

Microaggressions and the Enduring Mental Health Disparity: Black Americans at Risk for Institutional Betrayal

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Abstract

Despite federal focus on reducing mental health disparities for Black Americans, mental health disparities persist, resulting in reduced access to and benefit from mental health care. Amid calls for deeper examination of etiology, the current literature review introduces discrimination in the form of microaggressions at the institutional level as one changeable systemic cause for mental health disparities. In combining the mental health disparity and microaggression literatures, I first review the evidence regarding prevalence and contributing factors for current mental health disparities and microaggressions. Next, I examine the potential contributing role that microaggressions as a form of institutional betrayal within mental health care may play in perpetuating these disparities. Finally, I review implications regarding the particular role of mental health care systems, the field of psychology in general, and Black American psychologists specifically in systematically reducing mental health disparities for Black Americans.

Keywords

mental health, mental health disparities, discrimination, microaggressions, African Americans, institutional betrayal

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"It's been a long, long time coming, but I know a change is gonna come."—
Sam Cooke

Though multiple ethnic/racial groups suffer from mental health disparities as compared to their White counterparts in the United States (e.g., Snowden, 2012), Black Americans may be particularly vulnerable given their historical and present social status in society. As R. M. Sellers, Smith, Shelton, Rowley, and Chavous (1998) note, Black Americans' experience of inequality is distinct from that experienced by other cultural minorities due to slavery and subsequent laws that relegated Blacks to lowered status (e.g., second-class citizenship). Indeed, many of the stereotypes about Black Americans from the slavery and Jim Crow eras persist today, including assumptions of lower intelligence, lower class, and criminality (Watkins, LaBarrie, & Appio, 2010). Consequently, anti-self images—that is, internalized racism—may additionally plague some Black Americans (Mariette, 2013). Perhaps because of this reality, Black Americans—particularly those whose families can be traced back to these eras—are less likely to trust treatment options that are created and delivered by members of the dominant culture (Carpenter-Song et al., 2010), as options such as therapy may be a form of cultural oppression (D. W. Sue, 1978).

New theoretical approaches are needed to further explain the reasons behind these mental health disparities (Chavez, Shrout, Alegria, Lapatin, & Canino, 2010), as examining contributing factors is more beneficial than relying on between-group differences that do not provide explanations for these differences (Rosenthal & Wilson, 2012). Given the widespread nature of perceived discrimination, as well as its association with mental disorders (Pascoe & Smart Richman, 2009), this review utilizes the concept of institutional betrayal (Smith & Freyd, 2013) in combining two literatures—mental health disparities and microaggressions—to speculate about the contributing role that present day racism may have on utilization and efficacy of mental health services for Black Americans. Specifically, I will utilize institutional betrayal as a theoretical framework that offers testable hypotheses for understanding the potentially systemic nature of microaggressions and their role in perpetuating mental health disparities. By focusing on microaggressions, I am highlighting a specific changeable mechanism that could help reduce the mental health disparity for Black Americans.

An integrative review such as this is timely given that, despite the myth of a post-racial society, intergroup relations did not improve during President Obama's first term in office (Lybarger & Monteith, 2011), and in fact, negative opinions toward Black Americans have since increased (Valentino & Brader, 2011) for multiple reasons that are beyond the scope of this paper.

Consequently, microaggressions may be increasingly prevalent as a way for White Americans, particularly those who are privileged beyond or in addition to race, to perpetrate racism without having to take personal responsibility for their intentional or unintentional roles in inequality (D. W. Sue, Capodilupo, Nadal, & Torino, 2008), while simultaneously punishing those—typically people of color—who do confront microaggressions (Zou & Dickter, 2013).

Thus, in this review, I will first identify mental health disparities experienced by Black Americans while outlining some barriers to accessing services. Next, I will review the literature on microaggressions, detailing their known effects on Black Americans. I will then discuss the potential contributing role of microaggressions to current mental health disparities, with institutional betrayal (Smith & Freyd, 2013)—the role that depended-upon institutions, such as mental health care establishments, have in condoning, perpetuating, and perpetrating microaggressive practices—as a theoretical frame. Finally, I will conclude with wide and narrow scopes for active change that can help reduce mental health disparities for Black Americans.

Mental Health Disparities

Definition

Disparity has been defined as inequity in treatment opportunities that are changeable by health care providers (Alegría, Vallas, & Pumariega, 2010). Per this definition, disparities include poverty-related variables, such as violence, lack of food, and lack of insurance, while excluding clients' characteristics, such as groups' underestimated perceptions of need. However, the current review deliberately includes clients' characteristics in an effort to better understand the enduring inequity for Black Americans.

