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The Impact of Racial Microaggressions on Mental Health: Counseling Implications for Clients of Color

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This study examined the relationship between racial microaggressions (subtle and unintentional forms of racial discrimination) and mental health. Results from a large sample (N = 506) indicated that higher frequencies of racial microaggressions negatively predicted participants' mental health and that racial microaggressions were significantly correlated with depressive symptoms and negative affect. Differences in the types of microaggressions experienced by various racial groups (Asian, Latina/o, Black, White, and multiracial) and counseling implications are discussed.

Keywords: microaggressions, discrimination, psychotherapy, depression, affect

In recent years, it has become much more socially unacceptable for Americans to be overtly racist or discriminatory; thus, many individuals believe that they are not racist and that racism no longer exists (D. W. Sue, 2010). Despite this belief, previous authors have purported that while most people would not consider themselves to be racist (nor engage in hate crimes or blatantly racist activities), they may still hold racial biases and participate in subtle and unconscious racially motivated behaviors (Gaertner & Dovidio, 2006). This covert form of discrimination has been labeled as aversive racism (Dovidio & Gaertner, 2000), modern racism (McConahay, 1986), and racial microaggressions (C. M. Pierce, Carew, Pierce-Gonzalez, & Willis, 1978; D. W. Sue, Capodilupo, et al., 2007). More recently, there has been an increase in research focusing specifically on racial microaggressions, with results showing that these subtle forms of discrimination have a detrimental impact on the mental health of people of color (Nadal, 2011; D. W. Sue, 2010).

Racial microaggressions are defined as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, negative racial slights and insults to the target person or group" (D. W. Sue, Capodilupo, et al., 2007, p. 273). The authors identified three forms of racial microaggressions: microassaults, microinsults, and microinvalidations. *Microassaults* represent the more overt forms of discrimination and can manifest in verbal or nonverbal attacks, as well as avoidant behaviors. In microassaults, people may be more conscious of discrimination, but they often unintentionally hurt the people who experience the microassaults. An example of a microassault is when a White woman is walking toward a Black man and purposefully crosses to the other side of the street. The woman may be conscious in her decision to change her route, but she may be unaware that such behavior may represent her stereotypes that Black men are dangerous or criminal. Similarly, when people make racist jokes or use racial slurs, they may claim to be doing so in a "joking" manner; however, in doing so, they fail to recognize their internal biases or stereotypes, as well as the effects such words may have on individuals who hear them. *Microinsults* are rude or insensitive behaviors or statements that degrade a person's racial heritage or identity. An example of a verbal microinsult includes telling an Asian American woman that she "speaks good English," and an example of a behavioral microinsult may be a store owner who follows a Black man around while he shops. In the first instance, an underlying message is conveyed that Asian Americans are all foreigners, and in the second, a message is communicated that Black individuals are thieves. Finally, *microinvalidations* occur when a person negates or denies the thoughts, feelings, or experiences of a person of color. When a White person tells a person of color "Racism doesn't exist anymore" or "Stop complaining about racism," she or he invalidates the racial realities of people of color who experience racism in their everyday lives.

D. W. Sue, Capodilupo, et al. (2007) proposed a taxonomy of racial microaggression themes to highlight the various ways microaggressions manifest in the lives of people of color. Among these themes, Alien in Own Land refers to instances when people assume that non-White individuals are foreign born (e.g., asking a Latina or Asian American woman where she is from even after she asserts that she was born in the United States). The Ascription of Intelligence theme refers to labeling someone with a certain amount of intelligence based on her or his race (e.g., assuming that Asian Americans are

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good at math or sciences or that Black people are not intelligent or educated). The theme of Color Blindness occurs when people deny a person's experiences regarding race; for instance, when people make comments like "America is a melting pot" or "There is only one race, the human race," they are denying the other's racial reality. The Criminality/Assumption of Criminal Status theme occurs when a person of color is presumed to be deviant. One qualitative study found that when Black Americans are followed around in stores, they perceive that store owners and clerks stereotype them as thieves or shoplifters (D. W. Sue, Nadal, et al., 2008). The theme of Denial of Individual Racism manifests when an individual tries to deny her or his racial biases (e.g., when someone makes comments like "I'm not racist, I have Black friends"). The Myth of Meritocracy theme includes statements that emphasize race as having no role in people's life successes. This happens when people say things such as "Everybody can succeed here, if they just work hard enough." However, such statements negate the realities of people of color that race does serve as an obstacle in their lives (D. W. Sue, Capodilupo, et al., 2007). The theme of Pathologizing Cultural Values/Communication Styles is the idea that the dominant, White cultural values and communication styles are ideal and that anything different is abnormal or weird (e.g., when someone tells an Asian person that eating with chopsticks is strange or when a supervisor tells a Black employee to "wear her hair professionally"). Finally, the theme of Second-Class Citizen occurs when a White person is given preferential treatment as a customer over a person of color (e.g., when a cab driver passes a person of color and picks up a White passenger instead; D. W. Sue, Nadal, et al., 2008).

