist respectfully elicits data required to make an accurate assessment and to negotiate mutually satisfactory goals for treatment with the client. The assessment phase is a fundamental procedure in psychotherapy because many culturally diverse clients prematurely drop out of treatment at this point. For this reason, psychologists should consider identifying the first session as a consultation rather than as an intake concentrated on pathology with the goal of promoting client agency and fostering a collaborative therapeutic alliance (Comas-Díaz & Brown, 2016).

Besides not feeling heard or understood, many multicultural clients report that they encounter cultural neglect during clinical assessment. For example, it appears common for dominant-culture psychologists to ignore cultural and family norms when they request collectivistic clients to divulge intimate data, such as discussing family disputes and expressing feelings, in advance of initiating a therapeutic alliance and the requisite level of trust (Varma, 1988, as cited by Comas-Díaz & Brown, 2016). Failure to attend or give assessment might result in misdiagnosis that perpetuates stereotypes based on ethnicity, race, gender, age, and sexual orientation. This can, in turn, lead to mental health care disparities (Alarcón et al., 2009). Research has also demonstrated that clinicians' inattention to concerns arising from clients' experiences centered in their racial or other identities is likely to result in clients' dissatisfaction with the clinical encounter (Mulvaney-Day et al., 2011).

For these reasons, multicultural psychologies propose the use of a process-oriented clinical assessment, one that examines the multiple contexts in clients' lives in addition to their encounters of distress or dysfunction. The first task in the process-oriented assessment is to engage clients in treatment. Clients are likely to arrive at the consulting room requiring their clinician to show cultural credibility if the client is to trust the therapeutic alliance. Cultural credibility entails clients' perceptions of their psychologist as a trustworthy and effective clinician who shows sophisticated awareness of dynamics stemming from culture and identities (Comas-Díaz & Brown, 2016). Many multicultural clients expect clinicians to "give," that is, they expect to feel that they benefited from the initial session rather than see themselves as only having been assessed or judged (S. Sue & Zane, 1987 as cited by Comas-Díaz & Brown, 2016).

Race socially relates to rank and status in society. It categorizes and appraises individuals based on skin color, hair texture, and other physical features (Nadal, 2018). Historically, race was used to uplift and privilege White Americans while simultaneously marginalizing and degrading Native Americans, Black Americans, Asian Americans, Pacific Islanders, Latina/os, Arab Americans, and multiracial people (Day-Vines, 2018; Hook et al., 2016; Nadal, 2018; Sue et al., 2007; Wong et al., 2013;). To understand the relationship between race, discrimination, and trauma, Nadal (2018) reviewed the context of racism in the United States and the primary theoretical and empirical literature on racial microaggressions and its contribution to trauma.

Nearly 30 years after Pierce et al.'s (1978) initial concepts of racial discriminations, Sue et al. (2007) proposed a theoretical taxonomy to depict the many

types of racial microaggressions faced by individuals of color, citing an array of topics. Nadal et al. (2018) identified an array of topics including criminality/assumption of criminality; instances in which individuals of color, particularly Black and Latina/os Americans, are presumed to be dangerous or criminally deviant (e.g., a White grips her purse when a Black man enters an elevator).

In this chapter, the background includes depicting the racial ethnicity of the multicultural population that have encountered microaggressions in counseling. The literature includes supporting the research, the intent of the research, and the significance of the counseling profession and social change.

Background

Multicultural psychotherapy is a culture-centered holistic procedure that provides culturally relevant and practical procedures designed to enhance healing (Comas-Diaz, 2011b). As such, it involves the integration of ethnic psychotherapies, non-Western healing practices, cultural studies, and empowerment approaches into culturally altered psychotherapy (Comas-Diaz, 2014). Given that every interplay is multicultural in nature and shares the encounter of multiple and intersecting strands of identity, multicultural psychotherapy is applicable to everyone (Brown, 2010; Comas-Diaz, 1988). Multicultural psychologists in clinical contexts test the impact of cultural factors on human behavior, health, development of psychopathology, and treatment.

For the reason that all definitions of health, illness, healing, normality, abnormality, and cure are culturally embedded, multicultural psychologist critically test dominant psychotherapeutic models, assumptions, and practices. Given the persistent

inapplicability of dominant clinical practices to members of marginalize cohorts (Brown, 2006; Morales & Norcross, 2010; S. Sue & Zane, 2005), multicultural psychotherapists attempt to infuse cultural relevance into clinical psychology. To accomplish this goal, they may attempt to engage in reflexivity, mindfully scrutinize their biases and privilege, value diversity in a broadly defined manner, explore the cultural applicability of their interventions, and promote culturally relevant therapeutic strategies.

Multicultural psychologies surfaced during the decades of the 1960s and 1970s in the context of a variety of civil rights and liberation movements. It was a reaction to the ethnocentric, monocultural, and decontextualized Western-based psychologies in which, to rephrase Guthrie (1976), even the rat was White, male, heterosexual, and middle class. Historically, most theories of psychology have ignored cultural, historical, and sociopolitical factors, leading to a decontextualized practice. It has not been unusual for clients from marginalized cohorts to have discovered dominant psychotherapies to be aversive to their cultural experiences (Altman, 2010; Comas-Díaz, 2014). Consequently, multicultural scholars and practitioners have consistently challenged dominant psychological theories with conceptual, methodological, practical, sociopolitical, ecological, and ethical concerns (D. W. Sue et al., 1999 as cited in Comas-Diaz & Brown, 2016; G. C. N. Hall, 2001).

Empowerment

Most people coping with distress and disorders feel disempowered (Comas-Diaz & Brown, 2016). In addition, many culturally diverse people have endured historical or contemporary oppression, leading to feelings of disempowerment (Comas-Diaz &

Brown, 2016). When mainstream clinicians ignore their marginalized clients' historical and sociopolitical contexts, they could foster disempowerment in treatment. In contrast, therapists who foreground problems of power and powerlessness could empower their diverse clients by acknowledging encounters of oppression in the form of various types of specific and interactive systemic bias and oppression. Empowerment promotes awareness of how oppression influences psychological health.

An example of psychocultural disempowerment is dominant psychologists' unawareness of cultural microaggressions. This concept, also known as *insidious trauma* (Root, 1992), refers to the regular assaults on the victim's race, ethnicity, gender, sexual interaction, religion, or combination of identities (Comas-Diaz & Brown, 2016). For instance, because the direct expression of blatant racism is presently discouraged, racial microaggressions take the place of frontal racial discrimination. Common racial microaggressions (Pierce, 1995) include being harassed in public places by law enforcement, being ignored by clerks in favor of European American customers, being accused of racial favoritism, and being targeted for racial profiling (Comas-Diaz & Brown, 2016).

In addition to racial microaggressions, many marginalized people are exposed to other types of microaggressions based on elitism, sexism, heterosexism, ageism, ableism, homophobia, and interactions among these. For instance, women and girls might be told that they run or throw objects incorrectly ("like a girl") or that they lack rationality or are too emotional. Women's or girls' leadership might be called being bossy. Gay, lesbian, bisexual, and transgender individuals might be told that they cannot be good parents and

will find their rights to marriage and fair treatment in housing and employment put to a vote rather than simply treated as the rights they are (Comas-Diaz & Brown, 2016). The company picnic held during Ramadan or on Yom Kippur and the therapy office that is in a building inaccessible to individuals who cannot climb stairs are examples of microaggression. In addition, learning via the media of violence perpetrated on members of one's group could constitute *insidious trauma*. Microaggressions are generally a subtle form of discrimination whereby perpetrators may be unaware of their behavior. To illustrate, examples of cultural microaggressions include being frequently asked where one is from, assigning exoticism to a mixed-race person, and being told jokes that include stereotypes about the individual's cultural cohort (D. W. Sue et al., 2007). Examples of racial, gender, and sexual orientation microaggressions include attribution of being foreign or undocumented, assumption of inferiority, assumption of heterosexuality, so-called color blindness, the myth of meritocracy, and sexist and heterosexist language (D. W. Sue & Sue, 2008). Gendered microaggressions include women being assumed to be nonobjective or prone to exaggeration and thus disbelieved when reporting encounters of abuse or sexual violation (Comas-Diaz & Brown, 2016).

Awareness of cultural microaggressions in clinical practice is crucial because members of dominant groups are also affected by engaging in microaggressions. To illustrate, Derald Sue (2010) identified cognitive, emotional, behavioral, and spiritual costs of oppression. He described the cognitive consequences of microaggressions as involving systemic self-deception. A potential beginning step for clinicians to prevent engaging in microaggressions is to examine their areas of privilege and oppression.

Unfortunately, marginalized individuals exposed to cultural microaggressions frequently internalize negative feelings, contributing to impaired psychological functioning. The subtle aspect of microaggressions acts as an *insidious trauma*, ensuing in a cumulative effect that negatively influences how victims see themselves, their relationships, and the world (Root, 1992 as cited in Comas-Diaz & Brown, 2016). Microaggressions can also happen during treatment. For instance, clinicians' cultural ignorance, denial of the diverse forms of cultural oppression, adherence to the myth of meritocracy, rejection of the roles that privilege and oppression play in life, misdiagnosing, and pathologizing culturally diverse behaviors constitute examples of microaggressions (D. W. Sue et al., 2007). Moreover, if clinicians deny, minimize, defend against, or ignore clients' references to cultural oppression, they engage in microinvalidation.

All of these idioms have negative results on the therapeutic alliance; clients might encounter the microaggressing clinician as inauthentic, cold, or difficult to read and drop out of treatment prematurely or fail to form a functional therapeutic alliance (Brown, 2008). Sadly, clinician microaggressions further aggravate culturally diverse clients' distress and lead to ruptures in the therapeutic relationship that might be difficult to repair if the clinician is ascribing the rupture to client pathology rather than to their own lack of awareness. Clinicians most commonly engage in microaggressions out of an absence of awareness (Comas-Diaz & Brown, 2016). The ability to self-correct and repair the rupture engendered by one's own microaggressions toward a target-group client improves

therapeutic alliance and is a skill of the multiculturally informed clinician (Comas-Diaz & Brown, 2016).

This research will help fill the gap in literature by scrutinizing the perceived multicultural competence (MC) of counselor educators, while also exploring the ethnic identity awareness of the counselor educators committed to adhere to Council for Accreditation of Counseling and Related Educational Program (CACREP) and American Counseling Association (ACA) standards and policies (ACA, 2014; CACREP, 2015b). In conducting this research, I sought to provide a new perception of the dynamics of racial relations and their impact on the social involvement of ethnic groups in counseling.

Problem Statement

Racial microaggressions have been depicted to be subtle attacks (verbal, nonverbal, and visual) targeting racial minorities, sometimes self-activating or spontaneously (Solorzano et al., 2000, as cited in Wong et al., 2013). In 2013, Wong noted that they are hidden in everyday interactions. The undetectable tendency helps widen the gap of racial realities. White Americans in some cases see themselves as a respectable human beings who believe in inequality. Thus, they find it difficult to believe they harbor biased racial attitudes and express biased behaviors (Wong et al., 2013).

Wong et al. (2013) asserted that the cumulative nature of these innocuous expressions is harmful to racial minorities. Because they sap the energy of recipients, impairing performance in a multitude of settings (Omi & Winant 1994; Sue et al., 2007a, b). Building upon the work of McConahay (1986) who used the term “modern racism,” Sears (1988), who used symbolic racism, and Dovidio et al. (2002), who referred to

"aversive racism," Sue et al. (2007a, b) reintroduced the purpose of racial microaggressions and has been described as insightful and commonplace day to day comments, behavioral, and environmental humiliations, either deliberate or unintended that disclosed antagonistic, disrespectful or unfavorable racial slights and insults to an ethnic person or cohort (p. 273).

Smith et al. (2017) argued that professional counselors and counselor educators attempt to bring what is invisible or below the surface to light (Sue, 2004). The use of creative approaches facilitates such a procedure (Gladding, 2006). To achieve this, counselor training programs infuse experiential elements to heighten a counselor-in-training's awareness of social and cultural issues (Smith et al., 2017). The CACREP's standards requires training programs to furnish an understanding of the cultural context of relationships, issues, and trends in a multicultural society" (CACREP, 2009, p. 9).

Experiential earning activities that explore attitudes, beliefs, comprehension, and acculturative encounters are a platform to provide the cultural context in our multicultural society (Smith et al., 2017). Besides, the ACA's Code of Ethics (American Counseling Association, 2014) and the Multicultural and Social Justice Counseling Competencies (Ratts et al. 2015) call for counselor educators, counselors, and counselors-in-training to develop MC. The Advocacy Competencies (Lewis et al. 2003, as cited in Smith et al. 2017) address the critical role counselors have in breaking down oppressive barriers encountered by clients.

Counselor educators help develop multicultural and advocacy competence of counselors-in-training by engaging students in exercises that facilitate comprehension of

privilege and oppression (Smith et al., 2008) while motivating integration of one's cultural encounters (Gladding, 2006). Expressive arts provide a direct encounter to accomplish both multicultural encounters and integration (Atkins et al., 2003). To promote counselors-in-training cultural competence, cultural problems need to be openly prospected and processed in safe contexts (Constantine, 2007). Written and photographic journals provide such spaces (Smith et al., 2017).

Purpose of the Study

The purpose of this qualitative narrative research was to investigate the lived encounters of racial microaggressions as experienced by R/EM individuals during counseling. Therapists have their own beliefs, values, and worldviews that likely guide how they comprehend psychological distress and how individuals make changes in their lives (Hook et al., 2013). Therapists who do not create a therapeutic environment that is open to different beliefs, values, and worldviews might struggle to work effectively with diverse clients. Cultural humility might help counteract and regulate the sense of superiority that might happen when cultural differences arise in therapy. As such, cultural humility involves, "the capacity to keep an interpersonal stance that is other-oriented (or open to the other) in relationship with aspects of cultural identity that are most important to the client" (Hook et al., 2013, p. 2). Cultural humility is especially evident when a therapist can express reverence and a lack of superiority even when cultural differences threaten to weaken the therapy connection.

Culturally humble therapists rarely assume competence (i.e., letting prior encounter and even expertise led to self-assured) for working with clients just based on

their prior encounter working with a particular cohort (Hook et al., 2013). Instead, therapists who are more culturally humble approach. Counselors with respectful openness collaborate with clients to comprehend the unique intersection of clients' various aspects of identities and how that influences the developing therapy alliance (Hook et al., 2013).

Research Questions

Questions were developed from the need to better understanding the experiences of Native Americans, Black Americans/African Americans, Asian Americans, Pacific Islanders, Latinos, Arab Americans, and multiracial clients that have confronted racial microaggressions in counseling. Two questions were developed specific to this research problem:

Qualitative: RQ1. How do ethnic minorities experience racial microaggressions during counseling sessions?

Qualitative: RQ2. What strategies do clients from ethnic minorities use to overcome microaggressions in counseling?

Theoretical Framework

This study's framework was based on the theory of microaggression in counseling (Sue et al., 2007). Sue et al.'s (2007) theoretical work has been used extensively in all aspects of counseling and addresses ways of conceptualizing microaggressions against individuals from ethnic minorities. Perpetrators of microaggression are often oblivious that they engaged in such dialogues when interacting with R/EM individuals (Sue et al., 2007). Nearly all interracial meetings are prone to microaggressions (Davis et al., 2016; Edwards, 2017; Sue et al., 2007).