Critical Race Theory (e.g., Calmore, 1992; Solórzano, Ceja, & Yosso, 2000; Yosso, Smith, Ceja, & Solórzano, 2009) stresses the importance of experiential knowledge of people of color—that is, privileging and legitimizing counternarratives that may challenge the dominant ideology. Given that nearly 90% of psychologists and mental health practitioners in the United States are of the dominant group (American Psychological Association Research Office, 2002; Puryear Keita, 2006), these counternarratives are especially important when trying to understand the persistence of disparities despite large-scale federal efforts focused on benefitting Black Americans (e.g., Snowden, 2012; U.S. Department of Health and Human Services, 2001). Thus, the current review defines mental health disparities as inequity in treatment opportunities due to community and group characteristics, including unequal access to and benefit from quality—both efficacious and culturally appropriate—mental health care.

Evidence

Ethnic minorities generally receive poorer quality care (Alegría et al., 2010; Gone & Trimble, 2012; Harris, Edlund, & Larson, 2005; Institute of Medicine, 2002; Kales et al., 2000; Snowden & Yamada, 2005), and also experience greater psychological distress (Barrio et al., 2003; Proctor & Dalaker, 2003; Randall, Sobsey, & Parrila, 2001; S. Sue, 2003) than White Americans. Black and Latino/a Americans in particular are less likely than White Americans to receive mental health care (Cook, McGuire, & Miranda, 2007; Cook, McGuire, Lock, & Zaslavsky, 2010) and are disproportionately burdened with mental illness (Alegría et al., 2008; Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; U.S. Department of Health and Human Services, 2001; Wells, Klap, Koike, & Sherbourne, 2001; Williams et al., 2007). Even after adjusting for physical comorbidity (Cook, McGuire, Alegría, & Normand, 2011) and income (Snowden & Yamada, 2005), Black Americans are still subject to this disparity whereas Latino Americans are not—thereby suggesting that additional factors play a role in the enduring disparity for Black Americans specifically.

Barriers to Accessing Services

Multiple factors play a role in decreased access to care for Black Americans, such as clinician racial bias (D. W. Sue et al., 2007), preference for alternative treatment, level of trust in mental health care providers, receptiveness to treatment protocol, and self-stigma (Snowden & Yamada, 2005). While stigma may serve as a barrier to treatment in multiple American populations, the process of keeping mental illness within the family private may result from the salience of stigma for some Black Americans (Carpenter-Song et al., 2010), as well as the cultural values of family/relationship primacy (Schwartz et al., 2010). Additionally, given that the system of mental health care is dominated by the medical model, Black Americans, who are more likely to endorse nonbiomedical explanations for illnesses—behavioral, emotional, cognitive—may be increasingly critical of mainstream treatment options, favoring understanding over pathologization of transient feelings of sadness (Carpenter-Song et al., 2010).

There are also cross-cultural differences in definitions of and expectations for quality therapy. Black Americans emphasize the importance of therapists' listening and respecting the client, deeply understanding the client, and minimizing the power differential between therapist and client (Mulvaney-Day, Earl, Diaz-Linhart, & Alegría, 2011). In the same study, these priorities are contrasted with those of White Americans: Therapists' listening in order to ease comfort, understanding the importance of circumstance in the client's life, maintaining professional distance, as well as spending enough time with

the client without forcing issues. These factors suggest that current standards in mental health care may be systematically less desirable for some Black Americans. Given that the standard of care in therapy was created within the dominant culture (Benish, Quintana, & Wampold, 2011), it is not surprising that they match expectations of clients of this culture more so than those of Black Americans.

Discrimination

Multiple causes have been proposed for mental health disparities generally: cultural misunderstanding (Mckenzie, Fearon, & Hutchinson, 2008; Miranda, McGuire, Williams, & Wang, 2008), misdiagnosis (Patel & Hegginsbotham, 2007; Williams et al., 2007), and discrimination (Miranda et al., 2008). Though traditional racism, such as White supremacy and Jim Crowe (Bonilla-Silva, Lewis, & Embrick, 2004) are no longer socially acceptable (Dovidio, 2001), discrimination in the form of microaggressions—also known as modern, symbolic, or aversive racism (D. W. Sue et al., 2007)—may be contributing to disparities in a way that is more insidious than traditional discrimination.