Some studies have aimed to understand how racial microaggressions or subtle forms of discrimination affect the lives of people of color. Qualitative studies with Black Americans (D. W. Sue, Capodilupo, & Holder, 2008; D. W. Sue, Nadal, et al., 2008), Latina/o Americans (Rivera, Forquer, & Rangel, 2010), Asian Americans (D. W. Sue, Bucceri, Lin, Nadal, & Torino, 2007), and multiracial people (Nadal et al., 2011) have supported that people of color experience an array of microassaults, microinsults, and microinvalidations and that such experiences have an impact on their lives. Participants report that when they encounter microaggressions, they may feel immediate distress, and many report that the accumulation of such experiences have a detrimental impact on their well-being. Participants describe the conflict of responding to such interactions, as well as the protective factors that may alleviate the anguish they experience when they encounter microaggressions. However, one limitation to these studies is that most use only qualitative designs. Although qualitative research is valuable in illuminating the lived experiences of people of color, quantitative studies can be useful in empirically supporting the relationship between microaggressions and mental health problems.

Furthermore, some authors have questioned whether the research involving racial microaggressions is valid, existent, or worth studying. One author mentioned that the concept of microaggressions is "pure nonsense" (Thomas, 2008, p. 274) and that subtle discrimination does not exist or that clinicians should not be fixated on race. Another author focused on alternative hypotheses to explain microaggressions experienced by people of color (e.g., speculating on perpetrators' good intentions and victims' misperceptions) instead of validating others' perceptions and racial realities (Harris, 2008). These types of arguments elucidate the dilemmas that counselors and clinicians may have when examining microaggressions. What a person of color may consider to be a reality may be negated, or in direct contrast to, what is considered a reality of a White person. Furthermore, if individuals believe that microaggressions are harmless, then they may not recognize the importance of educating others about microaggressions and preventing such discrimination in individuals' everyday lives. Thus, empirical support that racial microaggressions are detrimental to the victims' mental health is necessary for counselors to fully understand their clients and assist in their mental health and development.

Previous literature has documented the detrimental impact of institutional racism and overt interpersonal racial discrimination on the lives of people of color. For example, research has found that an individual's perception of events as discriminatory or racist can have devastating effects on her or his psychological well-being (Lambert, Herman, Bynum, & Ialongo, 2009; Whitbeck, McMorris, Hoyt, Stubben, & Lafromboise, 2002). Racism has been linked to problems such as substance abuse (Gibbons, Gerrard, Cleveland, Wills, & Brody, 2004), lower self-concept (Nyborg & Curry, 2003), mental distress (Williams, Neighbors, & Jackson, 2003), and depressive symptoms (Schulz et al., 2006). Confirming all of these previous studies, Pascoe and Richman's (2009) meta-analysis of 134 samples examining discrimination and health found that perceived discrimination had a significant negative effect on both mental and physical health and is related to participation in unhealthy behaviors and nonparticipation in healthy behaviors. Given the previous literature, it is clear that when individuals perceive and experience discrimination in their personal lives, there may be detrimental impacts on their identity development and mental health.

A significant amount of literature has documented the harmful effects of racism on physical and mental health on specific racial groups. Studies with Black Americans have found that racism may be highly correlated with mental health issues (e.g., depression, stress) and self-reported physical health issues such as cardiovascular disease and obesity (Davis & Stevenson, 2006; Lambert et al., 2009). Other studies have shown that Asian Americans, Latinas/os, and Native Americans who perceive discrimination in their lives suffer from mental health problems. For example, Whitbeck et al. (2002) found that perceived discrimination was a powerful indicator of depressive symptoms among Native American adults; those who experienced discrimination were two times

more likely to score higher on a depressive symptoms scale. In another study consisting of Asian American and Latina/o participants, Hwang and Goto (2008) found that those who perceived discrimination were more likely to exhibit symptoms of psychological distress, suicidal ideation, state and trait anxiety, and clinical depression. Although findings of these studies are all useful, one limitation is that they tend to concentrate on overt discrimination, without examining how perceived microaggressions (or more subtle forms of discrimination) affect people's lives.

Given the lack of research examining the impacts of racial microaggressions on individuals' mental health, the purpose of the current study was to investigate the relationship between racial microaggressions and mental health. Because counselors are ethically responsible to be culturally competent in working with clients, it is necessary for them to be knowledgeable of the experiences of their clients of color (and other marginalized groups); to be aware of their attitudes, biases, and beliefs (and how they influence the therapeutic relationships); and to develop skills that would be effective in working with multicultural populations (D. W. Sue, Arredondo, & McDavis, 1992). On the basis of the previous qualitative studies, as well as quantitative studies involving overt forms of discrimination, there was one hypothesis to this study: Higher frequencies of experiences of racial microaggressions would negatively predict individuals' mental health. Furthermore, exploratory research questions included the following: (a) Is there a relationship between race and the total number of microaggressions that individuals experience? and (b) Is there a relationship between race and the types of microaggressions that individuals experience? Gaining this knowledge would assist practitioners in improving their understanding of their clients' presenting problems, which we hope would increase their multicultural awareness and assist in developing effective multicultural skills.

