Original Article

Topical Issue: The Elephant in the Room – Contributions of Psychology to the Study of Racism in Europe

Racial Microaggressions in Psychotherapy Dyads

Addressing Subtle Forms of Racism Mitigates Their Negative Relation With Working Alliance and Improvement

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Abstract: *Background:* Microaggressions are associated with negative health-related outcomes, and they can affect the quality of health care. There is limited evidence regarding the prevalence of microaggressions and their impact within psychotherapies, especially outside of the United States. *Research Question:* This work examines the occurrence of racial microaggressions within German psychotherapies, their relation to client-rated working alliance and treatment outcome, and the moderating role of subsequently addressing them. *Method:* Racially minoritized individuals (N = 209) who were currently in therapy or terminated within the last year reported their experiences in an online survey. *Results:* Most participants reported microaggressions from their therapists. Microaggressions were negatively linked to therapeutic working alliance and perceived improvement. These effects diminished when therapists effectively addressed previous microaggressions. *Conclusions and Implications*: Therapists may inadvertently perpetuate racism but are both responsible and capable of intervening once a microaggression has occurred. At an institutional level, this requires antidiscriminatory training and supervision.

Keywords: microaggressions, cultural ruptures, working alliance, therapy outcome, antiracism

Experiences of racism and other forms of discrimination are associated with impaired physical and mental health of minoritized individuals (for meta-analyses, see e.g., Paradies et al. 2015; Pascoe & Smart Richman, 2009). Theoretical models considering racism as a causal pathogenic factor (e.g., Harrell, 2000) are supported by growing longitudinal evidence (Paradies et al., 2015). This highlights a particular need for adequate mental health care within racialized groups. However, despite their higher psychosocial need, they are less likely to access (for reviews, see Priester et al., 2016; Taylor & Kuo, 2019) or to successfully complete psychotherapeutic treatment (Wierzbicki & Pekarik, 1993). Therefore, it is imperative to illuminate race-based discrimination ingrained in (mental) health care (i.e., institutional racism), including subtle forms that are often neglected or denied (Givens, 2022; Roig, 2017; D. W. Sue et al., 2007).

Racial microaggressions are defined as brief verbal, behavioral, or environmental offenses occurring on a daily basis. Such offenses, whether intentional or unintentional, convey hostile, derogatory, or negative racial slights to the targeted individual or group (for an evidence-based taxonomy, see Williams et al., 2021). They are experienced in interpersonal contexts through behaviors and statements (e.g., asking a person where they are really from) or are elicited by the environment (e.g., missing representation of minoritized individuals in educational materials). Unlike overt forms of racism, microaggressions are more ambiguous or subtle. Nevertheless, their accumulative adverse impact on a wide range of mental health indicators has been empirically demonstrated (for reviews, see Lui & Quezada, 2019; Owen et al., 2019; Wong et al., 2014). Qualitative (Wong et al., 2014), longitudinal (Goreis et al., 2024; Ong et al., 2013; Torres et al., 2010), and experimental studies (Fischer et al., 2017; Goreis et al., 2022; Tran & Lee, 2014) support a causal relation. Alarmingly, a majority of minoritized clients in the United States report experiencing racial microaggressions within psychotherapeutic settings

(Owen et al, 2019). For example, therapists may attribute (understandable) emotional reactions to a client's ethnic or cultural identity, pathologize their family systems, or dismiss their racist experiences. This might threaten both the therapeutic process and its outcomes.

One of the most extensively studied process variables associated with therapy success is the therapeutic working alliance characterized as agreement on goals, tasks, and an emotional dyadic bond (Bordin, 1979; Flückiger et al., 2018). Crucially, all studies on racial microaggressions within therapeutic dyads found negative associations between perceptions of racial microaggressions and the client-rated working alliance (for a review, see Owen et al., 2019).