The dominant culture's investment in color-blind racial ideology (Zou & Dickter, 2013)—the moral frame that race *should not* matter combined with the assumption that race *does not* matter (Neville, Lilly, Duran, Lee, & Browne, 2000)—may have made the nature of microaggressions less detectable and potentially more prevalent by reinstating the status quo of institutional racism (Bonilla-Silva, 2002). In fact, White Americans who most strongly adhere to the color blindness paradigm react more negatively to Black Americans who confront ambiguously racist comments (Zou & Dickter, 2013).

Microaggressions

As defined by D. W. Sue (2010), microaggressions are perpetrated by those with the power to define reality (D. W. Sue, Capodilupo, Nadal, et al., 2008)—the dominant culture—and are imposed onto any culturally marginalized or devalued group. Similar to traditional discrimination, microaggressions can come in two forms: interpersonal and environmental (Karlsen & Nazroo, 2002). D. W. Sue (2010) outlines the three types of interpersonal microaggressions: microassaults, microinsults, and microinvalidations. Microassaults are conscious degradations that are perpetrated by people who hold bigoted views (e.g., *Go back to your homeland, nigger*). In this way, microassaults most closely resemble overt, traditional bigotry. On the contrary, microinsults and microinvalidations are subconscious, thus, the perpetrators are often unaware they are communicating in an offensive manner.

D. W. Sue (2010) further explains the complexities behind microinsults and microinvalidations. Attributional ambiguity in microinsults is common, as this type of microaggression is often hidden under the guise of a compliment (e.g., *Wow, you speak so well; you don't speak Ebonics at all*). Microinvalidations, on the other hand, are the hallmark of the power to define reality. For instance, the microinvalidation, *The best applicant gets the job*, would be a sound statement if it were true. Persons who endorse this myth of meritocracy do not then explain the dominance of White Americans in high power positions. Did they all, individually and coincidentally, just try harder? Or have they been privileged with a different form of affirmative action that granted them an unfair advantage to succeed (D. W. Sue, 2004)?

Moreover, D. W. Sue (2010) discusses the reasons why perpetrators of microaggressions may be unaware of their own discriminatory beliefs: Microaggressions serve the function of allowing perpetrators not to have to acknowledge their power and privilege (e.g., *I got this job because I was the most qualified*), while maintaining the self-serving belief they are good and moral people. D. W. Sue (2010) also highlights how the viewpoints of the dominant culture are reinforced through perpetrator imposition, such as demanding that Black Americans assimilate to the dominant culture's way of communicating, and perpetrator deprivation, such as reduced access to quality healthcare services.

Effects of Discrimination on Black Americans

Perceived discrimination can have negative psychological effects (Kessler, Mickelson, & Williams, 1999; Pascoe & Smart Richman, 2009). Specifically, racial discrimination has been associated with higher levels of depression (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006; Donovan, Galban, Grace, Bennett, & Felicié, 2013; Karlsen & Nazroo, 2002; Landrine & Klonoff, 1996; Torres, Driscoll, & Burrow, 2010), anxiety (Blume, Lovato, Thyken, & Denny, 2012; Donovan et al., 2013; Landrine & Klonoff, 1996), stress (Torres, Driscoll, & Burrow, 2010), binge alcohol drinking (Blume et al., 2012), psychological distress (Pieterse, Todd, Neville, & Carter, 2012), and poorer health-related outcomes (Borrell et al., 2006; S. L. Sellers, Bonham, Neighbors, & Amell, 2009; Troxel, Matthews, Bromberger, & Sutton-Tyrrell, 2003).

Themes of microaggressions for Black Americans include environmental invalidations (D. W. Sue et al., 2007), as well as assumptions of inferiority; second-class citizenship; criminality; universality of the Black experience; superiority of White cultural values and communication styles (D. W. Sue, Nadal, Capodilupo, Lin, Torino, & Rivera, 2008); being an alien in one's

own land; colorblindness; absence of individual racism; and meritocracy (D. W. Sue et al., 2007). Not surprisingly, racial microaggressions expose predictable and degrading views of Black Americans as angry (Watkins et al., 2010), violent, criminal (Torres et al., 2010; Watkins et al., 2010), abnormal, untrustworthy, homogeneous (D. W. Sue, Capodilupo, & Holder, 2008), intellectually inferior, ignorant (D. W. Sue, Capodilupo, & Holder, 2008; Torres et al., 2010; Watkins et al., 2010), loud, tactless, and low class (Watkins et al., 2010). Microaggressions may result in feelings of powerlessness, invisibility, forced compliance, and loss of integrity (D. W. Sue, Capodilupo, & Holder, 2008), as well as pressure to represent all Black people; educate others about Black culture; and not perpetuate Black stereotypes (D. W. Sue, Capodilupo, & Holder, 2008; Watkins et al., 2010).