Method

Participants

Our study sample comprised 506 participants, including 375 women (74.1%) and 131 men (25.9%). Participants ranged in age from 18 to 66 years (M = 24.83, SD = 8.63). Of the participants, 157 were Asian Americans/Pacific Islanders (31.0%), 131 were Latinas/os (25.9%), 80 were Blacks/African Americans (15.8%), 63 were Whites/European Americans (12.5%), 48 were multiracial (9.5%), and 25 identified as other (4.9%); two (0.4%) participants did not indicate their race/ethnicity. Most of the participants self-identified as heterosexual (n = 431, 85.2%), 28 as gay/lesbian (5.5%), 14 as bisexual (2.8%), and four as other (0.8%); 29 (5.7%) participants did not respond to this question. A majority of the sample (n = 289, 57.1%) identified as living in a northeastern state (e.g., New York, Massachusetts), 99 (19.6%) in a West Coast state (e.g., California, Washington), 69 (13.6%) in a midwestern state (e.g., Illinois, Michigan), 17 (3.4%) in a southwestern state (e.g., Texas, New Mexico), 12 (2.4%) in a southeastern state (e.g., Florida, Georgia), 10 (2.0%) in Hawaii, and six (1.2%) outside of the United States; four (0.7%) participants did not respond to this question. Many of the participants (n = 244, 48.2%) had a high school diploma, 115 (22.7%) had a bachelor's degree, 89 (17.6%) had a graduate degree, and 54 (10.7%) had an associate's degree; four (0.8%) participants did not respond to this question. Three hundred and eighty-seven participants (76.5%) were born within the United States, and 112 (22.1%) were born outside of the United States; seven participants (1.4%) did not answer this question.

Recruitment

Participants were recruited in two ways: (a) through a Psychology 101 undergraduate pool (n = 288) and (b) through online e-mail groups and community websites (n = 218). Undergraduate students who were enrolled in introductory psychology classes from a large urban Hispanic-serving public college in the Northeast were given research credit for their participation (which in turn would be a portion of their overall grade). A community sample was recruited via e-mails to various community organizations (e.g., nonprofit community services centers in urban areas, multicultural college student groups, historically Black and Latina/o sororities and fraternities) and professional mailing lists (state counselor associations, Asian American Psychological Association); these participants were not offered any incentive. With both recruitment approaches, a snowball sampling method was used by encouraging participants to advertise the study to organizations and networks that matched the participant criteria.

Measures

Demographic questionnaire. Participants completed an open-ended demographic form asking them to identify their age, gender, race, ethnicity, sexual orientation, religion, occupation, highest educational level completed, place of birth, and years spent in the United States.

Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011). The REMS is a 45-item self-report measure that assesses the impact of various racial and ethnic microaggressions. Participants were instructed to indicate whether the item occurred in the past 6 months (i.e., 0 = *never*, 1 = *at least once*). The REMS has six subscales, including Subscale 1: Assumptions of Inferiority, Subscale 2: Second-Class Citizen and Assumptions of Criminality, Subscale 3: Microinvalidations, Subscale 4: Exoticization and Assumptions of Similarity, Subscale 5: Environmental Microaggressions, and Subscale 6: Workplace and School Microaggressions. The REMS is reported to have a Cronbach's alpha of .88, with subscale alphas ranging from .75 to .86, and it is positively correlated with the Daily Life Experiences–Frequency scale (r = .698, N = 253, p < .001; Nadal, 2011). For the current

study, the REMS produced a Cronbach's alpha of .91; subscale alphas ranged from .79 to .87.

Mental Health Inventory (MHI; Veit & Ware, 1983). The MHI is a 38-item Likert-type self-report measure that assesses positive and negative aspects of mental health status and well-being. For this study, a shorter version, the MHI-18, was used. The MHI-18 has four subscales: Anxiety, Depression, Behavioral Control, and Positive Affect. Scoring ranged from 1 (*all of the time*) to 6 (*none of the time*). Positively worded items were reverse scored so that higher total MHI-18 scores indicated better mental health. McHorney, Ware, Rogers, Raczek, and Lu (1992) reported that the MHI-18 had a reliability of .96. For the current study, the MHI-18 yielded a Cronbach's alpha of .95, with subscale alphas ranging from .90 to .95.

Procedure

Upon approval from the institutional review board of the first author's institution, all measures were made available through SurveyMonkey.com. First, participants were presented with an informed consent form, which indicated their voluntary participation, as well as potential risks and benefits to the study. Next, participants filled out a demographic questionnaire followed by the REMS and MHI-18. Each research session lasted 30 to 45 minutes. At the completion of the survey, participants received a debriefing statement, which listed the purpose of the survey and the first author's contact information.