The experience of microaggressions is associated with less therapeutic success or improvement (Davis et al., 2016; Kivlighan et al., 2021; Owen et al., 2019), therapy satisfaction (Constantine, 2007), and psychological well-being (DeBlaere et al., 2023; Owen et al., 2011, 2014). Moreover, the risk of dropping out of therapy is elevated according to qualitative work (Aikins et al., 2021; Yeo & Torres-Harding, 2021).

Several authors have drawn parallels between these findings and research on general alliance ruptures (e.g., Eubanks et al., 2018; Owen et al., 2011; Yeo & Torres-Harding, 2021). Meta-analyses demonstrated that general alliance ruptures negatively affect treatment outcomes only if unresolved but are positively associated with treatment outcomes if successfully resolved (Eubanks et al., 2018; Safran et al., 2011). This raises the question if therapists can mitigate potential harmful effects of microaggressions by addressing them. Indeed, initial evidence from the United States supports this notion (Owen et al., 2014). The quality of the client-reported working alliance in therapeutic dyads in which therapists successfully addressed said microaggressions (n = 12) was significantly higher compared to dyads in which they did not address them (n = 12) and equal to dyads in which microaggressions were not reported at all (n = 51; Owen et al., 2014).

The discourse on race and racism within clinical psychology is predominantly shaped by a US perspective (see e.g., American Psychological Association, 2021), potentially overlooking specific characteristics of European racism (e.g., externalization to right-wing extremism, other nations, or the past; Givens, 2022; Roig, 2017; Salem & Thompson, 2016). Due to its historical context, European racism is discussed to be less color-coded and more strongly influenced by aspects of nationality, migration, religion, and culture (Givens, 2022; Roig, 2017; Salem & Thompson, 2016). Therefore, it is crucial to investigate whether the reviewed findings are applicable to the German context. We are not aware that microaggressions have been directly studied within European psychotherapeutic practices. However, three qualitative studies allow to conclude that microaggressions may also be present in European therapies (e.g., avoidance of race-related topics; Gurpinar-Morgan et al., 2014; Messent & Murrell, 2003; Sarr, 2024). Recent quantitative studies conducted in Germany support this notion: Racialized individuals experience racism within the health care system, possibly as soon as they request a psychotherapeutic consultation (Deutsches Zentrum für Integrations- und Migrationsforschung, 2023). Furthermore, almost two-thirds of Black clients in Germany reported that their experiences of racism were questioned during psychotherapy (as measured with one item; Aikins et al., 2021).

The Present Study

Against this background, the present study is the first to directly and quantitatively assess a wider set of racial microaggressions specifically within German psychotherapy. By replicating and generalizing findings from the United States, their applicability to a Western European context is examined, enabling the identification of potential therapeutic implications.

We hypothesize that experiencing racial microaggressions in therapy will be negatively correlated with client-rated working alliance (Hypothesis 1a) and perceived improvement from therapy (Hypothesis 1b). Furthermore, we predict that clients' perceptions of whether racial microaggressions were adequately addressed and resolved with therapists will moderate both the relationship between microaggressions and working alliance (Hypothesis 2a), and the relation between microaggressions and perceived improvement (Hypothesis 2b). Specifically, we anticipate that addressing microaggressions will weaken both negative relationships.

Methods

Participants

Based on prior findings (Owen et al., 2014), we expected a small effect. An a priori power analysis using G*Power (Faul et al., 2009) resulted in a target sample size of N = 199 to test one of three predictors with 80% power and a 5% α-level. To account for exclusions, we aimed for N = 250. In total, 252 people completed the survey. We excluded participants whose therapy ended longer than one year ago (n = 41) or who identified as solely White without migratory background and German as their only native

language (n = 2). The final sample consisted of N = 209 participants (78% female, 15% male, 9% personally rejected gender categorizations, 2% diverse) with a M_{age} of 28.1 years (SD = 6.6). The mean estimated therapy length in the sample was 19.4 months (SD = 18.1). Table 1 shows variables related to clients' ethnicity and race. Demographic and therapy-related sample information is reported in Table E1 in Electronic Supplementary Material 1 (ESM 1).