In addition to these global microaggressions against Black Americans, men and women also face gender-specific racial microaggressions, with males being perceived as hypermasculine, physically threatening, emotionally restrained, and promiscuous, and females being perceived as nurses (e.g., Mammy), unattractive, emasculating, unfeminine, asexual (Watkins et al., 2010), and hypersexual (hooks, 1981). When not being perceived as conforming to these stereotypes, Black Americans are often understood as atypical—and thus tokenized—as superior to, or at least different from, “real” Black Americans (Watkins et al., 2010).

Despite both Black American men and women experiencing gendered racial microaggressions, Black American women may be at a distinct disadvantage compared to their male counterparts due to the intersection of racism and sexism (Donovan et al., 2013). The double jeopardy hypothesis suggests that Black American women may be particularly likely to experience discrimination given their dual lowered societal status—Black and female (Beal, 1970). Research regarding the double jeopardy hypothesis is mixed (Berdahl & Moore, 2006; Foynes, Shipherd, & Harrington, 2013; Raver & Nishii, 2010). Nevertheless, Black women almost universally (96%) report experiencing microaggressions at least a few times a year (Donovan et al., 2013), indicating the pervasiveness of microaggressions.

Protective Factors

In light of this research on the prevalence and detrimental psychological effects of discrimination, it is important to acknowledge the resiliency of Black Americans. Multiple studies have shown the resilience of some Black American college students who, for instance, persevere through college despite discouragement to attend university, false accusations of cheating, exclusions from peer study groups, harassment by the police (Solórzano

et al., 2000), and racist vandalism, such as *nigger* written on their dormitory doors (Harwood, Hunt, Mendenhall, & Lewis, 2012). Though there is likely variability among Black Americans' in response to the type of bigotry mentioned, this buffer effect may be related to the intraindividual diverse reactions to microaggressions: healthy paranoia—actively questioning if each incident experienced was racist in nature; sanity check—communicating verbally and nonverbally with other friends and colleagues who are Black Americans, who can validate responses; empowering and validating self—placing the onus of responsibility on the perpetrators, instead of on the self; and rescuing offenders—privileging the offenders' perceived or actual viewpoints over that of the self (D. W. Sue, Capodilupo, & Holder, 2008).

Additionally, the multidimensional model of racial identity (MMRI, R. M. Sellers et al., 1998) provides another potential explanation for this resiliency. MMRI outlines four dimensions of identity—salience, centrality, ideology, and regard—of which the latter three are empirically testable. By acting as psychological buffers, these identity dimensions may promote resiliency by reducing psychological distress associated with perceived discrimination (R. M. Sellers, Copeland-Linder, Martin, & Lewis, 2006; R. M. Sellers & Shelton, 2003).

Racial regard (Crocker & Luhtanen, 1990; Crocker, Luhtanen, Blaine, & Broadnax, 1994; Crocker & Major, 1989; Luhtanen & Crocker, 1992; R. M. Sellers et al., 1998) specifically may be an important identity buffer of discrimination-related psychological distress. As defined by R. M. Sellers and colleagues (1998), for Black Americans, "racial regard refers to a person's affective and evaluative judgment of her or his race in terms of positive-negative valence" (p. 26); racial regard has two components: public and private, with public regard referring to Black Americans' appraisal of other Americans' views of Black Americans and private regard referring to the value a Black American places on Black Americans generally, and the self as a Black American specifically (R. M. Sellers et al., 1998). This distinction between public and private regard has its roots in Du Bois' (1903) theory of double-consciousness—the necessary management of how the dominant culture views you (e.g., as criminal) alongside how you view yourself (e.g., gentle). Unsurprisingly, positive private regard is related to higher self-esteem for those whose racial identity is central to their self-concept (Rowley, Sellers, Chavoux, & Smith, 1998).

Regardless of the specific causes, this resilience could account for what Miranda and colleagues (2008) defined as *the paradox*—Black Americans and other ethnic minorities have equal or decreased likelihood of experiencing mental health problems, despite inequality, such as discrimination. However, this means that when Black Americans, for instance, do experience mental health problems, they are much less likely to receive quality mental

health care (e.g., Institute of Medicine, 2002), making the mental health care burden far greater for them than it should be. Therefore, the aforementioned resiliency should serve as motivation to adequately correct the enduring mental health disparity given that Black Americans, and society at large, would greatly benefit from the opportunity to live and work without these barriers.