Before analyzing the data, a team of three researchers met to code the open-ended data from the demographic sheet, categorizing answers into six categories: Black, Latina/o, Asian, White, multiracial, and other. This coding system was used because previous literature had observed that forcing individuals to choose preset boxes could be viewed as a microaggression in itself (Johnston & Nadal, 2010; Nadal, 2011). Most answers were easily coded (e.g., if a participant wrote "Mexican," she or he would be placed in the "Latina/o" category, and if a participant wrote "Black/Asian," she or he would be placed in the "multiracial" category). Many participants confused race and ethnicity, so the team of coders agreed on where participants would be placed (e.g., if a participant wrote "Filipino" for race, he or she would be placed in the Asian category). When there was doubt, the coders discussed each case (using context clues like place of birth and ethnicity) until they reached consensus on a category; if consensus was not reached, participants were placed under "other."

The number of participants is based on the a priori power analysis for regression described by Green (1991) in which sample size N is greater or equal to $50 + 8m$, with m being the number of predictors. For the current study, there were 13 predictors (e.g., race, REMS average, six REMS subscales, MHI-18 average, and four MHI-18 subscales); thus, a minimum of 154 participants was needed for the study. We also conducted a post hoc power analysis using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) with an alpha level of .05, a sample size of 506, and a large effect size of .35. Achieved power for the study was .999, with a critical F of 1.74.

Correlation analyses were used to examine initial relationships between racial microaggressions and mental health. We tested a linear regression model (using the enter method) to explore if racial microaggressions were predictors of mental health scores. A one-way analysis of variance (ANOVA) and comparative t tests were used to observe if race was a predictor of different types of microaggressions and if certain groups reported more experiences with certain types of microaggressions than other groups. We evaluated effect size through reported R-squared scores and eta-squared scores, which are most often used for straightforward ANOVA designs and can be computed with any number of independent variables and any number of groups in categorical variables (Fay & Boyd, 2010). Finally, White participants were included in the analyses for two reasons: (a) Previous authors have cited that Whites may indeed experience racial microaggressions even though they may have differential reactions because of issues of power and privilege (Nadal et al., 2010; D. W. Sue, Capodilupo, et al., 2007) and (b) we wanted to determine if people of color do indeed experience more microaggressions than Whites.

Results

We conducted correlation and linear regression analyses to test the hypothesis that racial microaggressions would have a negative relationship with mental health. The REMS average scores and MHI-18 average scores had a negative significant correlation ($r = –.11$, $p = .047$). REMS Subscale 4: Exoticization and Assumptions of Similarity was the only REMS subscale with a significant, negative correlation with the MHI-18 average ($r = –.15$, $p = .005$). Two of the four MHI-18 subscales were significantly and negatively correlated with overall REMS average scores: Depression ($r = –.12$, $p = .026$) and Positive Affect ($r = –.11$, $p = .043$). The MHI-18 Depression subscale had significant, negative correlations with REMS Subscale 4: Exoticization and Assumptions of Similarity ($r = –.16$, $p = .003$). The MHI-18 Positive Affect subscale had a significant, negative correlation with REMS Subscale 3: Microinvalidations ($r = –.13$, $p = .012$) and REMS Subscale 4: Exoticization and Assumptions of Similarity ($r = –.16$, $p = .002$). The MHI-18 Behavioral Control subscale also had a significant, negative correlation with REMS Subscale 4: Exoticization and Assumptions of Similarity ($r = –.12$, $p = .024$). All of the intercorrelations of the REMS and MHI-18 are presented in Table 1.

A simple linear regression model was tested (using the enter method), and REMS average scores were found to be a significant predictor of MHI-18 total scores, $F(1, 354) = 6.19$, $p = .013$; however, the effect size was small (adjusted $R^2 = .01$), accounting for only 1.4% of the variance. REMS average scores were also found to significantly predict MHI-

TABLE 1

Correlation Matrix for the Racial and Ethnic Microaggressions Scale (REMS) and Mental Health Inventory–18 (MHI-18)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. REMS average	—	.70**	.65**	.69**	.48**	.44**	.59**	−.11*	−.07	−.12*	−.06	−.11*
2. Inferiority		—	.57**	.48**	.39**	.20**	.59**	−.07	−.03	−.09	−.02	−.09
3. Second-Class			—	.40**	.27**	.18**	.60**	−.07	−.05	−.07	−.02	−.09
4. Invalidation				—	.25**	.25**	.44**	−.10	−.08	−.07	−.04	−.13*
5. Exoticization					—	.09	.34**	−.15**	−.07	−.16**	−.12*	−.16**
6. Environment						—	.05	−.02	−.06	−.01	−.02	.02
7. Workplace							—	−.05	−.03	−.07	−.01	−.06
8. MHI-18 average								—	.85**	.87**	.85**	.79**
9. Anxiety									—	.74**	.59**	.50**
10. Depression										—	.66**	.52**
11. Behavior											—	.66**
12. Affect												—

Note. Inferiority = REMS Assumptions of Inferiority subscale; Second-Class = REMS Second-Class Citizen and Assumptions of Criminality subscale; Invalidation = REMS Microinvalidations subscale; Exoticization = REMS Exoticization and Assumptions of Similarity subscale; Environment = REMS Environmental Microaggressions subscale; Workplace = REMS Workplace and School Microaggressions subscale; Anxiety = MHI-18 Anxiety subscale; Depression = MHI-18 Depression subscale; Behavior = MHI-18 Behavioral Control subscale; Affect = MHI-18 Positive Affect subscale.