"Microaggressions appear in three forms: *microassault, microinsult,* and *microinvalidation*. Microassaults is depicted as "good old-fashioned racism" (Sue et al., 2007, p. 273). Although explicit, overt, and intentional, they are regarded as "micro," given they are frequently conducted on a personal or private level. As these Microassaults are expressed in "limited" settings, they provide the attacker with an appearance of anonymity. "Micro insults represent subtle snobs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color. An example of this is when a Novice of Color is asked, "How did you get into this doctoral program?" or when a Professor of color is told, "You speak so well!" (Sue et al., 2007, p. 274). Microinvalidations are depicted as communications that expel, invalidate, or confirm the psychological ideas, emotions, or experiential actuality of an individual of color (Sue et al., 2007, p. 274). This could be typified by "color-blind racism," which equates to the notion of "not seeing color" or seeing all individuals as "humans" (Bonilla-Silva, 2009, p.5). These assumptions invalidated the particularism related to racial cohort identification, family heritage, and culture (Osanloo et al., 2016). Because microaggressions are often outside awareness, White mental health professionals perpetuate prejudice unknowingly (Sue et al., 2007). As a result, counselors should make a concerted effort to recognize and observe microaggressions within the therapeutic environment. This process is reminiscent of identifying and controlling transference and countertransference issues between counselor and client to prevent any interference with effective therapy (Woodhouse et al., 2003). Sue et al. (2007) argued that

> This is compounded by power dynamic in the therapeutic relationship in relation to diagnosis and treatment. The power dynamic between counselor and clients can create a "catch-22" as clients might be less likely to challenge their counselors and more likely to question their cognizance in the occurrence of a microaggression (p. 279).

The ethnic minorities are at increased risk of not continuing in treatment when such microaggressions happen. They will not get the support they require and might leave the session feeling worse than when they first sought-after therapy. It is doubtful that clinicians deliberately make unfriendly and inhospitable environments for their ethnic minority clients; therefore, it may be supposed that microaggressions convey these biases.

Nature of the Study

The nature of this study was of a qualitative narrative research design. Interviews were used to clarify common themes regarding how clients of color experienced the phenomena of microaggressions in counseling. Additionally, interviews were used to examine how microaggressions impacted the participants perceived efficacy of treatment. Finally, participant acknowledgments were qualitatively analyzed to recognize common schemes that clients from ethnic minorities used to subjugate microaggressions in counseling.

Ontological Assumption

For this research, I used a narrative design. Research participants were asked to share their lived encounters of ethnic racial microaggressions. Given the shared

phenomenon used in this research, each participant brought a unique point of view, based on the person's individual experience. Each person conveyed their encounter using different words, communications, and attitudes. The diversity of perspectives must initiate different topics, and lead to different findings throughout the study.

Epistemological Assumption

A qualitative researcher needs to be close to the participants to get the best interpretation of the studied phenomenon (Creswell, 2013). I personally performed semi-structured interviews through Zoom with my participants. I assumed that Zoom interviews did not create too much distance and did not affect the genuineness of participants' views as they expressed their lived encounters with racial microaggressions.

Axiological Assumption

I am a minority member with a similar multicultural and diverse background to the participants in this survey. This may be conducive to possible prejudice. Throughout the study process, I was able to stay objective and avoid bias. Research findings and conclusions were based on the practical lived experience of participants. I gave a logical and non-bias interpretation of my research findings.

Methodological Assumption

In this qualitative research, I used Delve Qualitative Program, which has proven to be conducive to qualitative research. Microaggressions of the multicultural individual of ethnic minorities in counseling participation in this research responded to survey open-ended questions that examine race, perceptions of ethnic identity awareness, and perceptions of MC in counseling. Therefore, an assumption in the present research

included the belief that ethnic minority individuals would answer the survey questions honestly with regard to personal perceptions, skills, and knowledge. The study preserved anonymity and confidentiality of participants through the online survey, which did not ask any personal identifying data. Informed consent forms were also signed by participants. Participation in the research was voluntary and multicultural individuals from ethnic minority groups could withdraw from the research at any time, without penalty, by exiting the survey.

Scope and Delimitations

The scope of this research is restricted to multicultural ethnic minorities residing in the United States who experienced microaggression in counseling over the past year. The purpose of this research was to assess the perspective of ethnic individuals in counseling they have lived through encounters with racial microaggressions from their counselors. I selected this theme and population because I felt that Native Americans, Black Americans/African Americans, Asian Americans, Pacific Islanders, Latinos, Arab Americans, and multiracial voices should not remain silenced about how it felt during their encounter with microaggression during counseling. I could not find any research that inquired how multicultural ethnic minorities experienced racial microaggressions during counseling sessions or what strategies do clients from ethnic minorities use to overcome microaggressions in counseling.

Adding this perspective to counselors' expertise while working with multicultural clients will help fill the gap in racial microaggressions research literature. Furthermore, there are limited studies on working with multicultural individuals in professional

counseling literature. Adding data from this research reduces the gap in creating effective interventions that work with this population (Nadal et al., 2014).

Limitations

The main limitation of this research comes from the nature of its methodology of qualitative approaches to corpus investigation. Their discoveries cannot be extended to more large populations with the same degree of certainty that quantitative investigations (Atieno, 2009). This is because the research findings are not tested to determine if they are statistically noteworthy or due to chance. Research quality is heavily dependent on the researcher's unique skills. It is more easily impacted by the researcher's biases and idiosyncrasies. Rigor is harder to maintain, assess, and depict (Atieno, 2009). Another challenge for this study is that the volume of data makes analysis and interpretation time-consuming. Data are sometimes not as well comprehended and accepted as quantitative research within the scientific community (Anderson, 2010). My presence during data gathering, which is frequently unpreventable in qualitative research, could have influenced the subjects' feedbacks. Problems of anonymity and confidentiality can present problems when presenting findings. Discoveries could be more difficult and time-consuming to characterize in a visual way (Anderson, 2010). I was unable to predict the course of how it would evolve. A second limitation was the small sample size, which prevents generalizability to all lived experiences of ethnic individuals because it is not a quantitative study. I only included people who identified as ethnic individuals from a minority group. Additionally, because of the qualitative nature of the study, I took more steps to show trustworthiness in the data to prove the research's integrity. For instance, I

sent emails to participants for clarification confirming with the participants that I was accurate with their experiences.

Moreover, as an African American person who has experienced racial microaggressions, I asked open-ended questions, did not give any personal opinions, did not make leading suggestions during the interviews, and did not impose my values on participants (Bourke, 2014). My personal biases could have affected the study. Therefore, I used reflexivity by saying my connection to the study that may have contributed to bias which included participant clarification (see Creswell, 2013; O'Connor, 2011; Patton, 2015). I was also mindful of my positionality to minimize bias, which includes the personality traits and experiences of a researcher that may influence their research (see Bourke, 2014). Researchers must be aware of and state their position including values and beliefs about the phenomenon studied to reduce personal biases from skewing their data (ACA, 2014; Bourke, 2014; Creswell, 2009). Finally, I did not interview anyone with whom I had a personal relationship.

Significance

The removal of racial and ethnic microaggressions in the therapeutic environment has the potential to promote social change and positively impact the overall mental health and well-being of R/EM (Owen et al., 2014; Pierce et al., 1978; Sue et al., 2007). Over half (53%) of R/EM clients from a university counseling center (n = 120) reported experiencing at least one microaggression from their therapist (Owen et al., 2014). This university counseling center is related to the area or population of my study.

Many members of ethnic minority groups such as African Americans, Latinos, Asian Americans, and American Indians and Alaska Native, the report is finding it difficult to communicate with their counselor throughout treatment (Gonzales et al., 2015; Wendt et al., 2015; Yip, 2015). Owen et al. (2014) found that, even after determining the behavior for reported psychological well-being, number of sessions, and therapist racial and ethnic status, the presence of microaggressions in therapy was negatively associated to the therapeutic alliance. Of those clients who reported experiencing a microaggression, approximately 76% stated that the microaggression was not addressed with the counselor (Owen et al., 2014). For those clients who experienced a microaggression and did not address it, alliance ratings were lower in contrast to clients who did not experience a microaggression or who experienced a microaggression but addressed it with the counselor (Bordin, 1979; Constantine, 2007; Orlinsky et al., 2004; Owen et al., 2014).

Indeed, the outcomes of this research could facilitate positive social change regarding how graduate colleges prepare mental health professionals to enhance their understanding of this pressing social issue. Graduate training programs could help psychologists decrease the prevalence of mental health disparities by incorporating plans to discuss the social determinants of mental health (Woods-Jaeger et al., 2020). Results from the study could provide more discernment into microaggressions against individuals from ethnic minorities. Researchers in this field might also gain insight into effective intervention approaches for decreasing mental health stigma (Gonzales et al., 2015). It could guide researchers to new strategies that best serve the needs of the ethnic minorities

in counseling. Future studies might want to investigate if and how microaggressions are experienced differentially among various racial and ethnic cohorts (Owen et al., 2014).

Summary

With this research, I intended to provide a better understanding of how counselors can support ethnic clients who have experienced racial microaggressions. This research is unique, as the individual voice of the client, as represented by the study participants, has yet to be embodied in the literature on counseling with multicultural individuals from ethnic minorities and racial microaggressions. Racial microaggressions pose significant mental and physical health risks to individuals who experience them. Counselors that do not effectively address microaggressions in treatment risk distorting the clients' experience or efficacy of treatment. Educators and supervisors have an ethical responsibility to prevent causing harm to, their students and, by virtue future clients, by elevating their knowledge of racial microaggressions. Therefore, increasing professional knowledge concerning racial microaggressions contributes to increased awareness and insight for counselors who work with multicultural clients. In Chapter 2, I review the current literature on racial microaggressions and the influence on ethnic people, in addition to reviewing the gaps in literature that supports the need for this research.

Chapter 2: Literature Review

Introduction

Contemporary research suggested that R/EM people within the United States are reluctant to pursue and persist in counseling and their lack of consensus on why this is the case (Hook et al., 2016). Racial bias might partially describe the low utilization and premature termination rates of R/EM clients (Hook et al., 2016; see also Sue et al., 2007; U.S. Department of Health and Human Services, 2001). It is speculated that counselor(s) bias might be one of the reasons for the reluctance to use mental health services and the abrupt ending of counseling by racial minorities (U.S. Department of Health and Human Services, 2001).

How this prejudice is communicated to clients remains unclear, one possible pathway by which R/EM clients experience discrimination in counseling is microaggressions. The term *microaggression* was first used to account for subtle, nonverbal "put-downs" (Pierce et al., 1978, p. 66). More recently, racial microaggressions have been defined as short, daily exchanges that send denigrating messages to individuals of color as a result of their membership with a racial minority cohort (Sue et al., 2007; Solórzano et al., 2000; Wong et al., 2014). There are three typologies of microaggressions covering the full range of race-related offenses: (a) *microassaults* are severe offenses that involve explicit and intentional denigration of a person's racial cohort (e.g., alluding to someone as "colored"); (b) *microinsults* include more subtle, frequently unconscious communications that demean a person's racial cohort (e.g., asking an individual of color, "How did you get this job?"); and (c)

microinvalidations are communications that negate or deny the thoughts, feelings, or experiences of an individual of color (e.g., telling an individual of color, "I do not see color"; Sue et al., 2007). Racial microaggressions constitute a specific form of abuse. Racial minority groups may internalize some of the historical and contemporary abuse they experience (David, 2008). The different ways abuse is internalized plays a role in an individual's acknowledgment of and experience with racial microaggressions and the impact those instances have on the individual. Microaggressions drain the energy of ethnic minority recipients and decrease performance in a high number of settings (Omi & Winant 1994; Sue et al. 2007a, 2007b).

Racial microaggressions take place in a variety of community settings, including domestic violence shelters (Nnawulezi, 2011), work environments (Hunter, 2011), sports (Burdsey, 2011), and places of worship as well as in the media and governmental policies (Wong et al., 2014). Studies have also tested racial microaggressions in counseling, indicating that at least half of the participating clients reported at least one microaggression during treatment (Constantine, 2007; Crawford, 2011; Morton, 2011; Owen et al., 2011, 2014). Other researchers have shown that majority of clients (81%) who reported encountering at least one racial microaggression in treatment (Hook et al., 2016). For mental health professionals, the most common racial microaggressions center around, participants who felt invisible in their counseling sessions, friction of racial realities, minimal harm of not being treated as equals, and not being heard. (Hook et al., 2016).

The occurrence of racial microaggressions in counseling are associated with negative treatment processes and outcomes (Hook et al., 2016). MC has generally been defined as having both the ability to work effectively across diverse cultural cohorts and the specific expertise to treat clients from certain culturally diverse cohorts as well as minority and underrepresented cohorts (Sue et al., 1992; Sue et al., 2009). Since 1973, the American Psychological Association has maintained that the provision of multiculturally competent mental health services is an ethical imperative (Korman, 1974; Ridley, 1985 as cited in Tao et al., 2015). Indirect therapist MC measures assess attributes or indicators connected to MC, including those that are conceptually antithetical (e.g., microaggressions) or parallel (e.g., feminist orientation, cultural humility).

For example, the perpetuation of racial microaggressions (whether conscious or not) has been addressed as a specific manifestation of culturally incompetent behavior. Theoretically, therapists who commit microaggressions are less likely than therapists with higher levels of MC to be aware of biases and stereotypes, as well as less knowledgeable concerning the potential harm microaggressions might have on historically marginalized clients (e.g., Constantine, 2007; Owen et al., 2011; Owen et al., 2014). Racial microaggressions in mental health professionals have been correlated to lower levels of reported perceived counselor competence (Tao et al., 2015). General counseling competence (GCC) refers to a therapist's perceived expertness (e.g., skills and knowledge), trustworthiness (e.g., openness, genuineness), and attractiveness (e.g., admiration toward, liking; Atkinson & Wampold, 1982; Barak & LaCrosse, 1975; Strong, 1968). A primary question in multicultural counseling studies has been to

determine if GCC is a distinct construct from MC (Coleman, 1998; Drinane et al., 2014; Sue et al.,2009). In one research study, MC and GCC measures were administered to R/EM clients (n = 112) to determine predictors of satisfaction with therapy (Tao et al., 2015). Results indicated that MC and GCC were highly correlated (r = .78). This was correlated with results from another research study with a similar population, which depicted a strong correlation between clients' (n = 85) perceptions of therapist GCCs and MC (r =.72) (Fuertes & Brobst, 2002). When clients do not see their counselors as trustworthy or when clients feel misunderstood and undervalued, the therapeutic achievement is less likely to happen (Sue et al., 2007). Poor therapeutic relationships are more often likely to produce less disclosure from the client and missed scheduled visits as well as early termination of the therapeutic relationship (Burkard & Knox, 2004; Kearney et al., 2005).

Thus, a therapist's commission of microaggressions may deter some R/EM clients from agreeing to and persisting in treatment (Sue et al., 2007). However, only a few studies have explored this topic as a barrier to effective clinical practice with R/EM clients (Constantine, 2007; Owen et al., 2011, 2014). The potential of this study lies in its contribution to current knowledge and its testing of existing theoretical propositions. As such, a therapist's microaggressions commission may deter some R/EM clients from initiating or persisting in treatment (Sue et al., 2007). However, only a few studies have explored this topic as a barrier to effective clinical practice with R/EM clients (Constantine, 2007; Owen et al., 2011, 2014). This study's potential lies in its contribution to current knowledge and its testing of existing theoretical propositions.