In order to make this hope of equality a reality, additional research needs to expand upon the limited extant literature that suggests negative effects are associated with microaggressions for Black Americans. Replications, along with further specifying both risk and resilience factors, will help inform both African-centered and mainstream interventions.

Microaggressions and Mental Health Disparities

In the previous section, I outlined the high prevalence (e.g., Donovan et al., 2013) and detrimental effects of discrimination generally (e.g., Pascoe & Smart Richman, 2009) and microaggressions specifically (e.g., D. W. Sue, Capodilupo, & Holder, 2008). Given that discrimination has been proposed to be a factor in mental health disparities for Black Americans (e.g., Snowden, 2012), I now will describe how Black-American-specific microaggressions may systemically contribute to these disparities.

Themes of microaggressions (e.g., superiority of White cultural values and communication styles; D. W. Sue, Nadal, et al., 2008), when present within the context of treatment, may be a form of cultural oppression (Ridley, 2005). For example, clinical training that encourages therapists to ask a Black American client about what it was like to grow up Black (Padesky & Greenberger, 1995) may be a form of unintentional discrimination. This query, which may appear to be benign or even beneficial, communicates the microaggressive theme *assumption of universality of the Black experience* (D. W. Sue, Nadal, et al., 2008), as it presumes that the social construction of being Black is central to all Black Americans' identities, contrary to research suggesting that centrality of racial identity varies across individuals (e.g., R. M. Sellers et al., 1998).

Black American clients may react to these and other microaggressions by adjusting behavioral and speech patterns, as they are keenly aware of how others view them (D. W. Sue, Nadal, et al., 2008). This awareness can be construed as a behavioral reaction to double-consciousness (Du Bois, 1903) or, as is currently conceptualized, the distinction between public and private regard (e.g., R. M. Sellers et al., 1998).

Apparently isolated examples such as those described may be part of a system that perpetuates oppression of Black Americans through discrimination. Given the high prevalence of microaggressions experienced by Black Americans (e.g., Donovan et al., 2013; Solórzano et al., 2000; D. W. Sue, Capodilupo, & Holder, 2008; Watkins et al., 2010), as well as the racial

homogeneity of the mental health care profession (e.g., Puryear Keita, 2006)—indicating that superiors, colleagues, supervisors, and students are more likely to be from the dominant group—it is possible that microaggressions are both prevalent in mental health care settings and particularly problematic to the therapeutic process and outcomes (Owen, Tao, & Rodolfa, 2010; Shelton & Delgado-Romero, 2011), given both the relational importance of the therapeutic alliance and the power differential between therapist and client (D. W. Sue et al., 2007).

Thus, the issue of microaggressions becomes not about individual mental health care providers and their clients, but rather about an intentional or unintentional discriminatory system. If this is the case, the effects of these microaggressions may have a greater psychological impact on Black Americans, ultimately contributing to mental health disparities by engendering decreased levels of trust in mental health care providers and decreased receptiveness to treatment (Snowden & Yamada, 2005) because of institutional betrayal (Smith & Freyd, 2013).

Institutional Betrayal

Smith and Freyd (2013) define institutional betrayal as occurring within organizations in which appropriate steps are not taken to prevent or address problematic events or situations, thus betraying its members in a way that “will be especially damaging” (p. 120). Smith and Freyd (2013) detail how institutional betrayal can take multiple, interconnected forms: apparently isolated, systemic, commission, and omission. The Institutional Betrayal Questionnaire (Smith & Freyd, 2013) also details how institutions can create an environment that normalizes some traumatic experiences or makes it difficult to report such experiences.

Smith and Freyd (2013) examined institutional betrayal in the context of sexual assault within the university setting. Their findings suggest that women who experienced institutional betrayal resulting from sexual assault experienced increased levels of anxiety, dissociation, and other psychological and behavioral distress.

Microaggressions in mental health care settings could be a form of institutional betrayal: apparently isolated, such as one therapist in a clinic behaving discriminatorily toward one Black American client; systemic, such as an institution with no Black therapists employed; commission, such as perpetrating microaggressions; and omission, such as lack of culturally competent therapies offered. Mental healthcare settings could also be further harmful by creating environments where microaggressions seem normal; this may include making the process of formulating complaints about discriminatory behavior difficult for or unknown to Black American clients.