*$p < .05$. **$p < .01$.

18 Depression subscale scores, $F(1, 354) = 7.43$, $p = .007$, and MHI-18 Positive Affect subscale scores, $F(1, 354) = 8.43$, $p = .004$. However, again, effect sizes were small, with adjusted $R^2 = .02$ for MHI-18 Depression and adjusted $R^2 = .02$ for MHI-18 Positive Affect.

We used multiple regression analyses to determine if an overall model of REMS subscales predicted MHI-18 average scores or MHI-18 subscales. Whereas the overall model of REMS subscales was not significant for MHI-18 average scores, a significant model emerged for MHI-18 Positive Affect subscale scores, $F(1, 344) = 2.55$, $p = .020$, accounting for 2.6% of the variance. Analysis of the beta weights revealed that Subscale 3: Microinvalidations was the only significant predictor ($t = –2.28$, $p = .02$). There were no other significant models involving the REMS subscales and other MHI-18 subscales.

To test the first exploratory research question about whether race influenced one's total experiences with microaggressions, we conducted a one-way ANOVA to determine if race (White, Black, Asian, Latina/o, multiracial, and other) influenced differences in REMS average scores. There were significant differences between racial groups in REMS average scores, $F(5, 456) = 6.12$, $p < .001$, $\eta^2 = .06$. Using independent t tests with an alpha level of $p < .05$ (two-tailed), we found significant differences between White participants ($M = 0.25$) and every other racial group: Black participants ($M = 0.40$, $p = .001$), Asian participants ($M = 0.35$, $p = .001$), Latina/o participants ($M = 0.39$, $p = .001$), and multiracial participants ($M = 0.36$, $p = .001$). There were no significant differences in average scores among any of the other racial groups, suggesting that Black, Asian, Latina/o, and multiracial people experience similar amounts of cumulative microaggressions. Table 2 presents the means and standard deviations for the REMS average and subscale scores for each major racial group.

To test the first exploratory research question about whether race influenced one's encounters with different types of microaggressions, we conducted ANOVAs to determine if race predicted REMS subscale scores. All six subscales yielded significant effects of race on REMS subscale average scores. There were significant differences between racial groups in Subscale 1: Assumptions of Inferiority average scores, $F(5, 452) = 6.22$, $p < .001$, $\eta^2 = .06$. Comparative t tests found significant differences between Asian ($M = 0.23$) and Black ($M = 0.41$) participants ($p = .000$), Asian ($M = 0.23$) and Latina/o ($M = 0.40$) participants ($p = .000$), Black ($M = 0.41$) and White ($M = 0.17$) participants ($p = .015$), Latina/o ($M = 0.40$) and White ($M = 0.17$) participants ($p = .001$), and White ($M = 0.17$) and multiracial ($M = 0.33$) participants ($p = .009$).

There were significant differences between racial groups in Subscale 2: Second-Class Citizen and Assumptions of Criminality average scores, $F(5, 454) = 4.77$, $p < .001$, $\eta^2 = .05$. Comparative t tests revealed differences between Asian ($M = 0.21$) and Black ($M = 0.36$) participants ($p = .000$), Asian ($M = 0.21$) and White ($M = 0.13$) participants ($p = .044$), Black ($M = 0.36$) and White ($M = 0.13$) participants ($p = .000$), Black ($M = 0.36$) and Latina/o ($M = 0.26$) participants ($p = .033$), multiracial ($M = 0.26$) and White ($M = 0.13$) participants ($p = .012$), and Latina/o ($M = 0.26$) and White ($M = 0.13$) participants ($p = .007$).

There were significant differences between racial groups in Subscale 3: Microinvalidations average scores, $F(5, 453) = 3.70$, $p = .003$, $\eta^2 = .04$. Using comparative t tests, we found significant differences between Black ($M = 0.48$) and Asian ($M = 0.32$) participants ($p = .001$), Asian ($M = 0.32$) and Latina/o ($M = 0.41$) participants ($p = .016$), Black ($M = 0.48$) and White ($M = 0.32$) participants ($p = .003$), and Latina/o ($M = 0.41$) and White ($M = 0.32$) participants ($p = .045$).