Table 1. Variables related to clients' ethnicity, race, and therapy

Variable	*n*	%
Ethnic self-identification		
Person of color	106	51
Black	37	18
Muslim	46	22
Afro–German	32	15
Arabic	28	13
White	28	13
Turkish–German	27	13
Polish–German	8	4
Russian–German	6	3
Jewish	3	1
Russian–Jewish	3	1
Not sure	10	5
Other	56	27
Anticipated attribution by others as German		
No	167	80
Yes	22	11
Not sure	20	10
Migratory background		
Parental	172	82
Own	31	15
None	6	3
Native language		
German and at least one more language	89	43
German only	80	38
Learned German as a second language	40	19
Therapy type		
Cognitive behavioral psychotherapy	106	51
Psychodynamic psychotherapy	55	26
Psychoanalytic psychotherapy	26	12
Systemic psychotherapy	9	4
Other	8	4
Not sure	5	2
Therapy status		
Ongoing	128	61
Terminated within the last year	81	39
Dropout		
No	165	79
Yes	44	21

The sample was predominantly recruited through social media complemented by mailing lists of migrant organizations and academia as well as flyer distribution at the university campus, psychotherapeutic practices, and intercultural centers. Given the comparably small size of the target population (Rommel et al., 2017), we relied on multiplicators for recruitment. That is, we specifically advertised via channels with a broader influence on the intended population including social media profiles and organizations with content related to discrimination, racism, and antiracism work. Upon completing the study, participants could enter their email addresses for a chance to win gift vouchers.

Procedure and Materials

After giving informed consent, participants completed a series of questionnaires and reported demographic as well as therapy-related information. All items assessing data related to categories of discrimination were constructed based on recent national guidelines (Baumann et al., 2018). We measured clients' ethnicities and race using items based on self-identification, anticipated attributions by others, and institutional ascriptions (migratory background) of ethnicity to adequately capture racial experiences (Nesterko et al., 2019). Participants further indicated perceived ethnic similarity toward their therapist on a continuous scale relative to their self-ascribed ethnicity ranging from 1 (*not at all similar*) to 5 (*very similar*). At the end of the survey, they received a debriefing giving information about microaggressions in general and suitable contact points for those affected.

Racial Microaggressions in Counselling Scale (RMCS; Constantine, 2007)

Perceptions of racial microaggressions in therapy were measured with a German translation of the Racial Microaggressions in Counselling Scale (RMCS; Constantine, 2007) as adapted by Owen et al. (2014). The RMCS is a 10-item measure that assesses clients' perceptions of their therapists' behavior related to race or ethnicity. Participants rate each item on five-point Likert-type scales in terms of frequency ("How often did the situation occur?") ranging from 1 (*never*) to 5 (*always*) and impact ("If this occurred, how much did it bother you?") ranging from 1 (*not at all)* to 5 (*very much*). Adapted from Owen et al. (2014), a total score can be calculated ranging

from 1 (*never experienced microaggressions*), over 2 (*experienced microaggressions and did not bother me at all*) up to 6 (*experienced microaggressions and bothered me very much*). We relied on a back-to-back translation process executed by clinical psychologists fluent in German and English and an expert in multilingual communication (for details, see ESM 2). In previous studies, Cronbach's α was above .85 for the frequency, impact, and total score (Hook et al., 2016; Kivlighan et al., 2021; Owen et al., 2014). In the current study, Cronbach's α for the German version was excellent for all three scores ($\alpha_{frequency}$ = .92, α_{impact} = .91, and α_{total} = .92).

We supplemented the measurement of in-therapy microaggressions with two additional items. On the same two scales as above (frequency and impact), participants responded to the following forced-choice item: "Did your therapist exhibit any other similar behaviors concerning your ascribed cultural or ethnic identity?" If this occurred, participants could elaborate on the situation in an optional open-ended item.