Thus, institutional betrayal (Smith & Freyd, 2013) may have exacerbated effects on Black Americans who experience microaggressions within mental health care. Based on its relative ubiquity (e.g., D. W. Sue, Capodilupo, & Holder, 2008), Black Americans generally may to some extent expect to experience discrimination in society; however, they depend on and potentially trust mental healthcare settings. Therefore, microaggressions within this system may have an even stronger negative impact for Black Americans than microaggressions that are perpetrated individually outside of institutions. Thus, institutional betrayal within the mental healthcare setting may affect not only current treatment outcomes, but also willingness to participate in treatment (current or future), thus systemically contributing to mental health disparities for Black Americans.

The theory of institutional betrayal (Smith & Freyd, 2013) offers testable hypotheses regarding the prevalence and impact of microaggressions within the mental healthcare professions. Specifically, future research should begin by examining the following: which types of microaggressions—environmental or interpersonal (microassaults, microinsults, and microinvalidations)—toward Black Americans are as widespread in the mental healthcare profession as the extant literature suggests they are in general American society? Does institutional betrayal exacerbate psychological and behavioral outcomes associated with microaggressions? Do these rates and/or levels of outcomes decrease the likelihood of receptiveness to treatment, trust in mental healthcare providers, and premature termination of treatment? Given that the concept of institutional betrayal is in its infancy, the results of studies similar to those proposed above will dictate further areas of needed research.

Reducing Mental Health Disparities

Microaggressions are prevalent in American society (e.g., D. W. Sue, Capodilupo, & Holder, 2008) and may be prevalent in the mental healthcare profession as a whole, indicative of a wider institutional problem. Therefore, systemically altering the discriminatory face of the mental health care profession will be difficult given the history of oppression of Black Americans, as well as the unacknowledged bigotry communicated through interpersonal and environmental microaggressions (D. W. Sue, 2010).

In order to witness lasting change, the following transformations must accompany the within-institution changes outlined in the next section: (a) societal advocacy for equality, (b) in-depth historical and cultural education in psychology training programs and continuing education courses, (c) relationship-building with professional allies, (d) creation and advertisement of concrete changes in the structure, policy, and professionals of organizations—thereby regaining trust in the Black American community,

and (e) recruitment and retention of professionals diverse in background and expertise into the field. By remembering that the process of systemic change is iterative, the aforementioned steps can be recycled and expanded upon as the needs of Black Americans change while the mental health disparity is reduced.

Implications for Clinicians

Cultural Competency. The guidelines for multicultural practice in the field of psychology offer a framework for professionals of different backgrounds to become more culturally competent through the following: examining oneself and one's worldview, familiarizing oneself with other cultures in order to hypothesize about a clients' sociocultural context (e.g., relevant for a Black American Southern therapist counseling a second generation Nigerian family), understanding America's historical and present states of inequality, and adopting a multicultural paradigm (American Psychological Association, 2003).

Inquiring about various aspects of identity (e.g., *How would you describe yourself?*) without projecting one's own experience onto that of the client of the same ethnicity is essential for Black American therapists who work with Black American clients (Hays, 2008). This may be particularly important given that perpetration of microaggressions by a Black American therapist onto a Black American client would be a form of cultural betrayal (Gómez, 2012), which may exacerbate the effects of discrimination even further. Thus, prioritizing cultural competency as a self-examining, ongoing learning process that begins in training and continues throughout careers may be a way to reduce the incidence of microaggressions while making treatment applicable and beneficial for Black Americans.

In their work with Black American clients, clinicians can borrow culturally competent techniques used with other marginalized or underrepresented groups. For instance, the men's center approach (Davies, Shen-Miller, & Isaacs, 2010) utilizes ways for therapists of various backgrounds to become more culturally competent while providing therapies that are also such. In this model, therapists debrief with one another to understand self-socialization—how their cultural backgrounds and respective roles in society make encountering specific cultural differences challenging—as well as examining if and how to address these challenges with clients in order to provide the best treatment possible. This iterative, self-reflecting, and self-adaptive process mitigate the effects of the value-laden judgments that can accompany encountering cultural differences. By institutionally promoting, organizing, and rewarding this kind of cultural competency, mental health care establishments can ensure

their therapeutic settings are in fact safe, as opposed to “dangerous safe havens” (Smith & Freyd, 2013).