TABLE 2

Racial and Ethnic Microaggressions Scale (REMS) and Subscale Mean Scores for Major Racial Groups

REMS Subscale and Racial Group	*n*	*M*	*SD*	*SEM*
Subscale 1: Assumptions of Inferiority				
Asian	137	0.23	0.29	0.02
Black	74	0.41	0.36	0.04
Latina/o	125	0.40	0.36	0.03
Multiracial	46	0.33	0.33	0.05
White	56	0.17	0.25	0.03
Subscale 2: Second-Class Citizen and Assumptions of Criminality				
Asian	137	0.21	0.27	0.02
Black	74	0.36	0.33	0.04
Latina/o	126	0.26	0.32	0.03
Multiracial	46	0.26	0.30	0.04
White	56	0.13	0.21	0.03
Subscale 3: Microinvalidations				
Asian	137	0.32	0.33	0.03
Black	74	0.48	0.33	0.04
Latina/o	126	0.41	0.30	0.03
Multiracial	46	0.38	0.36	0.05
White	56	0.32	0.25	0.03
Subscale 4: Exoticization and Assumptions of Similarity				
Asian	137	0.52	0.30	0.03
Black	74	0.35	0.30	0.03
Latina/o	126	0.55	0.28	0.03
Multiracial	46	0.43	0.30	0.04
White	56	0.14	0.18	0.02
Subscale 5: Environmental Microaggressions				
Asian	129	0.54	0.31	0.03
Black	73	0.37	0.34	0.04
Latina/o	126	0.46	0.32	0.03
Multiracial	42	0.53	0.35	0.05
White	54	0.43	0.34	0.05
Subscale 6: Workplace and School Microaggressions				
Asian	137	0.24	0.30	0.03
Black	74	0.34	0.37	0.04
Latina/o	118	0.24	0.34	0.03
Multiracial	46	0.34	0.37	0.05
White	56	0.14	0.18	0.02
REMS average				
Asian	86	0.35	0.18	0.02
Black	55	0.40	0.20	0.03
Latina/o	76	0.39	0.19	0.02
Multiracial	30	0.36	0.20	0.04
White	38	0.25	0.13	0.02

For Subscale 4: Exoticization and Assumptions of Similarity average scores, there were significant differences between racial groups as well, $F(5, 454) = 3.57$, $p = .004$, $\eta^2 = .04$. Significant differences were found between Black ($M = 0.35$) and Asian ($M = 0.52$) participants ($p = .000$), White ($M = 0.14$) and Asian ($M = 0.52$) participants ($p = .000$), Black ($M = 0.35$) and Latina/o ($M = 0.55$) participants ($p = .000$), Asian ($M = 0.52$) and White ($M = 0.14$) participants ($p = .000$), Latina/o ($M = 0.55$) and White ($M = 0.14$) participants ($p = .000$), and multiracial ($M = 0.43$) and Latina/o ($M = 0.55$) participants ($p = .029$).

There were significant differences between racial groups in Subscale 5: Environmental Microaggressions average scores, $F(5, 430) = 5.38$, $p < .001$, $\eta^2 = .06$. The *t* tests indicated significant differences between Black ($M = 0.37$) and Asian ($M = 0.54$) participants ($p = .02$), Asian ($M = 0.54$) and Latina/o ($M = 0.46$) participants ($p = .05$), White ($M = 0.43$) and Asian ($M = 0.54$) participants ($p = .05$), and Black ($M = 0.37$) and multiracial ($M = 0.53$) participants ($p = .05$).

Finally, there were significant differences between racial groups in Subscale 6: Workplace and School Microaggressions average scores, $F(5, 454) = 2.93$, $p = .013$, $\eta^2 = .03$. Significant differences were found between Asian ($M = 0.24$) and Black ($M = 0.34$) participants ($p = .04$), White ($M = 0.14$) and Black ($M = 0.34$) participants ($p = .009$), White ($M = 0.14$) and Asian ($M = 0.24$) participants ($p = .017$), White ($M = 0.14$) and Latina/o ($M = 0.24$) participants ($p = .03$), and multiracial ($M = 0.34$) and White ($M = 0.14$) participants ($p = .000$).

Discussion

Results from the current study suggest that there is a negative significant relationship between racial microaggressions and mental health. Individuals who perceive and experience racial microaggressions in their lives are likely to exhibit negative mental health symptoms, such as depression, anxiety, negative affect (or negative view of the world), and lack of behavioral control. This finding is first supported by the significant negative relationship between the total REMS score and total MHI-18 score. However, because it is a weak correlation ($r = –.11$), it can be inferred that other factors may mediate the relationship between experiences with racial microaggressions and mental health. Second, particular types of microaggressions may also be correlated with negative mental health symptoms. For instance, when individuals experience microaggressions related to being treated like a second-class citizen, microaggressions in which they are invalidated, and microaggressions in which they are exoticized or assumed to be similar to others in their group, they may also exhibit negative mental health symptoms. Results indicate that the experience of microaggressions may be correlated with specific mental health problems, namely, depression and lack of positive affect. However, again, because these correlations are somewhat weak ($r = –.12$ to $–.16$), it may be hypothesized that many other potential mediating factors may explain the relationship between racial microaggressions and mental health.