Addressing Ruptures in Therapy (ART)

Building upon the work of Owen et al. (2014) and in line with rupture resolution literature (Safran & Muran, 1996), we developed the four-item questionnaire "Addressing Ruptures in Therapy" (ART) to assess the extent to which microaggressions (i.e., cultural ruptures) were addressed in therapy and successfully resolved by their therapists from a client's perspective (e.g., "My therapist and I were able to discuss the situation in a way that made me feel comfortable"). Participants rated items on a Likert-type scale ranging from 1 (*never*) to 5 (*always*). Thus, higher scores indicate a higher frequency of successful discussions of the situation as perceived by clients (for a detailed description of the scale, see ESM 2). The ART was exclusively presented to participants who reported racial microaggressions. Cronbach's α was excellent in our sample (α = .90).

The German Version of the Working Alliance Inventory – Short Revised (WAI-SR; Wilmers et al., 2008)

The WAI-SR (Wilmers et al., 2008) is a validated German version of the well-established client version of the WAI-SR (Hatcher & Gillaspy, 2006). It consists of 12 items assessing Bordin's (1979) three dimensions of the therapeutic alliance (bond, tasks, and goals) on a five-point Likert scale ranging from 1 (*rarely*) to 5 (*always*). The German version of the WAI-SR has shown good internal consistencies for all subscales (Wilmers et al., 2008). In the current study, Cronbach's α for the total score was α = .95.

Patient's Estimate of Improvement (PEI; Hatcher & Barends, 1996)

We measured client-perceived improvement resulting from therapy using a translated version of the PEI (Hatcher & Barends, 1996). Perceived improvement is measured as change across various domains, such as general functioning, symptom distress, intimate relationships, general social life, work or school, feelings about oneself, behavior, control of life, tolerance for painful feelings, and ability to share feelings regarding one's therapist (e.g., "How much do you feel your behavior has changed as a result of psychotherapy?") on nine-point Likert-type scales ranging from 1 (*very much worse*), over 5 (*no change*), to 9 (*very much better*). Further items assess perceived helpfulness, benefit, productivity, satisfaction, and perceived change resulting from therapy, such as "How unhelpful or helpful has therapy been to you?"

The PEI has been used in the context of racial microaggressions in therapy and cultural humility research (Davis et al., 2016; Kivlighan et al., 2021) as well as in general psychotherapy research (e.g., Owen & Hilsenroth, 2011). It is associated with pre-post symptom change (Owen & Hilsenroth, 2011) and exhibits high internal consistencies across studies (e.g., Davis et al., 2016; Kivlighan et al., 2021). For the current study, we back-to-back translated the PEI as described above. Cronbach's α in the current sample was excellent (α = .96).

Analytical Strategy

We ran all analyses using the statistical software R (R Core Team, 2023). A total microaggression score was computed according to Owen et al. (2014), and the distribution of the data was examined for normality. We assessed the validity of the translated and self-developed questionnaires conducting item and exploratory factor analyses. For hypotheses 1a and 1b, bivariate Spearman rank correlations were calculated in the full sample (N = 209). Multivariate regression analyses were applied to test hypotheses 2a and 2b within the subsample of participants reporting microaggressions (n = 175). All predictors were mean centered.

To test the robustness of the hypotheses, all analyses were repeated with the RMCS frequency score and with therapy length as an additional predictor (see ESM 1). An exploration of the role of ethnic similarity on perceptions of microaggressions as well as on hypothesis 1a and 1b was also conducted. Finally, group differences in RMCS scores between participants who dropped out of therapy and those who did not were compared exploratorily with Mann–Whitney U tests. Access to all analyses is available at https://osf.io/3e5qc.

Results

Preliminary Analyses

Item and factor analyses yielded a one-factor solution for the RMCS and ART, respectively (see ESM 2). For the planned multivariate regression analyses testing hypotheses 2a and 2b, regression diagnostics suggested that all statistical assumptions were met. Residuals were normally distributed, relationships were linear, homoskedasticity was given, multicollinearity was not an issue (all VIFs below 5), and no outliers that were characterized as influential data points were detected.