Although creating a productive therapeutic alliance relates to the continuous helping spectrum, engaging with clients who differ from the counselor in race, ethnicity, culture, and sexual orientation creates unique challenges (Sue et al., 2007). White counselors who have not questioned dominant prejudices and who are products of their cultural conditioning might be prone to engage in racial microaggressions against R/EM clients (Locke & Kiselica, 1999, as cited in Sue et al., 2007). The American Psychological Association (2003) and the ACA (2014) have tried to address professional biases by executing multicultural guidelines and standards that criticize prejudice and discrimination in the delivery of mental health services to clients of color (Sue et al., 1992, as cited in Sue et al., 2007). Like most people in society, counselors and therapists consider themselves as fair and decent people who would never intentionally and willfully engage in racist acts toward clients of color. Sadly, when clinicians and clients are distinct from one another along racial lines, the association might then serve as a microcosm for the troubled race alliances in the United States (Sue et al., 2007). Although positive changes have occurred in the mental health profession in relation to decreasing unintentional prejudice and discrimination in the therapeutic process, the serious problem of microaggressions still persists. As in various other interactions, microaggressions are equally likely to happen in therapeutic transactions even with good intentions to avoid the occurrence of such (Ridley, 2005).

Although research has consistently identified the influence of racial microaggressions (Sue, 2009; Sue et al., 2008a, 2008b, 2008c), individuals within various ethnic and racial groups often experience racial microaggressions differently (Nadal,

2008a). For instance, visible racial and ethnic minorities (VREMs) may experience racial microaggressions differently from those who self-identify as a member of a VREM group but "pass" as a member of the dominant cohort (Harris, 2008, 2009, as cited in Wong et al., 2013). Researchers have suggested phenotype (i.e., observable traits) as a mediating or moderating variable in the frequency and effects of racial microaggression experiences (Johnston & Nadal, 2010; Nadal, 2008a, 2011a, 2011b; Watkins et al., 2010). Additionally, research has shown that historical abuse (e.g., in the cases of African Americans and American Indians) and histories of colonialism (e.g., Filipinos and West Africans) influences the recognition and experience of racial microaggressions (Wong et al., 2013). Further, there may also be varying experiences of racial microaggressions between documented and nondocumented R/Ems (Huger, 2011). Despite these known influences, other questions remain unexplored in the field, including the possibility of differential experiences of racial microaggressions between native English speakers and those who speak English as a second language as well as differences attributable to degrees of acculturation and racial/ethnic identity (Wong et al., 2013). Therefore, the inter-and intra-racial (or ethnic) experiences of racial microaggressions among different R/EM groups remain mostly unexplored in the literature. To further understand how racial microaggressions influence mental health, research efforts should be directed toward evaluating existing measures of microaggressions, creating new standards, and exploring the implications of these instruments in the clinical setting (Wong et al., 2014). Researchers have documented a positive relationship between racial microaggressions and binge drinking. Still, no other studies exist that investigate the relationship between

racial microaggressions and disorders that meet the DSM-IV/V diagnostic criteria of the DSM-IV/V (Blume et al., 2012). Knowing how racial microaggressions influence individuals' day-to-day well-being will inform researchers and practitioners concerning how racial microaggressions are fully processed by this population (Burke, 1984; Harrell, 2000; Outlaw, 1993, as cited in Wong et al., 2014). Clearly parsing out the proximal results will help generate informed pathways of the mental and physical influence of racial microaggressions. Understanding the source of psychopathology from racial microaggressions is an invaluable tool in helping targets learn to cope with the everyday wear and tear of racial microaggressions (Wong et al., 2014), thereby helping generate informed education, treatment, and policies and guidelines.

The use of experimental, longitudinal, and naturalistic designs will help identify the experience of microaggressions in counseling and how R/EM clients address these occurrences. It will fill this gap in the literature on racial microaggressions. Experimental paradigms permit researchers to examine the mechanisms by which racial microaggressions confers risk for psychopathology (Wong et al., 2014). Using this paradigm, the proximal and indirect influence of this race-related stressor will be testable. The results can be used to further tease apart the uniqueness of racial microaggressions from other general stressors. Manipulating and analyzing data related to exposures of racial microaggressions and other general stressors will determine the differential influences of racial stressors on psychopathology. Longitudinal and naturalistic research designs will permit a more in-depth consideration of the cumulative impact of racial microaggressions. Researchers using longitudinal designs can track racial

microaggressions' developmental trends within the same sample (Wong et al., 2014). This tracking can allow for more accurate assessment of the effects of racial microaggressions on individuals' physiological and psychological health outcomes. Naturalistic observations can also allow for a realistic and natural evaluation of racial microaggressions.

Given that racial microaggressions are theorized to have a negative impact on physical and mental health, ethical concerns arise from laboratory manipulations. To avoid this negative impact, researchers can gather immediate reactions and responses from racial microaggressions in a natural setting without actually inducing racial microaggressions on participants. Furthermore, the external validity of racial microaggressions research will be strengthened through naturalistic designs (Wong et al., 2014). The need for experimental, longitudinal, and naturalistic research designs has served as an impetus for me taking the naturalistic approach in this study of racial microaggressions. Use of these paradigms will not only improve scientific rigor but also help investigate the proximal and indirect mechanisms by which racial microaggressions affect psychopathology and allow researchers to reveal the link between these biological reactions to psychopathology and other health outcomes. Current literature examining microaggressive stress suggests four areas of study: (a) biological, (b) emotional, (c) cognitive, and (d) behavioral effects (Wong et al., 2014). In theories on the biological health results of microaggressive stressors, it has been postulated that the stress depresses the immune system, increases blood pressure and heart rate, and heightens the risk for hypertension (Lau & Williams, 2010). Researchers examining the emotional results of

microaggressive stressors have speculated that emotional dysregulation can bring about mental health disorders (Wong et al., 2014). In terms of the cognitive consequences of microaggressive stress, researchers have revealed that the microaggression incident sets off a chain of cognitive processes directed at comprehending and making sense of the incident (Wong et al., 2014). When undergoing microaggressive stress, an individual might spend energy appraising the situation and deliberating whether to respond and assess the consequences of making a response. This might divert the individual's attention and energies away from the task at hand. Studies on the behavioral results of microaggressive stressors have addressed hypervigilance and skepticism, rage and anger, fatigue and hopelessness, and strength through adversity (Wong et al., 2014).

Literature Search Strategies

I used the Walden University Library to access the EBSCO Host, PsychINFO, and PsychARTICLES databases. The Google Scholar search engine was also used to locate literature for this review. The keyword search terms used included: *microaggressions*, *counseling*, *cultural humility*, *multicultural competence*, *multicultural orientation*, and *microaggressions against ethnic individuals from minorities in counseling*. I concentrated on articles published within the past 5 years apart from some articles that provided background data on *cultural microaggressions*.

Theoretical Framework

The racial microaggression theory was based on the occurrence of microaggression in counseling (Sue et al., 2007). As post-Civil Rights racism is subtle, institutional, and seemingly nonracial (Bonilla-Silva, 2014), it is vital to identify its

exhibits. Equally crucial is the need to test how racism influences various groups in different settings to get a fuller picture of Latinos and other intermediate racial cohorts positioned within the United States racial hierarchy (Bonilla-Silva, 2015). Incorporating racial microaggressions into sociological analyses of racism and R/EMs is one way of evaluating Mexican clients' treatment in new destinations, whether they encounter discrimination, and the extent of their racialization (Ballinas, 2017).

Racial microaggressions are helpful in analyzing these issues as they embrace the ordinary everyday conversation, conduct, and their environmental indignities, whether intentional or not, that convey aggressiveness, disrespectful, or negative racial insults to individuals or group (Sue et al., 2007: 273). Taken together, racial microaggressions recommend that individuals of color are criminally inclined, foreign, unintelligent, and ultimately deserving of their low social status (Sue et al., 2007).

Sue and colleagues do not link the microlevel dynamics of racial microaggressions with larger structural forces. Sue et al. (2007:272) posit that racial microaggressions best depict contemporary racism's everyday phenomenon; there is a stress on the subtle and unintentional aspects of interpersonal interactions. As such racial microaggressions are not contextualized within persistent racial inequalities (Bonilla-Silva, 2014; Feagin, 2014; Omi and Winant, 2014), the implanted nature of white racial domination across societal institutions (Bonilla-Silva, 2014; Feagin, 2014), and the ideological justifications of racial inequalities and white domination (Bonilla-Silva, 2014; Feagin, 2014). These sociological contributions, particularly systemic racism, help ameliorate Sue and colleagues' restrictions and extend the collective comprehension of

racial microaggressions as part of a structural phenomenon. Simultaneously, racial microaggressions exemplify the recurring and unequal alliances that recreate the institutions perpetuating racial subordination, inequalities, and systemic racism (Feagin, 2014).

Review of the Literature

Awareness of cultural microaggressions in clinical practice is vital as members of dominant cohorts are also influenced by engaging in microaggressions. To illustrate, Derald Sue (2010) associated cognitive, emotional behavioral, and spiritual costs of oppression and depicted the cognitive results of microaggressions as involving systemic self-deception. A potential beginning step for clinicians to avert engaging in microaggressions is to test their own areas of privilege and oppression (Sue et al., 2010). Unfortunately, marginalized people exposed to cultural microaggressions can internalize negative feelings, contributing to impaired psychological functioning (Sue et al., 2007). Microaggressions' subtle presence acts as an insidious trauma, ensuing in a cumulative result that negatively impacts how victims see themselves, their connections, and the world (Root, 1992 as cited in Sue et al., 2007). Microaggressions could also happen during treatment. For instance, clinicians' cultural ignorance, denial of the diverse forms of cultural abuse, adherence to the myth of meritocracy, rejection of the roles that privilege and abuse play in life, misdiagnosing, and pathologizing culturally diverse behaviors constitute examples of microaggressions in treatment (D. W. Sue, Bucceri, et al., 2007). Moreover, if clinicians deny, minimize, defend against, or ignore clients' references to cultural abuse, they engage in microinvalidation. These actions have

adverse effects on the therapeutic alliance. The clients might encounter the microaggressive clinician as inauthentic, cold, or challenging to read, resulting in premature attrition from treatment (Brown, 2008).

Clinician microaggressions further aggravate culturally diverse clients' distress and lead to ruptures in the therapeutic alliance that might be difficult to repair if the clinician is ascribing the rupture to client pathology rather than his or her lack of cognizance. Clinicians commonly engage in microaggressions out of an absence of knowledge. The ability to self-correct and repair the rupture engendered by one's microaggressions toward a target-group client improves therapeutic affiliation. It is a skill of the multiculturally informed clinician (Comas-Diaz & Brown, 2016). Sue et al. (2007a, 2007b) stated that the perception of racial microaggressions gave investigators a framework to search these profound daily forms of discrimination. Therefore, we understand more about racial microaggressions than ever before. Nevertheless, Wong et al. (2014) critiqued that we know more concerning racial microaggressions than ever before; qualitative and quantitative research have explained the kinds of responses to and consequences of racial microaggressions in various settings with multiple racial and ethnic groups. Despite the efforts made, Wong et al. review of the racial microaggressions literature demonstrates, there remain conceptual and methodological problems that would advance our understanding of the what, why, and how of microaggressions.

Wong et al. (2014) gave suggestions for future studies and methodological enhancements to fortify the recent body of literature. Specifically required are studies

with more significant, more representative, and randomly received illustrations that go "beyond questionnaires" (see also Okazaki, 2002), and studies that (a) further interpret the concept of racial microaggressions and how it fits with other designs of anxiety; (b) scrutinize how diverse racial and ethnic cohorts encounter racial microaggressions; (c) explicate the viewpoint of the violators; and (d) identify long-term mental and physical health results of encountering racial microaggressions (as cited in Wong et al., 2014).

Wong et al. (2014) asserted that such a survey, critique, and proposed suggestions would further facilitate racial microaggression research, enhance the scientific rigor of racial microaggressions research, and contribute toward a fuller and cultivated comprehension of the concept of racial microaggressions and its probable outcomes. Anglin et al. (2016) argued that the information's cross-sectional nature restricts culminations concerning causal inference. Their discoveries recommend that ethnic bias and (rejection sensitivity) RS-race might both be significant for comprehending exposure for anxiety in the psychotic spectrum between racial and ethnic minority adolescents and adults. A few people who report ethnic bias might be more vulnerable to (attenuated positive psychotic symptoms experienced as distressing) (APPS-distress) because they are cautiously expecting to be ethnically insulted, and this shall be investigated more in potential clinical high-risk research. Accruing proof recommends that ethnic bias relates to clinical psychotic disorders and debilitated psychotic problems. A few professionals have argued that people who are more apt to discern racial prejudice are genuinely more inclined to be careful to indicate anticipated refusal developed upon their race (Anglin et al., 2016).

Mendoza-Denton et al. (2002) coined the term (R.S. race) to direct to how people discern and expect warnings of refusal due to their race. Rejection sensitivity is a cognitive-affective energetic method not yet tested in connection to psychotic symptoms. However, it is said to weaken an individual's certainty and sincerity in others, their environment, and their sense of belonging (Anglin et al., 2016). In connection to unprovoked aggression, the researchers' null discoveries for verbal unprovoked offense and antagonism advocated Lilienfeld's statement that conventional unprovoked offense is not an essential driver of cooperative behaviors. Nevertheless, these researchers defined this outcome not to blame the construct of ethnic microaggressions, yet to emphasize that all though well-intentioned, nonaggressive individuals might advocate or commit racial microaggressions.

Contrasted with brazen prejudice, this is in part, what makes ethnic microaggressions baffling. Their commission cannot easily be siloed to a blatantly combative and antagonistic depiction (Mekawi & Todd, 2018). To better comprehend joint and exclusive designs, one avenue for future studies is to recognize distinctness and populaces between individuals who support ethnic microaggressions contrasted with those who support brazenly biased assertions. A second critique is that research on ethnic microaggressions has trusted the untested hypothesis that microaggressions are seen negatively by R/EM (Lilienfeld, 2017). Even though microaggressions were not an energetic model of minorities asserting they were more unacceptable, there was proof that, on average, they were more apt to locate such assertions not suitable. This differed, relying upon the distinct kind of microaggression (Mekawi & Todd, 2018). These

researchers discovered that more continuous encounters of brazen prejudice related to less suitability of microaggressions recommend there might be numerous contextual elements (e.g., encountering bias) that predict preference and ethnic minority persons' behaviors acceptability of microaggressions being responsible (Mekawi & Todd, 2018). Osanloo et al. (2016) article compared different opinions on microaggression: Pierce et al. (1978) proposed, "the chief vehicle for pro-racist behaviors are microaggressions. These are subtle, stunning, often automatic, and nonverbal exchanges, which are 'put-downs' of blacks by offenders (p.66). Microaggressions could be hard to describe. Microaggressions are illustrated by arrogant and frequently harmless remarks, attitudes, or assumptions that detract, eject, or provide unimportantly. The Microaggressions: Power Privilege and daily life website consistently have anonymous posts from individuals that contribute commentary that illustrates microaggressions' predominance. A post from a person on March 6, 2014, states: "Are you sure you have the right room number? This is the honors section" (Osanloo et al., 2016).