Furthermore, our study's multiple regression analyses yielded two findings. First, individuals' REMS average scores were significant predictors of MHI-18 average scores, suggesting that a higher cumulative experience with racial microaggressions may predict more mental health problems. Second, higher cumulative experiences of racial microaggressions predicted depressive symptoms and one's affect (or how positively or negatively one views the world). However, because of small *F* scores and small effect sizes, it can be inferred that there may be other variables that mediate the

relationship between racial microaggressions and mental health. Similarly, although a significant regression model emerged for the REMS subscales as a predictor of positive affect, with Subscale 3: Microinvalidations as a significant contributor, this finding may be limited in that the total variance accounted for is less than optimal (2.6%). Although an array of mediating variables may influence the relationship between microaggressions and positive affect, the current results suggest that there is indeed a relationship between experiences of being racially invalidated and having a negative view of the world. Perhaps more complex models using other latent variables can be hypothesized to fully capture the impact of racial microaggressions on the lives of people of color.

ANOVA results indicate that different Black, Latina/o, Asian, and multiracial participants may experience a greater number of microaggressions than White participants, and that there are no significant differences in the total amount of microaggressions among Black, Latina/o, Asian, and multiracial participants. ANOVA results also reveal that there may be subscale differences between racial groups. For instance, (a) Black and Latina/o participants may experience more inferiority-related microaggressions than Asian participants, (b) Black participants may experience more criminality-related microaggressions than Latina/o and Asian participants, and (c) Asian participants may experience more environmental and exoticization microaggressions than Black participants. Thus, it appears that although there are no major differences between the total amounts of microaggressions among these three racial groups, some of these groups may experience certain types of microaggressions more than others. These findings align with previous qualitative research that has found that Blacks and Latinas/os experience being treated as inferior or as criminal (Rivera et al., 2010; D. W. Sue, Nadal, et al., 2008), whereas Asian Americans did not report such microaggressions (D. W. Sue, Bucceri, et al., 2007). These findings also align with previous research that reports that "invisibility" is a common microaggression experienced by Asian Americans, who often feel underrepresented in the media and other systems (D. W. Sue, Bucceri, et al., 2007). Using this information, counselors may further the knowledge component of multicultural competence by recognizing that different racial groups may experience different types of microaggressions and that different types of microaggressions may affect clients in diverse ways.

Implications for Counseling and Development

To develop effective therapeutic relationships with clients of color, counselors need to acknowledge that these clients may experience racial microaggressions. Several direct implications from the current study can be made to assist counselors' work with clients of color. First, being aware that there is indeed a link between racial microaggressions and mental health can be helpful in assisting clients to identify microaggressions when they occur and to cope with such experiences accordingly. Perhaps psychoeducational techniques can be used so that clients are knowledgeable about the concept of microaggressions and can feel comfortable discussing such incidents in therapy. Furthermore, knowing that different types of microaggressions may affect different racial groups may be helpful for counselors to pick up on the subtle racism that clients experience in their everyday lives.

Perhaps an important goal of a counselor is to validate the experiences of their clients of color (and other marginalized groups) and to help them to cope successfully with microaggressions when they occur. In doing so, counselors may be able to earn or achieve credibility with their clients of color, which in turn would lead to more successful therapeutic relationships (S. Sue & Zane, 1987). Some authors have described the different ways that individuals react to, and cope with, microaggressions and how such methods may help with their mental health processes or development. Nadal (2010) theorized a three-part decision-making model that individuals of various groups (e.g., people of color; women; and lesbian, gay, bisexual, and transgender people) undergo when they are victims of microaggressions. The three questions are (a) Did this microaggression really occur? (b) Should I respond to this microaggression? and (c) How should I respond to this microaggression?

Oftentimes, victims of microaggressions need to feel validated when a microaggression occurs. D. W. Sue, Capodilupo, and Holder (2008) described this as a "sanity check" (p. 332) in which the victims of microaggressions often turn to others, who either have witnessed the interaction or can help them process their cognitive and emotional reactions. Next, they decide whether to respond to the microaggression, by confronting the perpetrator or ignoring the incident altogether. In making such a decision, they consider the context (e.g., could their physical or psychological safety be compromised?). And if they choose to respond, they decide the means to do so (e.g., directly verbally confronting the perpetrator or passive-aggressively conveying one's feelings).

D. W. Sue, Capodilupo, and Holder (2008) reported that people of color often do not feel that they have dealt effectively with microaggressions when they occurred, leading to chronic psychological distress. For instance, if they chose not to confront the perpetrator, they might feel regret, remorse, guilt, or shame; however, if they did address the incident, they might fear appearing like a negative representation of their race or that they chose an ineffective method of communication. Given this psychological stress that may occur, perhaps counselors and other practitioners can assist their clients in thoroughly processing their thoughts and feelings regarding microaggressions during counseling sessions. Furthermore, perhaps counselors can provide opportunities for clients to recall past experiences of microaggressions in order to cope with any unresolved feelings that may lead to internalized

racism, self-doubt, or other negative mental health outcomes, or that may affect any other aspect of their social or identity development. Counselors may also recognize that although clients may not have the ability to confront the offenders of microaggressions directly, there may be other opportunities for them to respond through advocacy (e.g., by becoming involved in community organizations in which they can meet people with similar experiences or by educating others about racially charged issues in the media, such as the Trayvon Martin case in which a Black youth was fatally shot in Florida in 2012).