Primary Analyses

In total, 84% of all participants reported the occurrence of microaggressions elicited by their therapists (RMCS frequency score > 1). Of all participants reporting microaggressions, 53% reported that microaggressions were never or very rarely addressed adequately by their therapists (ART mean ≤ 2.5). Descriptive item statistics for the RMCS including proportions of participants reporting specific microaggressions are reported in Table E3 in ESM 2. The most frequently reported microaggression was the therapist's "unawareness of the realities of race and racism" (68%). *Mdn*, *M*, *SD*, and correlations among all dependent and independent variables are reported in Table E2 in ESM 1. Perceived microaggressions were associated with a lower working alliance score ($r = -.46$, $p < .001$) and less perceived improvement ($r = -.34$, $p < .001$). Addressing of microaggressions was positively associated with both working alliance ($\beta_{ART} = 0.49$, $p < .001$, $\eta_p^2 = .21$; see Table 2) and perceived improvement ($\beta_{ART} = 0.48$, $p < .001$, $\eta_p^2 = .10$; see Table 3). Furthermore, it was associated with a less negative effect of microaggressions on both dependent variables (working alliance: $\beta_{RMCS*ART} = 0.07$, $p = .014$, $\eta_p^2 = .04$, see Table 2; perceived improvement: $\beta_{RMCS*ART} = 0.18$, $p = .008$, $\eta_p^2 = .05$; see Table 3). To further investigate this moderation, we conducted follow-up simple slope analyses (see Figure 1). The Johnson–Neymar technique (Finsaas & Goldstein, 2021) indicated that microaggressions were only associated with lower working alliance if they were not successfully addressed (i.e., values on the ART measure were below 3.8). Similarly, microaggressions were only linked to less improvement if they were not successfully addressed (i.e., values on the ART measure were below 3.2).

Exploratory Analyses

When rerunning the main analyses replacing the RMCS total score with the frequency score, all hypotheses were confirmed again (for details, see ESM 1). Additionally, we repeated our main analyses controlling for estimated therapy length. While the observed main effects remained significant, the interaction of ART and RMCS no longer reached significance (for details, see ESM 2). Estimated therapy length was associated with higher alliances ($r = .26$, $p < .001$) and higher perceived improvement ($r = .34$, $p < .001$).

Most participants ($n = 158$) described their therapist's ethnicity as not at all similar to their own. Perceived ethnic similarity and the occurrence of microaggressions were weakly correlated ($r = -.14$, $p = .045$). However, when

Table 2. Results of multiple regression on WAI scores

Predictor	*b*	β	95% CI	*t*	*p*	η_p^2	*r*	Partial *r*
(Intercept)	3.63	0.11	[−0.03 to 0.23]	57.38	<.001			
RMCS	−0.21	0.32	[−0.46 to 0.18]	−4.52	<.001	.11	−.61	−.32
ART	0.37	0.49	[0.35–0.64]	6.66	<.001	.21	.64	.45
RMCS * ART	0.09	0.16	[0.04–0.29]	2.62	.009	.04	−.06	.20

Note. WAI = Working Alliance Inventory, RMCS = Racial Microaggression in Counselling Scale, ART = Addressing Ruptures in Therapy, $n = 175$, $F(3,171) = 56.69$, $p < .001$, adjusted $R^2 = .49$, *b* = unstandardized regression weight, β = standardized regression weight, CI = confidence interval.

Table 3. Results of multiple regression on PEI scores

Predictor	*b*	β	95% CI	*t*	*p*	η_p^2	*r*	Partial *r*
(Intercept)	6.58	0.14	[−0.02 to 0.29]	56.54	<.001			
RMCS	−0.29	−0.27	[−0.43, −0.11]	−3.29	.001	.06	−.48	−.33
ART	0.44	0.38	[0.21, 0.55]	4.38	<.001	.10	.48	.45
RMCS * ART	0.18	0.22	[0.07, 0.36]	3.00	.003	.05	.04	.20

Note. PEI = Patient's Estimate of Improvement, RMCS = Racial Microaggression in Counselling Scale, ART = Addressing Ruptures in Therapy, $n = 175$. $F(3,171) = 26.5$, $p < .001$, adjusted $R^2 = .31$, *b* = unstandardized regression weight, β = standardized regression weight, CI = confidence interval.