In addition to meta-awareness as a form of cultural competency (D. W. Sue, Nadal, et al., 2008), inquiring, acknowledging, and incorporating clients’ worldviews into therapy (Milstein, Manierre, & Yali, 2010) may be beneficial, as worldview match can increase the therapeutic bond (Shumway & Waldo, 2012). This point is especially important given there is likely to be much within-group variation among Black Americans. Therefore, assumptions about Black American culture will be less useful—and may in fact contribute to microaggressions that communicate the assumption of universality of the Black experience (D. W. Sue, Nadal, et al., 2008)—than identifying and incorporating the specific cultural context of each client (Hays, 2008). Along these lines, cultural adaptations and modifications in the clinical process of assessment, treatment planning, and case conceptualization (Alegria et al., 2010) may help reduce the likelihood of therapist-perpetrated microaggressions due to increased individualized cultural understanding.

Identifying the salience and centrality of Black identity with prompts such as “Finish this statement: I am _____.” may help tailor therapeutic techniques in such a way that utilizes aspects of clients’ identities to positively affect treatment outcomes. For instance, Black Americans whose race and ethnicity are central to their self-concept may benefit from identity-affirming therapy, akin to that described for the LGBT community (Nadal, Rivera, & Corpus, 2010). This may be particularly beneficial given that aspects of Black identity, such as group identification (Cross, 1991), racial ideology, and public regard (R. M. Sellers & Shelton, 2003), lessen the effects of discrimination, potentially facilitating healing by serving as buffers against the inequality—e.g., microaggressions—experienced in society.

Additionally, mental health care institutions that offer African-centered therapy (Mariette, 2013; McInnis & Moukam, 2013), including communal health models (Myers, 2013), or other alternatives to traditional treatment modalities that are culturally specific to the coping styles of Black Americans may be beneficial (Grier-Reed, 2013), as they can incorporate traditional therapeutic factors, such as interpersonal learning, development of new socializing techniques, catharsis, and universality (Grier-Reed, 2013; Yalom, 1995). Mental health care institutions could also include Emotional Emancipation Circles (EECs; Grills, 2013). Developed through the Association of Black Psychologists in collaboration with the Community Healing Network, EECs are community self-help groups for Blacks in the diaspora that work to address and eliminate internalized racism and racial stress (Grills, 2013). EECs can aid in “. . .restoring an African consciousness based on the best of a cultural legacy and heritage. . .” (Myers, 2013, p. 257).

The presence of such treatments within mental health care institutions further legitimizes the experience of Black Americans, thus systemically reducing existing environmental microaggressions (D. W. Sue et al., 2007) and potentially second-class citizenship microaggressions (D. W. Sue, Nadal, et al., 2008). The provision of multiple options allows Black American clients to choose the type of therapy that would be most beneficial to them and their needs.

These culturally competent techniques may indirectly systemically reduce microaggressions in mental health care by combating ethnocentric monoculturalism. By interpreting cultural differences as valid, the perception of superiority of the dominant cultural norms may diminish, and by extension, microaggressions would diminish as well. Thus, in incorporating systemic change on a variety of levels (e.g. environmental; individual training), the mental health care system is creating a truly safe space that does not betray Black Americans.

The Role of Psychology

The previous section outlined systemic ways the mental health care profession can take to reduce institutional betrayal (Smith & Freyd, 2013) in the form of microaggressions. Practitioners can employ additional strategies to immediately improve the state of the field long term. Given that ethnicity is a proxy for unmeasured, and potentially unacknowledged, cultural norms, beliefs, and behaviors (Abdulla & Brown, 2011), ethnic matching in the therapeutic context for Black Americans is not only preferable but also related to clients' perception of the therapist, and to a lesser degree their own outcomes (Cabral & Smith, 2011). Given that cultural adaptations of treatments have larger effects on outcomes than ethnic matching (Benish et al., 2011; Griner & Smith, 2006), it would behoove the field of clinical psychology to promote diversity not only in terms of imposed social identity, but more importantly, diversity in thought processes, worldviews, and backgrounds in order to accommodate the increasing diversity in the U.S. population (Hall, 2006).

Thus, diversifying clinical psychology (Hall, 2006) in particular may minimize the current disparities by: (1) establishing trust in Black Americans who feel betrayed by the institution of mental health care; (2) incorporating increased cultural competency and adaptations to current treatments (Benish et al., 2011); (3) reducing the prevalence of microaggressions—and institutional betrayal—within the treatment setting; and (4) fostering increased awareness about diversity issues. As explained by Hall (2006), promoting acculturated ethnic minorities in the field of psychology may do little to change the status quo. Therefore, the term *diversifying*

denotes recruiting, respecting, and retaining professionals from a variety of backgrounds, with a multitude of perspectives, in order to reduce the prevalence of microaggressions.