Moreover, counselors must be aware that some microaggressions may even occur in both mental health and school counseling settings and therefore may have negative consequences for their clients of color (Buser, 2009). An example of a microaggression in a counseling setting may be a counselor who tells a client of color that she or he complains about racism too much or a counselor who stereotypes that a client would have the exact same experiences as others in her or his racial group. The first instance would be considered a microinvalidation because it negates the racial reality of the client, whereas the second incident would be a microinsult because it reinforces the counselor's stereotypes of the client's racial group and may be subtly offensive to the client.

One study involving microaggressions against women found that female clients who perceive microaggressions in psychotherapy sessions were more likely to perceive a negative working alliance and less likely to report positive treatment outcomes (Owen, Tao, & Rodolfa, 2010). Thus, it is imperative for counselors to be cognizant of how their unintentional biased behaviors and statements may be perceived as microaggressions by their clients because such experiences may have detrimental effects on their therapeutic relationships and their clients' ability to succeed in counseling (Buser, 2009). Given the cultural mistrust that is often experienced by clients of color (Whaley, 2001), microaggressions must be prevented (and addressed when they occur) to decrease the dropout rates for clients of color in counseling. Engaging in honest dialogues about racial microaggressions and racial dynamics with clients of color may demonstrate that practitioners are addressing the awareness component of multicultural competence (D. W. Sue et al., 1992).

Finally, culturally competent counselors and other practitioners must be aware that intersectional identities may affect clients' experiences with microaggressions, which may then have an impact on their mental health. For example, when a young Black woman is spoken to in a belittling way, is she being treated in such a way because of her race, gender, age, or some combination of all three? Perhaps she experiences an array of microaggressions because of her intersectional identities, which in turn may affect her mental health and quality of life. Perhaps microaggressions are such a normalized part of her experience that she does not even recognize that such incidents have an influence on her mental health, her self-esteem, and other factors. Because intersectional identities are such a crucial aspect to an individual's development and sense of self, it may be beneficial for counselors to initiate conversations about potential microaggressions so that their clients can thoroughly process their feelings about past microaggressions, while preparing them to cope with future microaggressions.

Limitations and Recommendations for Future Research

As with any research, this study is not without its limitations. First, both the REMS and MHI-18 are self-report measures that involve people's perceptions; thus, they may not accurately reflect participants' true lived experiences. This is particularly important because people of color tend to underreport mental health issues; accordingly, it may be necessary to use alternative means of measuring mental health outcomes. Second, because participants took the measures in the same order, there could have been a potential priming effect of the first measure on the second measure. Third, we measured effect size using eta-squared scores, which previous researchers have cautioned against because they may be inaccurate or misleading (C. A. Pierce, Block, & Aguinis, 2004). Perhaps future studies can analyze effect sizes using Cohen's F^2 score as a more substantial way of analyzing the relationships between all of our variables.

Perhaps one of our biggest limitations was that our sample may not be generalizable to the general population. Because the mean age of the participants was 24 years, most were undergraduate college students, and most reported living in the Northeast, the sample may not be generalizable to all people of color across the United States. Future studies may aim to collect a more diverse sample in terms of age and geographic location, and further analyses of the current data set may examine influences of education, age, and gender on experiences with racial microaggressions and mental health.

Future research may also focus on understanding the relationship between other variables and racial microaggressions. First, because the correlations between the REMS and MHI-18 measures were weak, as was the total variance accounted for in the MHI-18, numerous moderating and mediating variables may affect the relationship between racial microaggressions and mental health. Perhaps constructs like self-esteem, personality traits, and social support may also influence how one perceives racial microaggressions and how such experiences may affect one's mental health. Second, because there were so many differences between the various racial groups, perhaps future studies can examine groups separately, looking at the other social identities (e.g., ethnicity, gender, sexual orientation, religion) to understand how other identities may influence one's perceptions of, and responses to, racial microaggressions. Third, because of the increase in research involving discrimination and health disparities,

it may be important to study the influence of racial microaggressions on physical health and functioning. Perhaps further analyses involving the interactions of race, gender, age, and other demographic variables may be helpful in understanding how intersectional identities may affect the types of microaggressions that people encounter and how such microaggressions may negatively influence their mental health. Finally, it may be important for future research to investigate how individuals cope with microaggressions and which counseling interventions are most effective when working with clients who experience microaggressions in their everyday lives. All of these studies can be advantageous in further understanding the impact of racial microaggressions (and microaggressions affecting other groups) so that counselors can assist their clients in developing healthy self-esteem and well-being.

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