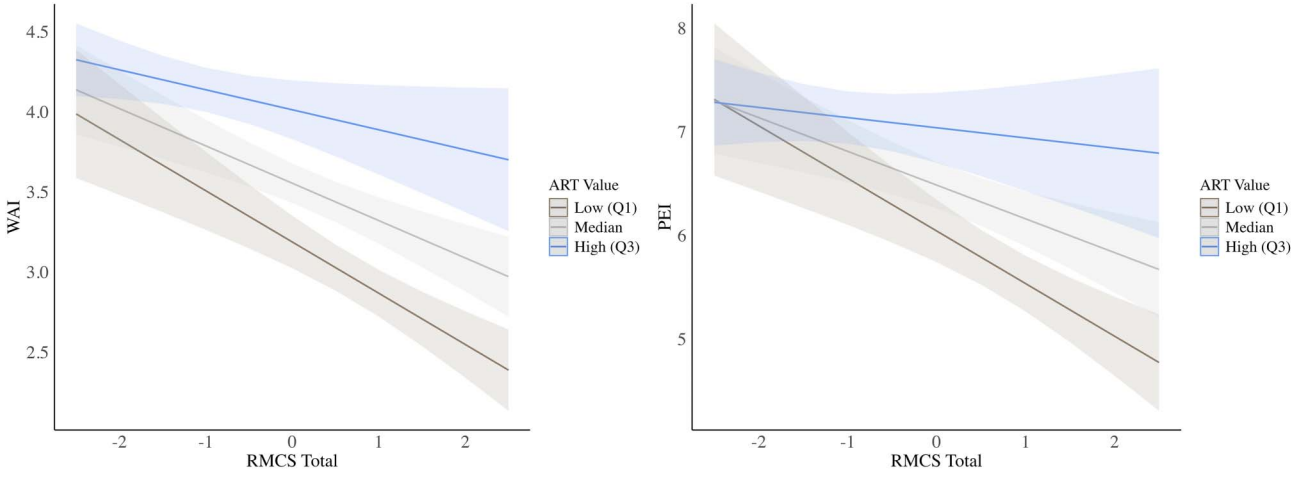

Figure 1. Plotted simple slopes of ART quartiles for WAI (left) and PEI (right). The *x*-axis is centered. ART = Addressing Ruptures in Therapy, RMCS = Racial Microaggressions in Counselling Scale, WAI = Working Alliance Inventory, PEI = Patient's Estimate of Improvement.

exploratorily adding ethnic similarity into our main analyses, we find that it neither predicts working alliance nor perceived improvement (for details, see ESM 1). Finally, participants who reported having dropped out of therapy (n = 44) reported higher perceptions of microaggressions (Mdn = 4.3, SD = 1.4) compared to those who did not dropout ($Mdn = 2.3$, $SD = 1.5$; $U = 5{,}585.5$, $p < .001$, $r = -.36$).

Discussion

The present study quantitatively investigates the occurrence and potential implications of racial microaggressions in German psychotherapies. Our goal was to replicate and extend US findings and examine their generalizability. The results highlight that the majority of racially minoritized clients report the experience of microaggressions elicited by their therapists. As hypothesized, clients' perceptions of microaggressions are related to a weaker working alliance and less perceived improvement from therapy. Addressing these microaggressions mitigated their negative impact on both the working alliance and perceived improvements.