Osanloo et al. (2016) asserted that the individual who contributed to this post felt that this remark started from the truth that the person who spoke was perplexed; a minority novice will deviate into an honors-level classroom. Another provider proposed: After seeing coverage of the Boston Marathon bombing, his mother, who is Caucasian, implies that Middle Easterners are continuously murdering everyone. He is Middle Eastern, in the early 20s, and is her son. His little sisters are South Asian happened to be in the same room, and they overheard everything. He became furious and felt vulnerable

and ashamed (April 23, 2013, p. 3). These observations disprove the particularism related to racial cohort identification, family heritage, and culture (Osanloo et al., 2016).

Racial Microaggressions and Filipino American Experiences

According to Nadal et al. (2012) racial microaggressions are premise forms of verbal and emphasizing behavioral prejudice toward people of color. The current qualitative study examines the encounters of Filipino American participants (N = 12), who described 13 classifications of microaggressions, encompass being regarded as an alien in one's own land or as a 2nd-class citizen, being assumed to have inferior status or intellect, being projected to confirm Filipino typecasts, or being misunderstood for another identity. Recommendations for therapist and progress are discussed. There were 12 participants in total; all participants were Filipino American adults ages 18 years and older, and each participant frequented only one focus group. Eight participants were women, and four participants were men. The majority of participants were born or raised in the United States, and one participant had lived in the United States for most of his adult life. Even though focus cohorts took place in the Northeast, four participants described that they were raised on the West Coast and one described previously living in the Southeast. Participants' ages ranged from 20 to 42 years, with a mean age of 29.5 (SD5.58). Participants exhibited a range of career fields, comprising cosmetology, art, research, education, nonprofit organizations, law, and business. These participants were enrolled via email reports to Filipino American electronic mailing lists and snowball sampling. Current research have found that xenophobia has become less clear and more secret because of American society's changing nature.

However, various authors have purported that premise forms of xenophobia might still occur and describe these harmful acts as racial microaggressions. Although racial microaggressions were primarily coined in the 1970s (see also Pierce et al. (1978); Sue et al. (2007) reintroduced the concept. They described racial microaggressions as "short and everyday verbal, behavioral, or environmental shame, whether deliberate or not done on purpose, that interchanged antagonistic, disrespectful attitude, or negative racial disdains and abuses toward people of color" (p. 271). A theoretical taxonomy of the categories of racial microaggressions was also initiated, with classifications including the premise of criminality (i.e., encounters in which people of color are conjectured to be dangerous or aberrant), second-class citizen (i.e., encounters in which people of color given inferior service contrasted with their White American equivalents), an alien in one's own land (i.e., encounters in which people of color are supposed to be foreign-born and or "not American enough"). Various qualitative research have ratified the topics presented in this microaggression taxonomy. In research with Black Americans (Sue et al., 2008) and Latinas/Latinos (Rivera et al., 2010) participants described occurrences in which they were treated as second-class citizens or supposed to be offenders. For example, one Black American female participant described a scenario in which a White American female crossed the street to avoid walking past her. Although there might be many meanings of the event, this participant concluded that the White American female was afraid of her and presumed that she might rob her or be violent (Sue et al., 2008). In studies with Asian Americans, participants argued that they were often treated as everlasting foreigners (or aliens in their own land), even when they were American born (Sue et al., 2009). Some

participants conversed how they were told, "You speak good English" or asked continually, "Where are you from?" These assertions might seem temperate and well-intentioned; however, the communication that might be sent to the recipient (who might encounter such assertions continually) is that they are not American enough (and perhaps never will be).

Through these studies, it is suggested that certain microaggressions that some racial cohorts face those other racial cohorts might not. For instance, in the study as stated prior involving Asian Americans, participants did not describe encounters of being treated as an offender or as a knowledgeable subservient (Sue et al., 2009), since participants in research with Black Americans (e.g., Sue et al., 2008) and Latinas/Latinos (Rivera et al., 2010) stated such occurrences as symbolic. Moreover, no known research focus on the microaggressions toward certain Asian American ethnic cohorts, disregarding the vast range of phenotypes, cultural values, and encounters. Previous authors have cited that Filipino Americans (one of the largest Asian American ethnic cohorts) are frequently perceived or mistaken as Latinos, Black Americans, Native Americans, multiracial individuals, and other non-Asian cohorts, and are habitually differentiated against appropriately (Nadal, 2004, Nadal, 2011; Uba, 1994). Hence, Filipino Americans might encounter the identical microaggressions that these other cohorts may face. Moreover, an array of literature has recommended that Filipino Americans are unlike other Asian American cohorts in various ways. First, because almost 400 years of Spanish colonial rule and almost 50 years of American colonial rule, some Filipino Americans might be influenced by a unique colonial mentality (i.e., seeing

the Spanish and American colonizers as being superior) that might impact their psychological procedures and mental health (David, 2008, David, 2010; David & Okazaki, 2006). Second, because of this colonial history and the effect of Catholicism, Filipino Americans might develop a unique set of cultural values and express emotions differently than other Asian American cohorts (Kim et al., 2001; Nadal, 2004; Okamura & Agbayani, 1991).

For example, although various East Asian American cohorts might value emotional limitations within alliances, Filipino Americans are likely to be emotionally conveying and caring with loved ones (Nadal et al., 2012). Notwithstanding the model minority myth, Filipino Americans have been found to encounter a vast amount of physical health, mental health, educational, and sociocultural disparities that other Asian American cohorts tend not to encounter, including higher high school dropout rates; lower college admission rates; and higher prevalence of HIV/AIDS, teen pregnancy, substance abuse, cardiovascular disease, diabetes, gout, and depression (see Nadal, 2011, for a review). Despite these findings, Filipino Americans have been depicted as the "forgotten Asian Americans" (Nadal, 2011, p. 10) since they are often unnoticed in nearly all academic literature (Nadal et al., 2012).

Implications for Counselors

Nadal et al. (2012) argued that their research has various implications for multicultural counseling and development. First, counselors should comply with the Multicultural Counseling Competencies of the American Counseling Association (see Arredondo et al., 1996; Sue et al. (1992) in which they display understanding,

awareness, and competence when working with diverse racial and ethnic people. It is exceedingly important for counselors to be aware of their attitudes, biases, and assumptions concerning this population in order to prevent microaggressions in counseling or to achieve the necessary skills to be most effective in working with multicultural groups.

In consideration of counselors in the academic environment, school counselors' biases might result in microaggressions against students thereby contributing to a negative influence on students' optimal success. Microaggressions among general mental health counselors may also impact the overall success of their clients and their process toward wellbeing. Numerous research have found that victims of microaggressions might perceive instant uneasy while encountering potential long-term mental health effects (Sue et al., 2008, Sue et al., 2009).

Hence, when clients talk about microaggressions, counselors need to make certain that these clients express their responses unquestionably rather than concealing or internalizing potentially damaging emotions (Nadal et al., 2012). Finally, counselors should also identify ways that they could assist to combat racial microaggressions on systemic and environmental levels (Nadal et al., 2012). Cohort dynamics (e.g., cohort think, social desirability) could have also impacted participants' answers and behaviors.

Summary and Conclusion

The literature review in Chapter 2 revealed an association between race, ethnic identity awareness, and multicultural competence within counseling practice. Researchers described a prevalence of negative results from multiculturally incompetent interactions

between counselor educators, students, supervisees, and other counselor educators (Brooks & Steen, 2010; Cartwright et al., 2009; Henfield et al., 2013; Pittman, 2012). An association exists between increased ethnic identity awareness and multicultural competence (Chao & Nath, 2011; Middleton et al., 2011). Nevertheless, literature neglects to explore or recognize the alliances between race, ethnic identity awareness, and multicultural competence in the counselor educator population. The present study will fill the literature gap by probing the concepts of ethnic identity awareness of counselor educators while also exploring multicultural competence perceptions within this population group. Studies on microaggressions in counseling are in an infantile phase. As more studies are introduced, this field's existing knowledge will help simplify how this idea could complement current ideology concerning alliance ruptures. Many studies have reported early proof that microaggressions can hinder the working alliance; Davis et al. (2016) encouraged investigators to change toward models to analyze the causal connections implied by this chain of experience. Chapter 3 will present the research method for this study, including the procedures for recruiting a community sample, data collection, and analyses.

Chapter 3: Research Method

Introduction

The purpose of this qualitative narrative research was to investigate the lived encounters of racial microaggressions as experienced by R/EM individuals during counseling. The lived experiences of R/EM clients can be examined as a starting point for understanding how individuals make sense of their lives in addition to the how and why individuals' stories are shaped and reshaped (Clandinin & Rosiek, 2007). Narrative research reflects both the participants, the researcher(s), and their respective contexts (Ravitch & Carl, 2016). Chapter 3 begins with a discussion of the qualitative research procedure proposed for this study, including the research design, rationale, research questions, the role of the researcher, methodological, instrumentation, data analysis, threats of validity, issues of trustworthiness, validity of the research and ethical procedures.

Research Design and Rationale

Research Questions

Questions were developed from the need to better understanding the experiences of Native Americans, Black Americans/African Americans, Asian Americans, Pacific Islanders, Latinos, Arab Americans, and multiracial clients that have confronted racial microaggressions in counseling. Two questions were developed specific to this research problem:

Qualitative: RQ1. How do ethnic minorities experience racial microaggressions during counseling sessions?

Qualitative: RQ2. What strategies do clients from ethnic minorities use to overcome microaggressions in counseling?

Research Design and Rationale

The current research study involved a qualitative research design. I used qualitative narrative to understand the lived experiences of R/EM microaggressions in counseling settings and prescribed meaning to the understanding derived by the experiences reported by participants (Ravitch & Carl, 2016). Ravitch and Carl (2016) asserted that the narrative research approach is one inquiry from which the researcher asks one or more individuals to provide personal histories concerning an aspect of their lives (Riessman, 2008). These data were then retold or restoried by the researcher into a narrative chronology. Frequently, the narrative combined views from the participant's life with those of the researcher's life in a collaborative narrative (Clandinin & Connelly, 2000). Common themes are identified throughout the narrative (Creswell, 2014). Zoom was used for my face-to-face interviews (30-45 minutes). Open-ended questions were used to solicit the opinions of participants. Therefore, the appropriate design for this study was narrative.

Role of the Researcher

The role of the researcher was to plan, design, and report research in a way consistent with ethical principles. They adhere to confidentiality and are bound to the same standards when conducting individual research as they would for an institution. The responsibility for ethical practice lied with the principal researcher (as cited in National Clinical Mental Health Counseling Exam [NCMHCE], 2019). According to Levitt et al.,

(2017), narrative qualitative methods are based on the subjective interpretation or description of patterns found in the data as perceived by the researcher(s) (Levitt et al., 2017). As such, researcher(s) engaged in self-reflection and assess how their perspectives and limitations might impact their study; they also depicted these considerations and the steps they took to address any concerns, as described in the Reporting Standards for Qualitative Research (JARS–Qual) guidelines (as cited in Levitt et al., 2020). In these techniques, researchers' transparency about their positions and any associations with participants contributes to readers' confidence in the research (Levitt et al., 2020), as it illustrated that the researchers either have taken care to limit the influences of their own perspective on the research or are candid concerning their perspectives so readers can comprehend the findings as coming from a certain position (Levitt, 2020). Reflexivity needs systemic attention to our subjectivity: this entails that subjectivities and biases are confronted and scrutinized in systematic ways (L. Anderson, 2008; Denzin, 1994; Guba & Lincoln, 2005; Steedman, 1991, as cited in Levitt, 2020). It is the responsibility of the researcher to understand the nature of those subjectivities as they directly connect to the construction, design, and enactment of the study (Ravitch & Carl, 2016). Reflectivity has already been mentioned as a core characteristic of the researcher regarding how their interpretation of the findings is shaped by their background, such as their gender, culture, history, and socioeconomic origin (Creswell, 2014). The researcher's role also included finding and selecting participants, collecting information by way of interviewing, transcribing the interview information, coding the information to locate emerging topics,

examining the information collected, interpreting the information, and reporting the discoveries of the study (Creswell, 2014).

Creswell (2014) cautioned that a close alliance between the researcher and participants may be the source of personal biases that need to be recognized. I am an African American who is a licensed psychotherapist who is self-employed. I am a Black woman who has lived experiences with ethnic microaggressions, so I took precautions to evade skewing the participants' answers by bracketing my experiences and convictions concerning the topic. Throughout the interviews, I did not give perspectives, share individual experiences, or construe what participants said (see Bourke, 2014; Smith et al., 2009). I asked the participants open-ended questions and probed to get more data on important points (see Smith et al., 2009). When needed, I asked participants for clarification, rephrased interview questions to ensure understanding, and made statements to facilitate the discussion and build rapport (see ACA, 2014). I also engaged in transcript clarification with participants to ensure data accuracy. My relationship with the participants was for this study only. In the "Limitations of the Study" section of Chapter 5, I will further discuss this topic.

Methodology

Participant Selection

To meet the collection criteria for this study, the research participants were volunteers and were members of an ethnic minority group. For the purposes of this study, an ethnic minority group is recognized as Native Americans, Black Americans/African Americans, Asian Americans, Pacific Islanders, Latinos, Arab Americans, and

multiracial. Purposeful sampling: I sent Appendix A, Invitation to the participants explaining the particulars and if they felt that they met the criteria request the consent form and to send it back signed at the bottom “I consent.” I therefore took their emails to contact them for the interview on Zoom with a code. The survey was done during my interview with them on Zoom. There was not a pilot study conducted therefore, posting debriefing document was not necessary. Interviews were conducted and audio-recorded via Zoom with participants permission. The interviews were about 30-45 minutes. The participants were instructed that the transcript of their interview will be shared with them via email so that the participant can make any revisions or clarification. The participants were also told that it should take about 20 minutes to review the transcript. The interview on Zoom was audio recorded. It took less than an hour. The interview was performed through Zoom, at a time and date that was convenient for the participant. The interview volunteers were later emailed the date and time of their interview session at least 2 weeks in advance for confirmation.

I gave each participant a $10 E-gift card through their email once they had clarified the transcript instead of the $3 E-gift card which had been originally stated for the completion of the study. It was done for the interview to express my gratitude for their time. Data from each interview were kept strictly confidential. No one who participated was identified in any of the research report. All people in this study were adults since they can provide their own consent for treatment and identify as ethnic minorities male/female. Participation in this study was voluntary and could be discontinued by the participant at any time.

I recruited only through social media/Walden research Participant Pool. Before recruiting through social media/Walden research Participant Pool, I contacted the Institutional Review Board (IRB) approval for the study (Walden University's approval number for this study is 08-30-21-0571145). Inclusion criteria: Research ethnic minorities participants were volunteer individuals who wished to participant and met inclusion criteria. Research participants were volunteer individuals who experienced microaggressions in counseling. The purpose of this study was to ensure that individuals understood the experiences of ethnic minorities in counseling. The aim of this study was to benefit society by letting the participants' voices be heard concerning their microaggressions experiences in counseling. Counselors can then use this information to better understand their clients and ways to interact with them.

A participant must have attended at least one counseling session within the past year and experienced at least one microaggressions in the course of treatment. Selected participants explored their experiences in counseling, their relationship with the counselor, interactions or events that have impacted their decision to stay or terminate counseling, and any social factors that influenced termination or retention specific to racial microaggressions.

Sample Size

Concerning sample size, Patton (2002) expounded that there is no set rule in qualitative inquiry. The size is determined on the purpose of inquiry, the nature of the research and availability of time and resources. He further posited that a sample size of one (in a case study for instance) might provide more in-depth data than a sample size of

ten. In the case of my research study, I was contacted by thirteen potential ethnic minorities. There were 13 participants who responded over a 10-month period, but only four of the qualified participants completed the study. I had one participant scheduled for a Zoom interview who did not attend or provide an explanation. Another declined because she felt that it might be a trigger for her. The other seven never responded to my reminders. Four initially accepted to participate and were actually recruited for the study.