Additionally, research that focuses on the intragroup differences between Black Americans (Earl, Williams, & Anglade, 2011)—such as generational history in the United States—as well as the influence of intersecting identities (Hill Collins, 2009)—e.g., race, ethnicity, gender, sexual orientation, class, physical ability, and religion—may be particularly important in uncovering the complex ways in which microaggressions within mental health care can affect racially Black Americans who hold a multitude of different oppressed and privileged identities that vary in salience and centrality across individuals and situations. Clinicians could incorporate this information into their evolving conceptualization of culture, both globally and individually, thereby reducing both underlying discriminatory assumptions and microaggressions.

Hall (2006) further suggests motivational interviewing as a tool to promote a change in the larger culture of practicing psychologists. Given that most microaggressions occur outside the awareness of perpetrators (D. W. Sue, 2010), demonstrating to well-meaning professionals who are willing to examine their own behaviors that some of what they communicate—regardless of intention—is hostile and discriminatory could engender change within psychologists' interactions with Black American clients, supervisees, and colleagues.

As outlined by Smith and Freyd (2013), organizations engage in institutional betrayal when they either do not prevent or do not adequately address injustices within their systems. Thus, microaggressions that continue to occur within the mental health care profession are indicative of institutional betrayal insofar as the institution does not actively acknowledge, address, and correct this oppression. Therefore, on a systemic level, community centers, university counseling centers, and others could choose to employ only those clinicians who operate with their clients in culturally appropriate ways. Institutions that employ a four-step process—ascertaining this information about therapists from client surveys, having a standard protocol for taking action, taking the appropriate action when institutional betrayal through microaggressions is discovered, and communicating said actions to the parties involved—would be most successful in fomenting change.

Furthermore, mental health care systems could adapt the Inclusive Excellence Model (Association of American Colleges and Universities, 2002), which was created for colleges and universities, to systematically create a welcoming, bigotry-free environment. This model (Association of American Colleges and Universities, 2002) promotes inclusivity in all processes, highlighting five avenues of change: historical (e.g., addressing past

systemic discrimination within the organization), compositional diversity (e.g., transferring from conceptualizing diversity as numbers to understanding diversity in terms of backgrounds, thoughts, etc.), climate (e.g., examining the overall inclusive or hostile nature of the establishment), organizational diversity (e.g., acknowledging and changing discriminatory policies), and social influences (e.g., addressing how societal discriminatory practices may impact professionals and clients within the establishment). Therefore, alongside the ability to institutionally betray Black Americans lies the power to create a protective system that engenders trust by systemically rejecting bigotry of all forms.

Finally, possibly the most important elicitor of change would be the empowering belief within the field that change is not only necessary, but also possible. It is possible for each of us to begin and maintain an iterative process of cultural competency that includes examining oneself and one's culture with a focus on how each influences one's viewpoint; familiarizing oneself with other cultures and cultural contexts in a way that is open to differences while not stereotyping; knowing American history in order to understand how the past and present systematically affect disparities currently; and adopting a multicultural approach that notices and values differences in culture (American Psychological Association, 2003)—not just race.

Concluding Thoughts

Now is a crucial time to address mental health disparities because we have vast documentation that Black Americans have been systemically oppressed (e.g., R. M. Sellers et al., 1998), are overrepresented in in-patient and psychiatric hospitals, and receive lower quality of care (e.g., Smedley, Stith, & Nelson, 2003; Snowden, Catalano, & Shumway, 2009; Snowden, Hastings, & Alvidrez, 2009). I do not propose that microaggressions, and the resulting institutional betrayal, entirely account for mental health disparities—defined as inequity in treatment opportunities due to unequal access to and benefit from efficacious and culturally appropriate mental health care. However, I do suggest that addressing microaggressions among mental health professionals of all cultural backgrounds is a way to effect change at individual and systemic levels.

From examining one's own privilege (Hays, 2008) to acknowledging and addressing the potentially oppressive nature of therapy that is encapsulated in the dominant culture (D. W. Sue, 1978), to utilizing African-centered (e.g., Myers, 2013) and Black-American-centered therapeutic alternatives (Grier-Reed, 2013), we can reduce the likelihood of creating the barrier of microaggressions and institutional betrayal in the mental health care profession. Thus, the Black American community can mobilize by taking ownership of

the multitude of solutions available to Black psychology professionals in order to systemically reduce the mental health disparity for Black Americans.

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