The high rate of perceived microaggressions is consistent with studies from the United States reporting frequencies between 53% and 89% (Davis et al., 2016; DeBlaere et al., 2023; Hook et al., 2016; Kivlighan et al., 2021; Owen et al., 2014; Yeo & Torres-Harding, 2021). The experience of racial microaggressions in therapy should therefore not be considered a phenomenon exclusive to the US psychotherapy setting. Interestingly, clients in the present study primarily reported that their therapists were unaware of the realities of race and racism. In contrast, studies conducted in the United States have consistently reported that a therapist's avoidance of discussing cultural issues was the most prevalent form of microaggressions (DeBlaere et al., 2023; Hook et al., 2016). Although strictly descriptive, these results resemble the sociological idea of unawareness and denial being characteristic of European racism in particular (Lentin, 2008; Roig, 2017; Salem & Thompson, 2016). Ultimately, it becomes evident that racism in the form of racial microaggressions is reproduced even in the seemingly safe setting of psychotherapy. Arguably, the microaggressions reported in our sample can be understood as interpersonal indicators of a broader phenomenon, namely institutional racism within (clinical) psychology and psychotherapy (Jones & Rolón-Dow, 2019). They may be unintended and appear subtle but their experience within the therapy dyad adds to the accumulated experiences minoritized clients collect in their daily lives (Lui & Quezada, 2019). Arguably, by failing to actively counter structural and institutional racism, this could contribute to its reinforcement (Williams et al., 2022).

Experienced microaggressions were negatively related to working alliance and improvement due to therapy. The strength of these associations is consistent with previous studies conducted in the United States (for a review, see Owen et al., 2019). Based on a German sample, the current study extends the generalizability of these findings to a psychotherapy setting in Europe.

The results also show that addressing microaggressions has the potential to diminish these negative effects on the working alliance and perceived improvement. In fact, both effects were no longer significant when successfully addressed by therapist which is consistent with Owen et al. (2014) and aligns well with robust findings from rupture resolution research (Eubanks et al., 2018; Safran et al., 2011). Thus, it is important to strive for effective handling of microaggressions in psychotherapy.

Client-perceived ethnic similarity was mildly correlated with lower perceptions of microaggressions. If controlled for microaggressions, it was not associated to working alliance or perceived improvement. This is congruent with a meta-analysis suggesting that overall treatment outcomes are usually not associated with therapist ethnicity (Cabral & Smith, 2011) and highlights the need to prioritize more proximal factors (i.e., processes within the therapeutic dyad) to understand potential threats to a fair provision of care (S. Sue, 1988).

Clients who dropped out of therapy reported more microaggressions. Interpreted causally, this finding may at least partially explain meta-analytical findings identifying racially minoritized clients at higher risk for dropout (Wierzbicki & Pekarik, 1993). Indeed, in qualitative interviews conducted in both the United States (Yeo & Torres-Harding, 2021) and Germany (Aikins et al., 2021), participants also reported ending therapy due to in-therapy racial microaggressions.

Limitations and Future Directions

Of course, these findings do not come without some limitations. First, a cross-sectional, correlational design does not allow for causal inferences on the observed associations. Nonetheless, some evidence for the causal impact of microaggressions outside of therapeutic settings stems from qualitative (Wong et al., 2014), longitudinal (Goreis et al., 2024; Ong et al., 2013; Torres et al., 2010), and experimental studies (Fischer et al., 2017; Goreis et al., 2022; Tran & Lee, 2014). To date, only one longitudinal study has shown that moments of low state cultural humility in therapists (i.e., demonstrating a lack of awareness, understanding, and respect for cultural differences in specific situations or interactions, possibly indicative of the occurrence of a microaggression) precede decreases in the working alliance (Dixon et al., 2022). Future research is needed to investigate the impact of racial microaggression on subsequent measures of therapy processes. Experimental studies could also implement interventions targeting therapists' management of microaggressions and examine their effects within the therapeutic dyad.

Second, the sample was obtained using online convenience sampling, supported by multipliers involved in antiracism work resulting in a predominately female, highly educated sample (see Table E1 in ESM 1). The recruited participants might have been able to recognize microaggressions with above-average accuracy. Conversely, we failed to recruit less privileged individuals who potentially experience microaggressions more frequently. Either way, the generalizability to minoritized clients outside our cohort might be limited and the effect sizes presented here must therefore be interpreted with caution. However, previous studies relying on a recruitment in the context of counseling centers (Constantine, 2007; Owen et al., 2011, 2014) or organized by a panel provider (Hook et al., 2016) showed comparable but smaller base rates of microaggressions.