Consent

Participants reviewed the consent form and if participant felt that they understood the study and wished to volunteer, had to reply to the consent email with the words 'I Consent.'

Data Collection Procedures

I talked to the participants and concluded a post-interview debriefing via of online platform like Zoom. The interview required asking the participants if the questions were comprehensible and congenital to answer. It also helped me to determine the time each interview, so the study's consent form provided an accurate estimate of the study's time commitment. Participants completed the survey through Zoom interview "face-to-face." The face-to-face interview with the target population are not already known to the researcher.

Transcript Review

I contacted the participants by email for the transcript clarification after I composed the transcription. In the email, I offered to share my takeaways from that individual's interview via email so the participant could validate if my explanations were

correct. Participants were interviewed by Zoom and asked to make sure that no one could overhear their conversation. There was no one present on my end to overhear our conversation. Any data collected by email was done through participants' code which was needed for participants to access information. During our face-to-face interview, participants names were not used. Ex. A1, A2, A3 etc. was used in place of their names. The data were confidential. Each participant was given a code that represented them without using their names. Participants were recognized by this code. I will make my research available consistent with Walden's social change mission. The formant will be audience appropriate.

The minimum risk that can be involved is that it can be stressful for participants. I am aware that there are unknowns, and this was taken in consideration. My intent was to ask participants if the question is too sensitive for them to answer. Whether we continue will be based on their reply. I also took in consideration their vulnerability. I showed empathy and genuine regard and was truthful to gain their rapport. Assured participants that they are in a safe environment. There were no other potential risks that have not been acknowledged to my knowledge. Nothing pertaining to their personal life was gathered. The data collected only dealt with microaggressions during counseling. Therefore, there was no minimum risks. I did not know any of the participants prior to the study. If such error had occurred, I would have excluded participant from the survey. I was able to proactively manage any potential conflicts of interest. All participants were recruited through the Walden participation pool. I solely recruited through Media/Walden participation pool. I did a confidential survey. I had identifiable information to make my

report. The participants names were not mentioned. They were identified by their codes. There was no reference to participants' medical condition. This was not relevant to my study.

This research was filtered through Delve Qualitative Program, which is a software program utilized by researchers studying qualitative data. Qualitative data are non-numerical data that are produced from qualitative research methods. Transcript can be used in data coding. The Delve Qualitative program (2022) is designed to help organize and analyze qualitative data, including how to turn research questions into my initial set of qualitative codes. The questions might be how to use qualitative coding to find themes and patterns in my data? How to turn my qualitative coding into my final research report? How to use the tools required to conduct qualitative data analysis? Qualitative coding is a procedure of systematically categorizing the responses to determine emerging themes. Coding my qualitative information made my examination more systematic and rigorous. It also contributed transparency and reflexivity to both me and others. It helped me to discover themes that were a valid representation of the participants' responses. There are multiple benefits of qualitative coding. First, it increases validity. Qualitative coding provides organization and structure to information so that a researcher can examine it in a systematic way to increase the validity of their analysis. It decreases bias. Qualitative coding enables one to be aware of potential biases in the way information is analyzed. Qualitative coding also accurately represents participants by allowing the researcher to assess if their analysis represents their participant base and helps them avoid over representing one person or group of individuals. Finally, it

enables transparency. Qualitative coding enables other researchers to review my analysis methodically and systematically.

I used Inductive coding which is a ground-up approach where I can determine codes from the responses. This ground up approach manifest organically from the raw data without interference from preconceived notions of how it should look. This method is effective when engage in an exploratory research. The first-round pass of coding qualitative data involves reading the data and assigning codes to various excerpts. This step is fast and loose. You don't have to worry so much about creating the perfect codes since you'll be iterating and evolving the codes as you go onto the second pass at coding, and beyond. So how do you determine what to name the codes and what parts of the data to code? Here are some examples of types of coding methods that are commonly used in the first-round pass.

In Vivo coding a very common method to code data, and it is the effective means to code raw data with less interference from the researcher's interpretation of the data. In Vivo coding is often the first step in the process of taking segments of data and honing it down to a few words or themes.

Delve flexible coding system evolves with how you find insights: Research analysis is an iterative and evolving process for finding grouping, themes. Delve's analysis interface, with the ability to nest and merge codes, is flexible to adapt to your evolving insight. Delve allows you to see data from different dimensions: By categorizing your quotes, you can look at your data according to code, pattern, demographic information, and more. Delve created the software, Delve, a cloud based

CAQDAS tool for coding in qualitative research. With Delve, researchers can analyze transcripts from in depth interviews and focus cohorts in order to find rigorous, human insights quickly. In survey research, researchers frequently choose a sample size based on selecting a fraction of the population (i.e., 10%), select the size that is unusual or typical based on past studies, or base the sample size simply on the margin of error they are willing to tolerate. Fowler (2009) suggested that these techniques are misguided. Instead, Fowler recommended that sample size determination relate to the analysis plan for a study. One needs to first determine the subgroups to be analyzed in research. Fowler (2009) also suggested going to a table found in many survey books which is an arbitrary selection (see Fowler, 2009) to identify the appropriate sample size (Creswell, 2014).

According to Ravitch and Carl (2016), "purposeful sampling, which is sometimes referred to as purposive sampling, is the primary sampling approach employed in qualitative research (p. 128)." Due to the specificity of a research question, purposeful sampling is often needed and is frequently used in qualitative research. These reasons could include that people might have had a certain experience, have knowledge concerning a phenomenon, live or work in a particular place, or some other specified reason related to your research questions. Qualitative research, through purposeful sampling, provides context-rich and detailed accounts of specific populations and locations. Thus, random probability sampling is not frequently used. Instead, qualitative researchers tend to deliberately select people because of their unique ability to answer the study's research questions. This is frequently called strategic, purposive, or purposeful sampling. Purposeful sampling includes people that are purposefully chosen to participate

in the research for specific reasons, such that they have shared a certain experience, have knowledge of a specific phenomenon, reside in a specific location, or some other reason (Ravitch & Carl, 2016). Purposeful sampling allows the researcher to deliberately select individuals and/or research settings that will help you to get the information needed to answer your research questions (Coyne, 1997; Patton, 2015). Multiple strategies could be utilized to achieve purposeful sampling, as detailed by Patton (2015).

Data Saturation

Indicated in the literature and methodology, I had calculated achieving saturation between 8 to 10 participants. Concerning saturation and sample size, Merriam and Grenier (2019) expounded that saturation happens once the identical patterns and topics emerge from the information collection. Moreover, Creswell and Creswell (2018) asserted that saturation happens when new data no longer generates new insights, topics, or shows new data concerning the theme. Therefore, saturation with this research happened when the semi-structured in-depth interviews remained to show the identical class or divisions formerly found with the participants. This is symbolic of an adequate sample size for this recent research (Creswell & Creswell, 2018). Once saturation had occurred the interviews stopped. There were no other participants waiting and all interviews were stopped.

Instrumentation

The research design for this study is narrative. The data collection was from the media and Walden University participant pool. This platform supported the preparation of qualitative data by organizing participants replies into compatible formats for data

analysis software (Creswell, 2014). Benefits of utilizing survey methodology included the ability to collect data electronically from large numbers of population cohorts with quick results (Creswell, 2014). The questions used in this research were informed by multicultural research that documented R/EM clients feeling invisible in the context of therapy and hesitancy to speak to this situation with their treatment provider. I was able to use this platform to see a summary perspective of my data; browse individual answers, use filter, contrast, and show rules to examine particular facts outlook and sections; view and labeling open-ended answers, and easily download my outcomes in multiple formats. These functions was used with qualitative data. By analyzing text responses, I was able to find insights and trends by tagging responses, creating a word cloud, or automatically detecting the sentiment behind each response. After viewing the overall Question Summaries, I was able to create Filter, Compare, and Show rules with respect to my data. Which permitted me to concentrate on specific themes and analyze results in a way that is most meaningful. The data collection instruments that I used included a guided interview of written, open-ended questions' that I have designed (Appendix B). These questions were developed to help the participants describe their lived experiences with racial microaggression in counseling. A demographic questionnaire (Appendix C) was also collected to ensure participants met inclusionary limits of the study. To help the participants depict their lived experiences with racial microaggression in counseling was through Zoom face-to-face interviews entered into the Delve Qualitative program after transcripts had been clarified by participants.

Data Analysis

Online Delve Qualitative Program (2022) supported the preparation of qualitative data by organizing participant responses into compatible formats for data analysis software (Creswell, 2014). Benefits of using survey methodology included the ability to collect data electronically (Creswell, 2014). Some additional advantages of survey methodology included quick results and the ability to obtain facts from large numbers of population cohorts (Groves et al., 2009). The survey link initially reviewed informed consent that aligns with the ACA code of ethics (ACA, 2014). The consent detailed the purpose of the study, risks and benefits, the voluntary nature, limits to confidentiality and privacy, and proper contacts concerning the study. Participants were also provided with the researcher's contact information, if they had any questions, at this point.

Issues of Trustworthiness

Issues of trustworthiness for this research included the validity of the research and ethical procedures.

Validity of the Research

According to Ravitch and Carl (2016) validity and trustworthiness are most commonly used and evoke the importance of ensuring credibility and rigor in qualitative research.

> Validity is a method to accomplishing complexity through systematic ways of implementing and evaluating a study's rigor. Qualitative research reveals a fidelity to participants' encounters rather than specific techniques (Hammersley & Atkinson, 2007); this is equally true for the concept of qualitative validity. In

> comparison with quantitative researchers, qualitative researchers use a lens not based on scores, instruments, or research designs but a lens established using the perspectives of people who conduct, participate in, or read and review a study (Creswell & Miller, 2000, p. 125).

The different lenses that shape the validity work of qualitative researchers include the lens of the researcher, of the research participants, and of other individuals external to the research. In addition to these lenses, specific criteria for assessing validity differ for qualitative researchers depending on the qualitative paradigm to which they subscribe (Creswell & Miller, 2000).

Credibility is the researcher's capability to consider all the complexities that present themselves in a study and to deal with patterns that are not easily explained (Guba, 1981). This is akin to the quantitative notion of internal validity (Guba, 1981; Lincoln& Guba, 1985; Miles et al., 2014). Internal validity, or credibility, is directly associated to research design and the researcher's instruments and data. The attempt to establish credibility are accomplished by structuring a study to seek and attend to complexity throughout a recursive research design procedure, and the notion of credibility is a good example of the concept of "the inseparability of methods and findings" (Emerson et al., 1995, as cited in Ravitch & Carl, 2016). Credibility is an important part of critical research design. While there is not -and should not be a checklist that can be applied for achieving validity (Ravitch & Carl, 2016). Qualitative researchers show credibility by executing the validity approach of triangulation, member checking (what we think of and describe as participant affirmation), submit thick

description, talk about negative cases, having prolonged engagement in the field, utilizing peer interviews, and/or having an external auditor (Toma, 2011).

Transferability is related to the extent to which from findings a study can be generalized to other contexts or situation similar to the topic of study. Lincoln and Guba (1985) pose an important question that helps us to understand the concept of transferability and the parallel notion of external validity: "How can one determine the degree to which the finds of an inquiry might have applicability in other contexts or with other respondents?"(p. 218). A primacy is placed on fidelity to participants' encounters in qualitative research, it is essential to understand that the goal of qualitative research is not to produce findings that can be directly applied to other settings and contexts. However, qualitative research certainly can be transferable to other contexts (Ravitch & Carl, 2016). Methods for accomplishing transferability comprise having specific illustrations of the information themselves as well as the circumstances (also called thick description) so that readers /research audiences can make contrast to other circumstances based on as much information as possible (Guba, 1981). This authorizes audiences of the study (e.g., readers, other researchers, stakeholders, participants) to transfer features of a research design and discoveries by taking into consideration different contextual factors in lieu of trying to duplicate the design and discoveries. Dependability alludes to the stability of the data. Dependability is similar to the quantitative concept of reliability (Guba, 1981; Lincoln & Guba, 1985). Qualitative research studies are considered dependable by being what Miles et al. (2014) depict as consistent and stable over time. Dependability involves that you have a reasonable argument for how you are gathering the facts, and the facts are

congruous with your argument. In addition, this concept means that facts are dependable in the sense that they are replying to your research question(s). This entails using appropriate procedures (and making an argument for why the procedures you use are appropriate) to answer the core constructs and concepts of your study. The methods for accomplishing dependability are the triangulation and sequencing of procedures and developing a well-articulated rationale for these choices to validate that you have developed the relevant information collection plan given your research questions. As with the other validity constructs, a solid research design is key to accomplishing dependability (Ravitch & Carl, 2016).

Confirmability, which is frequently depicted as the qualitative equivalent of the quantitative concept of objectivity, considers the idea that qualitative researchers do not claim to be objective (Guba, 1981). Qualitative researchers seek to have confirmable information and "relative neutrality and reasonable freedom from unacknowledged researcher biases-at the minimum, explicitness about the inevitable biases that exist" (Miles et al., 2014, p. 311). Especially, building on a foundational premise of qualitative study that the world is a subjective place, qualitative researchers do not look for objectivity; nevertheless, your discoveries should be able to be authenticated. Therefore, one goal of confirmability is to recognize and examine the ways that our partialities and bigotries map onto our explanations of facts and to mediate those to the fullest extent possible by way of structured reflectivity methods (Ravitch & Carl, 2016). Methods to accomplish confirmability comprise implementing triangulation approaches, researcher reflexivity procedures, and external audits (Guba, 1981). Researcher positionality and

bias are essential aspects of qualitative research that must be scrutinized, problematized, and complicated. The researcher is viewed as a primary instrument in qualitive research (Lofland et al. 2006; Porter, 2010), the researcher must challenge herself/himself and be challenged by others in systematic and ongoing ways throughout all stages of the study. This must be concertized within the research design itself (Ravitch & Carl, 2016).

Ethical Procedures

The researcher has the responsibility to respect the rights, needs, values, and desires of the informant(s). To an extent, ethnographic studies can be intrusive to the private experiences of the participants. Participant observation invades the life of the informant (Spradley, 1980, as cited in Creswell, 2014) and sensitive data is often revealed. This is of particular concern in this research where the informant's position and institution are highly visible (Creswell, 2014). The following safeguards was employed to protect the informant's rights: First, the study objectives was articulated in writing so that they are clearly understood by the informant (including a depiction of how the information will be used). Second, written permission to proceed with the research as articulated was received from the informant. Third, a research exemption form was filed with the Institutional Review Board. Fourth, the informant was informed of all information collection devices and activities. Fifth, the informant's rights, interests and wishes was considered first when choices were made regarding reporting the information. Finally, the decision regarding informant anonymity rest with the informant. [Author addressed ethnical issues and IRB review.] Ethical reflections are crucial in social research **(**Wassenaar & Mamotte, 2012). To guarantee compliance with ethical research

standards, I applied for a research ethics evaluation with the proposal and supporting documentation to Walden Institutional Review Board (IRB) and received approval **08-30-21-0571145.** before recruiting participants for the study.