Furthermore, the assessment of microaggressions neglected intersectional phenomena. Characteristics such as gender, class, education, and especially language skills might have had varying influences. Future studies should systematically investigate intersections of racial microaggression.

Another bias that has been criticized before is that almost all studies conducted in broader microaggression research rely on self-reports from those experiencing them (i.e., mono-source bias; Lilienfeld, 2017; Lui & Quezada, 2019). Unfortunately, therapists themselves might fail to recognize more subtle ruptures in general (Eubanks et al., 2018) and are inaccurate in detecting microaggressions of colleagues (Owen et al., 2018). Future research would benefit from the implementation of valid and reliable observer-based rating systems.

We used a retrospective design and time that passed since the last therapy session varied between participants. We restricted this variation by only including clients who were still in therapy (63%) or ended therapy not longer than a year ago (37%). In addition, the effect of estimated therapy length was analyzed. Previous studies have shown that retrospective self-reports in psychotherapy research are generally consistent with prospective (Howard et al., 2001) and pre-post assessments (Flückiger et al., 2007). In addition, the present results align well with self-reports from microaggression research during ongoing therapies (Constantine, 2007; Kivlighan et al., 2021; Owen et al., 2011, 2014). However, assessments of potential microaggressions immediately after each session would constitute a promising direction for future research.

We demonstrated that a one-factor solution is suitable for the German version of the RMCS (see ESM 2). Item analyses revealed deficits in some of the translated items. These might stem from differences between the German and US sociocultural context and highlight the need for future research and possible adaptations.

Implications

Most racially minoritized clients report that their therapists commit microaggressions. The prevention of microaggressions should thus be a key objective. However, rather than exclusively striving for complete avoidance, a more constructive approach may lie in openly acknowledging and addressing microaggressions in a collaborative manner (Yeo & Torres-Harding, 2021). In other words, while the complete elimination of microaggressions in

therapy may not be a realistic goal, effective therapy remains attainable as long as therapists can identify, acknowledge, and address them appropriately. Consequently, therapists should take responsibility for developing these individual competencies to (re-)establish antidiscriminatory spaces (Bundespsychotherapeutenkammer, 2024; Williams et al., 2022). Arguably, these should incorporate a critical confrontation with whiteness, the privileges it provides, and the power imbalances it creates. However, the Federal Chamber of Psychotherapists only very recently suggested that human diversity must be considered in psychotherapy (Bundespsychotherapeutenkammer, 2024). Consequently, the majority of therapists (in training) does not feel prepared to address clients' experiences with discrimination (Krammer et al., 2024). Promising materials and trainings toward this endeavor, including the management of microaggressions, have already been developed (see e.g., Aggarwal & Lewis-Fernández, 2020; Schütteler & Slotta, 2023; Williams et al., 2022). The prevention of microaggressions can be further enhanced by the application of tools specifically designed to integrate diversity within therapy. For example, the DSM-5 Cultural Formulation Interview offers guidance for addressing race and culture in a client-centered manner, reducing the risk of overlooking these essential factors in etiology and treatment (Aggarwal & Lewis-Fernández, 2020). Furthermore, managing microaggressions when they occur could become a key component of psychotherapy training, incorporating structured interventions to improve therapists' abilities to both detect and repair them.

Conclusions

Racial microaggressions are a much too common phenomenon within psychotherapeutic dyads and are associated with both a weaker working alliance and less improvement from therapy. When therapists successfully address racial microaggressions, these negative effects diminish. To provide adequate treatment for minoritized clients in an increasingly racist societal climate (Givens, 2022), therapists must reflect their own biases and develop antiracist competencies and stances. Our profession must address racism not only on an individual level, but also systemically through training, supervision, and research.

Electronic Supplementary Material

The following electronic supplementary material is available with this article at https://doi.org/10.1027/2151-2604/a000588

ESM 1. Descriptives and additional analyses.

ESM 2. Item and factor analyses.

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