Summary

In this chapter, I presented the procedures that I followed in conducting this qualitative narrative research about the lived experiences of microaggressions in counseling experienced by individuals from ethnic minorities in the United States. I also accounted for criteria for participants' selection, data collection protocols, responsibility and roles of the researcher. I provided an overview of data analysis procedures and steps that I took to ensure the trustworthiness of the study. I also presented the research instrument and the steps I took to guarantee instrumentation credibility and dependability. In Chapter 4, I will provide the results of the study.

Chapter 4: Results

Introduction

The purpose of this qualitative narrative research was to investigate the lived encounters of racial microaggressions as experienced by R/EM individuals during counseling. The participants were interviewed face-to-face interview through the zoom platform.

The research questions that guided this study were:

RQ1. How do ethnic minorities experience racial microaggressions during counseling sessions?

RQ2. What strategies do clients from ethnic minorities use to overcome microaggressions in counseling?

The research questions that influenced the study concentrated on the alliance between race-related stress and interracial microaggressions in anticipating the internal effectiveness, and chance self-efficacy of ethnic individuals of minority descendants. This chapter includes a review of the data collection procedure, summary of the participant demographics, utilization of the research tools, and overview of the results. This chapter concludes with a summary of the findings.

Setting

Participants were selected from a student participation pool at Walden University. This participation pool is a forum in which student researchers are permitted to post an outline of their research projects to obtain volunteers. I began recruiting participants after the approval from Walden University the IRB approval for the study. Research

participants were individuals of ethnic membership who reported experiencing microaggressions in counseling. For anonymity and confidentiality purposes, the participants were coded as they agreed to participate, using the letter A with the number 1 through 4 (A1, etc.). The participants were interviewed through Zoom. Participants A1-A3 completed the interviews in their respective homes on a scheduled at a time and date that was convenient to the participants. The fourth participant, A4, completed the interview in the privacy of her work office. Each interview lasted between 30 and 45 minutes and was audiotaped with the consent of the participants. Upon completion, I transcribed the interview and sent the transcript to each participant for clarification. At the beginning of the interview, participant A4 was at work and stated that "I have to stay plugged into an ongoing meeting to a device on my desk during the interview." During the interview, a conversation was overheard from the plug-in device on A4 desk to listen to the meeting that was going on, but we could not be heard. She apologized stating that "I was not aware that the plug-in device was that loud." No problems were visible during the interviews.

Demographics

Four Walden University students, unknown to me, participated via recruitment through the institution's participation pool. There were 13 participants who responded over a 10-month period, but only four of the qualified participants completed the study. One participant scheduled for a Zoom interview did not attend or provide an explanation. Another declined because she felt that it might be a trigger for her. The other seven potential participants did not respond to my email reminders.

Recruitment efforts focused on ethnic participants of both genders, but only female participants volunteered. Participants were asked to provide their age, education level, race and ethnicity, employment status, and if they were United States citizens. A1 was a 34-year-old, African American female of United States citizenship. She identified highest level of attained education as a master's degree and reported her current employment as a social worker. A2 was a 36-year-old, White Hispanic female of United States citizenship. She identified highest level of attained education as a master's degree and reported her current employment as an educator. A3 was a 30-year-old, African American female of United States citizenship. She identified highest level of attained education as a bachelor's degree and reported her current employment as a customer service worker. A4 was a 51-year-old, African American female of United States citizenship. She identified her highest level of attained education as a Ph.D. and reported her current employment as a public health worker.

Data Collection

Interviewing of Study Participants

Emailed invitations (Appendix A) were sent to interested parties that outlined the purpose of the study and introduce myself. This email explained that this study was to better understand how ethnic minority individuals experience covert and subtle forms of microaggressions(bias) in counseling. The participants were compensated by email for their time with a $10 E-Gift card after completion of study. The data from each interview were kept strictly confidential and no identifying information would be included in the research report. Participation in this study was voluntary and could be discontinued by

the participants at any time. I emailed the consent form after potential participants had met the inclusion criteria for ethnic minorities. The consent form included background information about the study, the procedure, the voluntary nature of the study, the risks and benefits, confidentiality clause, compensation, contact information, and the five questions to be asked during the interview. For each participant, samples of the five interview questions were included. All participants were requested to sign the consent form electronically by responding with the words "I consent." The interview was scheduled upon receipt of the signed consent form.

Semi-structured interviews gave rich, detailed information due to their open-ended nature and flexibility to ask probing questions. Some of the advantages of a semi-structured interview include merging the elements of structured and unstructured interviews, so it increases reliability, and provides comparable information as well as increasing and allowing flexibility to ask follow-up questions (as cited in Delve, 2022). The predetermined questions helped me to concentrate on the topic of interest and avoid distractions. I started analyzing the data following information collection and transcription. While I transcribed the interviews, I was able to familiarize myself with what participants had said in their interviews and it led me to notice commonalities in the interviews. I made note of these commonalities as possible codes to use in later steps of the analysis. After I had completed my transcriptions of the interviews, I started the coding process. Interview transcripts were uploaded into Delve, 2022, a data analysis qualitative software program. When coding in Delve (2022), all passages of text (e.g., words and sentences) connected to the research questions were coded.

Data Analysis

Narrative research is a type of study that is used to understand and encapsulate the human encounter by using in depth methods to explore the meanings related to individuals' lived encounters. Narrative analysis can be used in narrative research as well as other approaches such as grounded theory, action research, ethnology and more. Narrative analysis was used to analyze data from the semi-structured interviews. Researchers use narrative analysis to organize how research participants construct story and narrative from their own personal encounters (Riessman, 2007, as cited in Delve, 2022). First, the research participants explain their own lives through narrative story telling. Then the researcher expounds the construction of that narrative. While humans naturally create narratives and stories when explaining their own lives, certain information collection techniques are more conducive to comprehending your research participants' sense of self narrative (Delve, 2022). I took the narrative analysis since it stresses taking verbatim transcription of narrative interviews, where it is significant to include pauses, filler words, and stray utterances like "um…." I used the narrative codes, which I gave a brief title to the coded passages, and in vivo codes, where the coded passages were titled verbatim from participants interviews. With In Vivo coding, using the participants' exact words, the data was coded for themes with a ground up approach without me injecting my own preconceptions onto the data. An example of this coding process is presented in Table 1 below.

Table 1

Example of Coding Process

Raw data	Code
"Ah, there was a lot of Christian influence on the. Ah, recommendations by the counselors that I had seen. Everything was revolved around ah going to church and reading the bible. And ah which are not things that I practice since I am not Christian."	Microaggressions
"No, I felt very misunderstood. So, we were having a discuss the session, and she say things like ah so don't use any lingo because you know different groups us different types of lingo for things. I want to make sure I understand you. So don't use any slang or things like that. Is like, I don't know if you say this to all of your clients but why would you just assume I going to use slang words or words you're not possibly going to understand. So, you know, it just kind of felt like she was already picturing in her mind who I was. And instead of just letting me say, whether I use slang or not, let me as the client get it out how I need to, and if you have questions, follow up with your follow-up questions on what I've said."	Felt Very Misunderstood
"Ah, I think the only thing that I could say is ah honestly had my husband not... It was just mainly my husband coming, and I think that I just really needed him to validate what I was feeling and so having him come is probably the only reason why I went ahead, and ah switched. Because again like in my mind I was thinking that maybe it's me, and I'm just misinterpreting, and I'm being too sensitive. So that is kind of what I was thinking. Honestly, I probably would have gone maybe a few more sessions just to see if things got better. Ah, because I don't want to assume bad about people. Ah and so, having him come was really solidified, ok, I am not crazy. We are done here."	Just Misinterpreting

The coding of all transcripts provided a list of codes that I analyzed further based on the alliances between these codes and the ways the codes connected to or addressed

the research questions. I put codes that were similar, such as those that expressed similar sentiments or used similar language or wording, together into larger categories. For instance, all participants told me about the individuals who perpetrated microaggressions against them in the counseling session(s) and where this microaggressions occurred. Upon analyzing these stories, I identified a primary category of microaggressions and two subcategories based on the setting of the microaggressions: Microaggressions by counselor(s) and Microaggressions in session(s). An example of this process is presented in Table 2. I probed all codes in the code list and searched for other codes that were similar, placing them into larger categories based on similarity. Upon deeper probing, I decided that some codes did not fit well with other codes, or they did not have enough support (either through the number of participants whose responses aligned to that code or the number of total references in the code) to stand on their own as a possible subtheme, and these codes were rejected.

Table 2

Example of Code Placement Into Larger Categories

Codes	Categories
Microaggressions from counselor(s)	Microaggressions Racism by those in power
Assumptions made concerning ethnic clients based on color	Microaggressions based on assumptions

After I had completed grouping the codes into these larger categories, I probed these categories further to determine if there were existing connections between the categories. In this step of analysis, I put similar categories together into larger categories based on similarity, where relevant. The similar smaller categories became the subthemes and the new, larger categories became the themes. This procedure provided the final semi structure of the findings in hierarchical form, from codes to subthemes to themes. I aligned these to the two research questions of this study. I gave all themes and subthemes an in vivo title, and this final semi structure is presented in Table 3.

Table 3

Semi-Structure Aligned to Research Questions

Research questions	Themes	Subthemes
RQ1. How do ethnic minorities experience racial microaggressions during counseling sessions?	1. Experiencing racial Microaggressions by counselors in session	1a. Emotional responses to microaggressions
RQ2. What strategies do clients from ethnic minorities use to overcome microaggressions in counseling?	2. Alleviating microaggressions insensitivity in sessions.	2a. Microaggressions based on assumptions

According to Rubin and Rubin (2012), a narrative analysis entails examining individuals' descriptions of encounters as apprised in story form. With this form of analysis, how stories are told is more important than the content itself. Narrative analysis can be used to examine how individuals establish meaning out of their encounters, how they depicted them, and how they shared encounters with others. Here, the actual contents of the story sometimes are not as important as looking at the values or beliefs systems that underlie the story. These researchers also asserted that they frequently asked for narratives or stories and recognized that when they are told a story, it is frequently more important to look for secondary messages, such as moral values or cultural beliefs, than it is to track down whether the story is true. In each interview transcript, I identified important statements concerning how the participants encountered microaggressions. I labeled each statement with a phrase to represent the concepts or small units of meaning

that were significant to the research issue. I created a list of important statements, making sure that they were not repetitive and did not overlap with one another. I organized the statements by category and assigned a core narrative or large unit of meaning to each category. The core narratives summarized the small units of meaning cohort into the categories. I wrote a depiction of what the participants encountered in terms of microaggressions in their counseling session(s), and I demonstrated the descriptions with direct quotations from the transcripts. I also wrote how the participants encountered the phenomenon of microaggressions. Finally, I synthesized the depictions of what the participants encountered as microaggressions and how they encountered them, concentrating on their perception of feelings to communicate the essence of their encounters. As to discrepancies, I reread the connected segments of the transcripts to make sure that I did not misconstrue or misread the responses of the participants. I did not find any discrepancies. The participants sent clarifications to that effect.

Evidence of Trustworthiness

Evidence of trustworthiness is essential for the integrity and effectiveness of the findings of a study (Cope, 2014). I addressed trustworthiness by ensuring credibility, transferability, dependability, and confirmability. The promise of credibility involved the use of bracketing, member checking, and transparency. Transferability was accomplished through the use of thick description. I used triangulation, extended engagement with data, and audit trail to address dependability. Paraphrasing during the interview, collaboration with participants, precise transcription of the interview audio recordings, triangulation, and direct quotes accounted for confirmability of the study.

Creditability

Credibility was achieved through bracketing, member checking, and transparency. Through the practice of bracketing, I developed an awareness of the own bias by setting aside my assumptions and experiences with the phenomenon throughout the study, mostly during the collection of data, the analysis of data, and the reporting results. The interview transcripts were sent to the participants by email to solicit their review and feedback on the accuracy of the transcription, in observance of member checking. I received one response suggesting a change in the transcript. A2 participant wanted to reword her response so that it would be understood what she had attempted to say. Participant felt that she had not worded it correctly. Transparency required maintaining an audit trail. The audit trail consisted in creating a log of research activities and remarks during data collection, data analysis, and report writing. It also comprised of thorough documentation of data collection and data analysis methods. As part of the audit trial, I secured and organized the interview recordings and transcripts, the signed consent forms, and the competed demographic questionnaires. I also organized and stored relevant communications with participants, interview notes, and other documents related to the study.

Transferability

Accomplishing transferability necessitated the use of thick description. I clearly depicted data collection and data analysis in the report of the study, utilizing a rich and thick description. The description involved the presentation of the data and findings of the research in a detailed manner to provide readers with sufficient information. The

information I provided in the description may empower readers to assess the applicability of the research findings to other times, populations, or settings.

Dependability

Dependability was established via triangulation, an audit trail, and extended engagement with data. In terms of triangulation, I checked the interview data, the demographic data contained in the pre-screening questionnaires, the interview notes, and the literature concerning microaggressions in counseling sessions against one another to confirm consistency and to well conceptualize the participants' depiction of their encounters with the phenomenon. An audit trail in the context of dependability consisted of accounting for the research activities and decisiveness which I addressed throughout the report. Being the interviewer, the transcriber, and analyst, and the report writer enabled me to have extended engagement with the data.

Confirmability

I effectuated confirmability through paraphrasing during the interviews and collaboration with participants. Precise transcription of the interview audio recordings, triangulation, and direct quotes were also my efforts to achieve confirmability. I utilized member checking as portrayed earlier and direct quotes from the participants' responses to support the themes found in the data. As validation strategy, I collaborated with the participants during and after the interviews to gain a good understanding of their responses by email for clarification. Such collaboration helped ensure the validity of the transcription and minimized the chances of distortion during analysis.

Results

Theme 1: Experiencing Racial Microaggressions Perpetuated by Counselors

Theme 1 addressed the first research question. How do ethnic minorities experience racial microaggressions during counseling sessions? Data analysis depicted ethnic minority individuals encountered a myriad of emotions as a result of strategies used to manage microaggressions insensitivity in sessions. I developed this theme based on the language participants used to depict their encounters of microaggressions insensitivity in sessions. I looked specifically at the words that participants used, like anger, uncomfortable, disrespected, felt judged, not welcome, insulted and not heard. In addition to this language, I noted participants use of body language when they spoke of their encounters. All four of participants depicted feeling angry at the bias they had encountered. Participants tied this anger to different encounters with counselors and facilities. All four felt that it was based on their ethnicity. Participant A1 stated:

> Her. I would just say… just I didn't feel comfortable and so, for me I have to feel comfortable to obviously share and open up about the concerns I am experiencing. And I could just tell by the vibe that ok this is not probably going to be good. But I wanted to give her the benefit of the doubt and so I tried to stick through with it. But I wished I would have listened to my gut more and intuition which was telling me that you are not crazy she's being rude, and disrespectful and she doesn't have any respect for your culture your background, or anything, and so, you know it is one of those things where I wished it would have worked out better, but I think she played a large part as to why nothing got accomplished.

Three participants felt similar feelings of anger but spoke concerning this in the context of the impersonal alliance that the counselor had with them. Participant A2 stated:

> Ah, it was very uncomfortable to not feel... To feel judged to feel that when I select Hispanic and then not look whatever they, I don't know what they were thinking what I should look like. They said, oh okay you're Hispanic you don't have to say Hispanic ah and White, you can just select White. The intake document did not include a "Hispanic" section in the race/ethnicity. When I questioned it, the front desk receptionist said, "just select white." And I was like but I'm not. It was just off-putting to feel that I had to change who I was since I didn't meet their visual expectation of what I should be. Ah and just not really liking the vibe that they were giving off.

Participant A3 did not feel that this was the right counselor for her by the conversation that the two of them were having. Participant A3 stated:

> Probably my negative social interactions with him. I think they ultimately just told me like yeah this probably not the counselor for you. Mind you in my first session he did say like you are supposed to be like a tight-knit bond between you and your counselor and it's okay if he wasn't the right one for me. So, I was like okay, I can take that, and I can run with that. So, either it's going to work or it's not going to work, or either we going to have this rapport or not have this rapport. I did understand that if this isn't working, I knew I could go on my own. It wasn't like somebody was kidnapping me or holding me hostage or anything. I did

understand that. Just the social interactions say this is probably not working for me.

Participant A4 felt comfortable with her original counselor, but when she was referred to another counselor she did not feel any warmth and was uncomfortable. Participant A4 stated:

> The initial counseling office was very welcoming, it was a warm environment, it was quiet, it was refreshing, there was no hesitancy there. The ambiance that was there, it was soft, it was relaxing. So, it made you okay with opening up to discuss whatever situations I was dealing with, the initial office was great. Second office immediately when I walked towards the door it was just an uncomfortable feeling to know there were a lot of other people there. So that made me feel uncomfortable even though I did not know them, and they did not know me it was uncomfortable sitting in a waiting room with several people on various levels of seeking counseling. I felt uncomfortable and then to go through the process of going to the back to be seen and so forth did not make it any better. It did not feel…The environment just was not welcoming you could tell it was the environment of these individuals just used to having patients come in or their clients come in and running them through the process and getting them out, to me there were no patience. There was no true understanding of customer service. I would say you just looked at one patient and I guess that one ideal of a patient we all fit for them and that wasn't, no that wasn't for me, and it was very uncomfortable to be there. The office environment was cold the lights were very,

> very bright and in some offices it was dark. The office space that you sat in was small and how you are positioned sitting in the office was uncomfortable. It's almost like you were sitting either right next to the desk of the counselor or no true separation in space, so very uncomfortable being there.

Subtheme 1a: Emotional Experience of Microaggressions During Sessions

The participants described their emotional experiences of microaggressions during sessions as being insulted, disrespected, not welcome, felt judged, anger, not heard and uncomfortable. All four participants encountered their emotional microaggressions in different ways. Participant A1 stated:

> Ah, the very last one that I had, her, and my husband ah not gotten into it cause she had said something to him. She actually said to him that so what I am hearing is you like to act like a woman then, because we were talking about... I was talking about how sometimes when we are having like an argument or something he may give me the silent treatment, and that is just because he is trying to keep the peace. So, what she said was, so you like to act like a woman then, so that did not go over well, and so especially because my husband is African American and so one thing you don't do is question his manhood. And so, yeah that is how it, ended it. Shortly after that, he told her that ah she needed to do some more research and that ah basically that we weren't coming back, and we would find somebody else.

Participant 2 felt that she was being discriminated because of counselor's lack of understanding what she meant by Higher Power and constant reiteration of going to

church ah praying to Jesus and all of that it made participant feel uncomfortable. Participant A2 stated:

> I did not feel understood ah even though I was respectful of their religious beliefs. I did mention that I am not Christian and that I believe in the Higher Power but not the Christian God or the Southern dogma of the Baptist God. Ah and so that just flew right over their heads and that was even something to consider. Ah, and so the constant reiteration of going to church ah praying to Jesus and all of that it made me feel uncomfortable. Ah, and just the expectation to spank my child for discipline when they're undergoing chemo just was crazy to me. So, I don't think that we had an understanding at all.

Participant A2 also felt that culture had not been acknowledged. Participant A2 stated:

> Ah, just not understanding where I was coming from. They didn't ask my religious beliefs at all. Ah they didn't ask ah what kind of cultural beliefs might change what they're presenting. Ah and so that really hindered being on the same page for goal setting.

Participant A3 felt her counselor was not listening to her. She felt that the counselor was attempting to make her compromise. Participant A3 stated:

> At first it was okay and then when I was stating my long-term goals. He was kind of pushing off his goals and then I had to keep reminding him like these goals are not my goals. That's not what I wanted to do, so that was the first initial like the primary reason why I didn't want to work with him anymore. So, you are not

> supposed to do that in counseling at all. Like that's not at all… And I absolutely hated it and no matter how many times I kept reiterating like I don't want to do that. I don't mind working for someone. I am not trying to own my own practice. He just kept telling me what my goals were when I was stating what my goals were. So, I did not like that, so goal setting was kind of he had his goals for me, and then I had my goals, and we just really kind of didn't discuss my goals.

Participant A3 found a way to terminate herself from this situation. Participant A3 stated:

> Eventually covid came about, so I was in counseling prior to covid and then I kind of used covid as the excuse not to continue counseling. Then I found another counselor. So, I don't know if I used that as and scapegoat or not, but I just saw an out and so I just kind of took the out.

Participant A4 felt that the White counselors did not understand her culture. Participant A4 stated:

> Yes. Well, I did stay with the original counselor because there was the connection and there was the understanding the roundabout understanding of why we feel the way we do as African Americans with that stigma being associated with seeking counseling and plus there was that spiritual connection that was there as well with the other facility there was no spiritual connection, there was not that holistic approach. It was just a mill to me; it was just like truly going through a factory of people being pushed through a door. Sitting down, they take their preliminary report, and they prescribe you these pills and you are out the door and we will see

> you in how many of weeks they are going to assign you to come back. So, I did not like that, so, for them that was the reason I decided to end that particular session and then they could not relate. But with my original counselor like I said the connection was there spiritually, mentally the connection was there, so it was just a roundabout connection that also assisted and helped me to remain with her.

Based on the findings participants did experience microaggressions in counseling sessions. The second theme will discuss strategies used to alleviate microaggressions insensitivity in sessions.

Theme 2: Alleviating Microaggressions Insensitivity in Sessions

Theme 2 partially addressed RQ2: What strategies do clients from ethnic minorities use to overcome microaggressions in counseling? While this theme does not directly explore how participants relieved microaggressions insensitivity in their lives during sessions, Theme 2a does. All participants had ideas for ways to address microaggressions in counseling. This, in turn would relieve the insensitivity on a structural and systemic level and could help ethnic individuals continue to come to counseling. All four participants felt that counselors needed better training and to be made aware to acknowledge ethnic minorities culture. Also, participants would like counselors to see them as a human being with the same rights as other cultures. Participant A1 stated:

> No. And that no, because there were things that I would bring up and it felt like she was trying to give me solutions that like made absolutely no sense for what I was talking about. So, it kind of felt like maybe she was trying to pull straws, or

> she had a lot of sets of answers that she normally, typically gives. Because she tried to assign me like homework assignments that like made absolutely no sense for what I'm there to talk about, so it felt like assignments that she gives everybody regardless of what you were in there for. So, it did make me question how long she had been doing it and what her background really was. Ah, and it made me think that I really should have checked her background and should have done more research on her before setting up the appointment.

Participant A2 felt that the counseling facility the Pediatric oncology had recommended did not fit her circumstances as a mother of a child with cancer during Covid-19. Participant A2 stated:

> I do not. I honestly don't know that even if they were recommended through Pediatric oncology ah I don't think that they quite understood the ah tremendous expectations that parents' ah as a pediatric caregiver ah have ah or some of the limitations. You can't just go to church, especially during a pandemic. You can't do that ah because you have an amino compromise child some of the expectations that they set for were unrealistic, ah and they didn't account for the immutable compromise aspect of everything. You can't just go out to lunch with your friends all willy-nilly because your child is in the hospital. So, I don't really want to go hang out with a punch people that if during the pandemic ah when I have a child that needs me at home where I would be a threat to them by bringing home a communicable disease.

Participant A3 felt that counselor did not understand her culture by the conversations that they would have. She felt that she should have had a better rapport and not have a problem with communication. Participant A3 stated:

> That's a very good question. Sometimes yes and sometimes no it kind of depends on like what we were discussing that day. Because I am somebody big on if you give me homework I actually enjoy doing the homework, that in counseling because I am learning a lot about myself, but sometimes no. That's another thing that kind of didn't cross over. I am not sure if that was like a personal belief or cultural difference. But sometimes yes and sometimes no, just really depends on what we were talking about.

Participant A4 felt that although the counselors had good training, but they lack bedside manners. She felt that this was just as important as being properly trained. Participant A4 stated:

> Initial counselor yes, and I will say that the secondary facility. I would say that they also had the proper training received all of what is required to do that profession. However, it's almost like a doctor they go to school to be a doctor, they pass and then they specialize in what they specialize in. However, if there's poor bedside manners all of the training as a doctor goes out the window to me. So being able to have that training, receive that education, and also have the people skills, the understanding, the cultural diversity, the understanding all of the inclusion. I think when I went through all of this that was not a big topic. Now with everything that's going on in society, inclusion, equity the diversity is a huge

> topic now. So, unfortunately, you get these very small courses or the very small role of education, information that you received on those topics back then. But now these are huge major factors in every aspect of society that we look at now. So even with medical treatment, so hopefully the secondary office has taken a look at that and made some adjustments so that they understand that everyone is not a cookie-cutter personality and that you do have to be ethical, or you have to be diverse, you have to be competent with diversity. Unfortunately, a lot of offices are not, it's just that straight cookie-cutter industry, and everyone fits one mole, and this is how we do it.

Participants A1, A2, A3 and A4 all stated that diverse counselors would contribute better perception of the concerns that ethnic minority clients possess. In addition to hiring more counselors of color, participants believed counselors would profit from diversity training. Greater support systems for ethnic clients would also help clients feel more welcome in sessions.

Subtheme 2a

Microaggressions based on assumptions. Microaggressions toward ethnic clients was by their counselors. This type of microaggressions was based on assumptions made about participants based on their ethnicity. Participant A1 stated:

> No, I felt very misunderstood. So, we were having a discussion in the session, and she would say things like ah so "don't use any lingo because you know different groups use different types of lingo for things. I want to make sure I understand you. So don't use any slang or things like that. " Is like, I don't know if you say

this to all of your clients but why would you just assume I going to use slang words or words you're not possibly going to understand. So, you know, it just kind of felt like she was already picturing in her mind who I was. And instead of just letting me say, whether I use slang or not, let me as the client get it out how I need to, and if you have questions, follow up with your follow-up questions on what I've said.

Participant A2 felt that counselor had no knowledge about her culture. Participant A2 stated:

Ah, it was very Southern sheik and ah very limited in world view. Ah very uncomfortable. Ah, and overly, it started almost a false sense of security ah with the counselor being extremely ah energetic and exciting sounding and then not really understanding any of the ah cultural, ah the culture around coping among the Hispanic community of how ah speaking about your personal feelings is not huge among family members. Ah, anger is typically one of the bigger models that ah Hispanic women ah use for coping ah and so trying to find something less than that was difficult when ah there was no cultural understanding from the counselor. She didn't understand how Hispanics interact with one another ah or the fact that I speak White according to her. And not, I don't have an accent. I grew up in Canada, so I grew up with the Canadian accent ah if anything else, but that doesn't diminish what my culture is. And the fact that neither one of my parents are American. Ah was...There were questions if I am an immigrant or if my parents were legal which was off-putting, to begin with, and so just a lot of bias

> from the actual counselors themselves. There are misconceptions of people that are not that identified as a culture that visually don't meet up with what they think I should look like or think I should talk like or think how I should have been raised. We don't do spanking. But there is a lot of ah I don't do spanking, but I grew up in the era where spanking was very prevalent, and my Hispanic mother was very pro-spanking. Ah so, I was looking for ways that I could be a better parent for my own children without using that that was some of the things I was looking for. That was kind of reinforcement with them was the spanking is ok. And that wasn't something that I was looking for at all that was the opposite.

Participant A3 felt that the counselor had assumed she would act like the stereotyped African American who is irate. Participant A3 stated:

> Anger is probably the first thing that came to me because initially during like our first formative session I was kind of perceived as like the mad black woman and I absolutely cannot stand that stereotype of black women being really, really angry people. So, it was like kind of putting off like I would probably come in here being irate, off the wall, off the hinges, I would be cussing a lot. I know how to express myself in other ways. I don't know using profanity and stuff. So not being so involved in sessions, but anger was the first initial thing and then maybe shame and confusion because I love being a black woman. I am very empowered black woman. I love being in my own skin but when you see stuff like that, and you know that you are supposed to be coming here for something completely different

than anything having to do with like race, ethnicity that is confusing stuff ultimately.

Participants utilized strategies of self-care to help them cope with microaggression in counseling. All four participants also used their self-confidence and internal strength.

Summary

The purpose of this qualitative narrative research was to investigate the lived encounters of racial microaggressions as experienced by racial/ethnic minority (R/EM) individuals during counseling. Four females of varying ethnic groups served as participants. Two themes and 2 subthemes were developed. Finding indicated that participants were victims of all three forms of racial microaggressions, which are microassaults, microinsults, and microinvalidations (Forrest Bank & Jenson, 2015). The findings also indicated that to cope with racial microaggressions, ethnic minorities ignored the problem; they focused on performing well in the counseling session(s).The interpretation of limitation of study and recommendations are presented in Chapter 5. Chapter 5 will also address the implications of social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative narrative research was to investigate the lived encounters of racial microaggressions as experienced by R/EM individuals during counseling. I used a qualitative narrative approach to analyze the participants meaning making concerning their lived encounters with racial microaggressions as well as added my perspectives and interpretations concerning their encounters.

This study contributes to the current research by detailing ethnic minorities encounters with racial microaggressions directly, indirectly, personally, and through witnessing others' encounters with them, and the mechanisms used to cope with the microaggressions. It also provides implications for counselors working with ethnic minorities clients such as the significance of awareness of a client's racial history and providing culturally sensitive interventions. In this chapter, I summarize and interpret the key findings of the research, which include using critical race theory (CRT) as the theoretical framework for data analysis (see Creswell, 2013; Frey, 2013; Jordan, 2009; Kress et al., 2018; Parsons & Zhang, 2014; Patton, 2015). I also discuss recommendation for further research and implications for counseling.

Interpretation of Findings

The findings of this research support the current literature on ethnic minorities of different ages and backgrounds experiencing racial microaggressions at different time settings throughout their lives (Griffin et al., 2016; Owen et al., 2014; Robinson-Wood et at., 2015). I conducted a narrative semi structured interview with four ethnic individuals

from a minority setting, who gave their encounters of racial microaggressions in counseling. In Chapter 4, all the outcomes from the categories that emerged from the narrative analysis of the data were detailed. Here, I analyze the findings of each research question in the framework of CRT and the literature on racial microaggressions.

Experience of Racial Microaggressions

The main research question was, "How do ethnic minorities encounter racial microaggressions during counseling sessions?" Findings from the interview responses indicated that all of the participants encountered racial microaggressions directly or indirectly. Racial microaggressions are an endemic problem in counseling, but most of the time, microaggression in counseling are committed unconsciously or out of ignorance. The findings validates CRT tenets that the concept of racism is not new in the United States, but emanated from the history of slavery and microaggressions, and is culturally enrooted (Mills, 2009), and that racism is endemic to United States life (Matsuda et al., 1993).

The analysis of data also revealed that racial microaggressions resulted in negative emotions for participants, which included feeling angry, uncomfortable, disrespected, judged, not welcome, not heard, and insulted. This finding is in alignment with research on the physical and emotional consequences of racial microaggressions. Nadal (2011) asserted, for example, that racial microaggressions were connected with high blood pressure, depression, and posttraumatic stress disorder. Nadal et al. (2014) also asserted that victims or racial microaggressions had a high propensity to be depressed and anxious, to have low self-esteem, and to be bitter. Therefore, this finding

provides evidence that racial microaggressions have the potential to negatively influence the physical and emotional wellbeing of ethnic individuals in counseling, because they encountered disrespect, anger, uncomfortable, felt judged, not welcome, insulted, and not heard in counseling sessions.

Overall, my findings demonstrated that participants were victims of all three forms of racial microaggressions, which are microassaults, microinsults, and microinvalidations (Forrest-Bank & Jenson, 2015). According to Forrest-Bank and Jenson (2015), microassaults are, "acts of racism or discrimination that are enacted knowingly toward others" (p.143); microinsults are "messages relayed interpersonally or environmentally that relay negative, degrading, or exclusionary messages" (p.143); and microinvalidations occur when people pretend that color does not matter and behave as if racism did not exist. While participants encountered all three forms of racial microaggressions, they developed coping strategies as self-confidence and internal strength to overcome the effect of racial microaggressions.

Strategies

The second question was, "What strategies do clients from ethnic minorities use to overcome microaggressions in counseling?" The findings indicated that to cope with racial microaggressions, ethnic minorities ignored the problem; they focused on performing well in the counseling session(s) by using their self-confidence and internal strength. This finding validates the contention of Davis et al. (2016), Edwards (2017), and Sue et al., (2007), who performed research on ethnic minorities microaggressions in counseling.

Due to the participants sharing their lived encounters with racial microaggressions during the interviews, the study's results also answered the main research question and second question. Additionally, the participants' suggestions that counselors need to be nonjudgmental, compassionate, and use culturally competent interventions with ethnic minority clients are consistent with counseling literature. For example, prior researchers depicted that counselors working with clients who have had encounters with racial microaggressions use basic counseling skills such as empathy, nonjudgement, and unconditional positive regard to help their clients work through them effectively (Mazzula & Nadal, 2015; Stambaugh & Ford, 2015). Counselors using the CRT lens to work with clients from minority populations should explore if they have encountered microaggressions, societal traumas, or bias, which may contribute to their social disconnections (Jordan, 2009; Kress et al., 2018). Another element of past research literature that this research did confirm was participants encountering racial microaggressions in counseling examples; A1, A2, and A3 encountered racism-type behaviors. A2 also felt that she was being persecuted for not being a Christian, and A3 felt that the counselor lacked proper cultural awareness and being stereotyped as an angry Black woman.

The outcomes also depicted that multiple theoretical methods to counseling could be effective with proper cultural awareness when addressing ethnic minority clients' mental health concerns and racial microaggressions. The counseling profession, in general, are that counselors must use mutual empathy and empowerment, remain genuine, corroborate clients, depict compassion, be nonjudgmental, and have a

willingness to learn and grow to promote healthy and successful therapeutic alliances with clients (Haskins & Appling, 2017; Hook et al., 2016; Jordan, 2009; Kress et al, 2018; Mazzula & Nadal, 2015). Therefore, counselors who are aware of how their worldviews may affect their work with clients can strive to create a warm, nonjudgmental, mutually empathetic, and inclusive milieu for all clients (ACA, 2014; Haskins & Appling, 2017; Mazzula & Nadal, 2015; Stambaugh & Ford, 2015).

Acknowledging an ethnic minority client's race and what being an ethnic minority means to them can also strengthen the counseling alliance and help clients to relax and open up in counseling. Therefore, if counselors address race connections early in the counseling alliance, they may help foster a positive therapeutic alliance based on trust and safety from the onset of therapy (Hook et al., 2016; Kress et al., 2018; Mazzula & Nadal, 2015). It is crucial for counselors to learn about, support, and validate ethnic minority clients' lived encounters with racial microaggressions to comprehend how those encounters affect them (Jordan, 2009; Knight, 2013; Kress et al., 2018; Mazzula & Nadal, 2015; Nadal et al., 2017**)**. On the other hand, counselors must also avoid analyzing clients for racial problems beyond what the clients want to discuss (Jordan, 2009; Knight, 2013). Using this method takes practice, supervision, trial and error, and counselors' willingness to push beyond their comfort zone by starting conversations about these often sensitive and uncomfortable problems (Knight, 2013; Mazzula & Nadal, 2015).

Based on the results of this research, I interpreted that ethnic minority individuals continue to persevere despite the generational adversities they have faced. The coping skills that the participants in this research used such as having self-confidence and

internal strength are how they overcame these encounters. For example, A1, A2 and A3 all felt that they should always trust their instincts and should have spoken out when feeling offensive by the words or nonverbal encounters by the counselor(s) attempting to make them feel less than or incompetent or needed validation.

Although the data in this research confirmed some of the literature, it did not support other elements in the existing research. For example, although the participants in this study discussed feeling angry and hypervigilant about their encounters with racial microaggressions, they did not report having serious mental health, substance abuse, low self-esteem, or self-concept problems. The participants reported feeling confident and empowered to overcome their encounters. In contrast, participants in other studies reported having mental health and substance abuse issues associated to encountering racial microaggressions (Liao et al., 2015; O'Keefe et al., 2015; Smith et al., 2016; Williams et al., 2017). Furthermore, none of this study's participants reported having any mental illnesses, which made them targets of microaggressions, while participants in an earlier microaggressions research reported that they were targets of microaggressions because of their mental illnesses (Gonzales et al., 2014).

The participants in this research also did not report having any physical health concerns because of their encounters with racial microaggressions as those in a study where the researchers found a negative correlation between physical health conditions and racial microaggressions, which led to people having role limitations (Nadal et al., 2017).

Limitation of the Study

The first limitation of this research applies to the qualitative nature and small sample size of four participants, prohibiting the findings from relating to the entire community of ethnic minority individuals. However, generalizing was not the purpose of this research. Additionally, three of the participants were of African American descent, and one was of Latina descent which is a subset of ethnic minority individuals represented in the United States. A second limitation was that the study included more African Americans than other minority individuals. While individuals from other racial and minority cohorts also encountered racial and other types of microaggressions. I had hoped to get more from other ethnic minority cohorts since I am an African American. Using purposive sampling was a limitation of the research. Purpose sampling was utilized to select participants that possess characteristics that improve credibility (Miles et al., 2014). However, the sample size was small and may not represent a larger group of ethnic minorities. There were thirteen participants who responded over a ten-month period but only four of the qualified participants completed the study. One participant scheduled for a zoom interview did not attend or provide an explanation. Another declined because she felt that it might be a trigger for her. The other seven potential participants did not respond to my email reminders.

The limitation to trustworthiness that arose from the research was transferability, which referred to the degree to which the outcomes of qualitative study could be generalized or transferred to other contexts or settings (Miles et al., 2014). Although thick in-depth descriptions were used, the outcomes of the research may not apply to another

cohort of ethnic minorities. Confirmability was a limitation of this research. Confirmability was the ability to keep and decrease bias (Polit & Beck, 2012; Tobin & Begley, 2004). This aspect was a significant component to decrease microaggressions, assumptions, and preconceived ideas concerning an encounter or phenomenon, which could affect transferability and generalizability (Miles et al., 2014).

Recommendations

Recommendations for this study are based on the participants' response to a question concerning what changes they would suggest the counseling profession should implement to solve the problem of racial microaggressions. The data gathered from this research contributed the perspective of ethnic minority clients only. If a future research contained clients of ethnic minorities, it could contribute more data advantageous for Counseling Institutions outcome for clients of color.

Future researchers could analyze the experiences of ethnic minority clients in counseling. I focused solely on microaggressions against ethnic individuals from minorities in counseling. Information gathered from a research on ethnic minorities in counseling might yield data concerning microaggressions experienced at this level. Research should be conducted on communication (i.e., frequency of contact and communication type) between client and counselors.

Participants in the research suggested that communication was lacking among clients and counselors within the session(s) setting. The findings from this research recommended that the participants believed additional communication opportunities

would enhance rapport and build better client and counselor alliances to improve the quality of communication.

Implications for Counseling

The implications for counseling, which came from this research are homogeneous with prior research findings on how counselors can work effectively with ethnic minority clients. For example, the participants in this research said that it is essential for counselors to be nonjudgmental, demonstrate unconditional positive regard, and use individualized and unconventional counseling interventions with ethnic minority clients. These suggestions are consistent with the findings of several research that found these suggestions to be effective strategies in counseling (Haskins & Appling, 2017; Knight, 2013; Kress et al., 2018; Nadal et al., 2017). The participants also expressed the significance of counselors comprehending their personal biases and channeling them to avoid impeding the counseling alliance.

Additionally, Participants A1, A2, A3, and A4 said that counselors need to know ethnic minority clients' histories to help them effectively. The current literature emphasizes the importance of counselors comprehending a client's racial history as a counseling implication (Hook et al., 2016; Jordan, 2009; Kress et al., 2018; Mazzula & Nadal, 2015). When counselors comprehend and accept clients' lived encounters in counseling, it can foster healthy therapeutic alliances (Haskins & Appling, 2017; Knight, 2013; Nadal et al., 2017). A1, A2, and A4 felt that a counselor of their ethnicity was appropriate to receive equality during counseling session(s).

The current research also presented implications for counselor educators and

supervisors charged with teaching counselors-in-training and novice counselors in regard to working with clients from various backgrounds. Therefore, a final recommendation would be for counselor educators and supervisors to stay current on empirical findings on this topic to inform their students and supervisees in regard to them. Counselors could also do a better job of motivating clients to share positive counseling encounters with their support networks to help decrease the stigma of mental health counseling in ethnic minority communities. A part of this negative counseling stigma came from slavery when White people were the ones with access and money to afford counseling and other health services, while ethnic minority individuals depended entirely on their self-confidence and internal strength to cope with stressors (Holder et al., 2015). However, post-civil rights era, many ethnic individuals gained access to counseling, but the stigma surrounding it continued prevalent within the culture (Fripp & Carlson, 2017). Although current studies supports some of these suggestions (Bowleg et al., 2013; Kress et al., 2018; Mazzula & Nadal, 2015), it is helpful to hear from ethnic minority people that these are what they have or would find effective in counseling.

Conclusion

The outcome depicted how ethnic minority clients were subjected to microaggressions in counseling session(s) in the United States. Four ethnic individuals who encountered racial microaggressions were willing to share their encounters and provided implications for counselors working with ethnic minority clients. Hearing directly from minority clients or potential clients of counseling concerning what will be helpful to them in counseling gives counselors a non-clinical perspective on how to

enhance their interventions to meet the needs of their minority clients. It is not possible for all members of the counseling profession to have awareness or competence in all areas of counseling. However, the more active role counseling professionals take in enhancing their awareness and skills, the better professionals they will be to the individuals they serve. Research scholars in the counseling profession frequently collect data from counselors to inform their work which may or may not be beneficial for enhancing counseling disparities. Therefore, in this dissertation study, hearing directly from ethnic minority clients about what would be beneficial to them in counseling provides counselors a non-clinical perspective on how to enhance their interventions to meet the essentials of their ethnic minority clients.

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Appendix A: Invitation to Participant

Dear Sir/Madam

My name is _____. I am a doctoral student at Walden University. I am presently performing a research study to comprehend how ethnic minority individuals experience covert and subtle forms of microaggressions(bias) in counseling. I would appreciate your voluntary participation in an interview. The interview on Zoom will be audio recorded.

- Will take about one (1) hour
- Interview will be performed through Zoom, at a time and date that is convenient for you.
- Interview volunteers will later be emailed the date and time of their interview session at least 2 weeks in advance for confirmation. $3 E-Gift card after completion of study.
- Data from each interview will be kept strictly confidential.
- No one who participates will be identified in any of the research report.
- All people in this study will be **adults** since they can provide their own consent for treatment and identify as ethnic minorities male/female.
- Participation in this study is voluntary and can be discontinued by the participant at any time.

If you are interested in participation and believe that you meet eligibility, to receive the consent form please email me at XXXX.XXXXXX.XXXXXXX.XXX Thank you in advance.

Best regards,

XXXX XXXXXX

Appendix B: Interview Guide & Questions

Introduction

• Welcome the participant and introduce myself.

• Explain the general purpose of the interview and why the participant was chosen.

• Explain the concept of racial microaggressions.

• Discuss the purpose and process of the interview.

• Explain the purpose of recording the interview

• Outline general rules and interview guidelines such as being prepared for the interviewer to interrupt to make sure all the topics can be covered within the allotted time.

Review break schedule

• Address the issue of confidentiality.

• Inform the participant that information discussed is going to be analyzed as a whole and participant's name will not be used in any analysis of the interview.

Discussion Purpose

The purpose of this research is to explore the lived experience of racial microaggressions in counseling sessions.

Discussion Guidelines

The interviewer will explain the following: Please respond to the questions and if you don't understand the question, please let me know. I am here to ask questions, listen, and answer any questions you might have. If we seem to get stuck on a topic, I may interrupt you. I will keep your identity, participation, and remarks private. Please speak

openly and honestly. This session will be tape recorded because I do not want to miss any comments.

General Instructions

When responding to questions that will be asked of you in the interview, please exclude all identifying information, such as your name and other parties' names. Your identity will be kept confidential and any information that enables identification will be removed from the analysis.

Interview questions

1. What are some of the personal thoughts and feelings that helped you continue counseling?
2. What was it like for you to decide that you were being treated with microaggression (bias) by your counselor?
3. Was there anything significant that impacted you wanting to stay in counseling?
4. Describe the emotions that occurred when making the decision to terminate the relationship?
5. What was your reason to continue to stay/or terminate counseling?
6. Share with me the factors that lead to your choice of a counselor or did you feel like you had choices?
7. Describe what it was like in the counseling office?
8. Tell me about your experience during informed consent and required paperwork?
9. Share with me what was your first session experience?
10. Tellme how it felt as an ethnic individual client with the office staff?
11. What was your experience like with the office staff, if there was office staff?
12. Share with me the goal setting process, if there were any goals, and if you met any of the goals personally or in counseling?
13. Explore what it was like for you to set goals with the counselor?
14. If there were no goals, what was it that hindered setting them?
15. Explain what the relationship with the counselor was like for you?
16. Tell me about any positive experiences you had with the counselor?

17. Was there anything that you enjoyed about the counseling relationship?
18. Explain any negative encounters or things that you disliked about the counseling relationship?
19. Share with me your feelings and thoughts about whether you thought the counselor had adequate training to deal with the mental health issues you bought forward.
20. Did you feel understood? If so, tell me more. If not share with me more about feeling misunderstood.
21. Tell me more about the remaining sessions that you had with the counselor?
22. What, if any, were some of the social influences that impacted your reason for termination in counseling for the length of time that you stayed?
23. What, if any, counselor attribute regarding cultural humility or a lack thereof kept you engaged in the counseling setting or deterred you from furthering your counseling process? (Cultural humility being a term that means the counselor understood your identification and culture from a much deeper understanding than just basic knowledge).
24. What solution would you recommend to counselors?

Conclusion

Discuss the transcript clarification process with the participant, answer any questions, and thank the participant for his/her time.

Goodbye

Appendix C: Demographic Questions

1.What is your age?

2. What is the highest level of education you have completed?

3. What is your race and ethnicity?

4. Are you employed?

5. How would you classify the type of job you have?

6. Are you a United States citizen?

Thank you.