Research Square

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Experiences of racialized individuals in psychotherapeutic treatment: resilience, coping, and support factors

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Abstract

Background

Racial microaggressions are subtle, everyday interactions that are often ambigous, indirect, and difficult to identify. Their occurrence in psychotherapeutic settings is associated with poorer working alliance, reduced treatment satisfaction and improvement. Although international research has established the harmful effects of racial microaggressions, empirical evidence on their manifestation within the German mental health care system is scarce. Furthermore, racial microaggressions are mostly examined in connection to psychological disorders but little is known about their relation to resilience and how this relation is affected by coping behavior and social support factors.

Methods

The cross-sectional study analyzed how racial microaggressions manifest itself in the German mental health care system and how their occurence in psychotherapeutic settings relate to resilience levels of patients. Additionally, it was examined whether proactive and secondary coping strategies mediate this relationship and how social support and sense of belonging to one's self-identification group are connected. Data were collected via an online survey. A structural equation model with racial microaggressions in psychotherapy as predictor, proactive and secondary coping strategies as mediator, resilience as outcome variable, and social support as well as sense of belonging as covariates was conducted (*N* = 190).

Results

The results indicate that racial microaggressions occur within the German mental health care system and psychotherapeutic settings. Racial microaggressions, resilience, and coping were not significantly associated with each other. However, social support and proactive coping emerged as robust predictors of resilience while social support and sense of belonging were positively associated with proactive coping.

Conclusion

These findings highlight the benefit of fostering proactive coping strategies and social support factors in psychotherapeutic settings. Simultaneously, it should be acknowledged that resilience and coping strategies are not solely an individual's responsibility to adapt well to a discriminatory environment. That experiences of racial microaggressions were not significantly related to resilience or coping does not mitigate their harmfulness but rather suggests that their impact might be more complex than initially

assumed and cannot be sufficiently explained by both factors alone. The results still emphasize the need for increased awareness and structural improvement to address racist practices in mental health care.

1. Introduction

Racial discrimination is an important social determinant of mental health (1). It operates not only through overt hostility or explicit discriminatory acts, but also through subtle, everyday interactions that communicate exclusion, devaluation, or non-belonging to racialized individuals. Those subtle discriminations are conceptualized as racial microaggressions which are brief, commonplace verbal, behavioral, or environmental indignities that can be intentional or unintentional. In contrast to overt racism, microaggressions are often ambiguous, indirect, and difficult to name. This ambiguity renders them especially harmful, as affected individuals may not only experience the racist instance but also the burden of interpreting, questioning, and potentially having their judgment doubted (2, 3).

Racial microaggressions are associated with adverse psychological outcomes, for example, depressiveness, anxiety, reduced self-esteem, and diminished locus of control (4–6). These findings are clinically relevant because exposure to racial microaggressions can increase the need for psychological treatment while racist structures simultaneously shape the access to mental health care. Individuals who are subjected to racism are less likely to seek psychotherapy or are more likely to discontinue it (7, 8). In a German study, every third racialized person reported giving up search for a psychotherapeutic appointment. Among individuals frequently experiencing discrimination in health care, more than half of self-identified Black, Muslim, and Asian respondents stated to have stopped their search for therapy in general (9). Reasons for discontinuation of therapy search in other studies include a lack of racism specific knowledge among healthcare professionals, insecurity of treatment suitability, fear of harm, long waiting lists, poor accessibility, and distrust of institutions (7, 10). A particularly crucial reason for discontinuation of psychotherapeutic treatment are racist dynamics within the therapist-patient dyad. Psychotherapists may enact racial microaggressions by minimizing experiences of racism, avoiding discussion of those, being unaware of structural racism, adopting “color-blind” perspectives, making racist comments, or failing to recognize the relevance of discrimination for clients’ mental health (11, 12). Racial microaggressions in psychotherapy are associated with poorer working alliance, lower satisfaction, and reduced treatment improvement. On the other hand, addressing and repairing these incidents can reduce those negative effects (13, 14). Since racism in relation to mental health is a still a developing research area in Germany, very few studies have examined the occurrence of racial microaggressions in the mental health care system in general and in therapist-patient dyads (9, 13). Hence, further investigations are needed to understand the nature of racial microaggressions in psychotherapeutic settings in the German context.

Although a considerable body of international research has documented the harmful effects of racism and racial microaggressions on mental health, less is known about the psychosocial processes that could support resilience among individuals experiencing it. Resilience generally refers to the ability to resist, cope with, and grow from adverse life experiences (15). However, there is an ongoing debate

whether resilience should be understood as a stable trait or a dynamic state. Trait-based perspectives emphasize relatively stable, heritable characteristics, whereas state-based perspectives conceptualize resilience as a set of cognitive, emotional, and motivational capacities that can develop through environmental interactions (16, 17). Despite extensive research, no universally accepted definition exists to date (18). More recently, research on resilience has shifted from identifying resilient personality traits toward examining the biological, psychological, social, and spiritual processes that promote resilience (19, 20). This distinction is important because framing racialized individuals as “naturally resilient” risks shifting responsibility away from racist structures onto those affected by them (21).

One potential mechanism underlying resilience is Coping. It is defined as the cognitive and behavioral efforts individuals employ to manage stressors, whether originating from within themselves or from external sources (22). Encounters with racial microaggressions constitute a highly stressful instance in which coping strategies are applied. The present study conceptualizes coping behavior as proactive and secondary. Proactive coping refers to strategies such as clarifying a stereotype or affirming one’s positive qualities. Secondary coping includes more avoidant or reactive strategies, such as disengagement from a situation or rude confrontation with an aggressor (23, 24). These strategies have been similarly documented across North American and European qualitative and quantitative studies exploring coping responses to racial discrimination (25–31). One qualitative study investigating explicitly coping responses to racial microaggressions found that particularly seeking social support and adressing microaggressions emerged as strong proactive factors (32). Proactive coping, more broadly, is associated with reduced psychological distress, enhanced well-being, and a buffering effect against the adverse mental health consequences of racial discrimination (33, 34). Further, it has been consistently linked to higher levels of resilience (35–37). In contrast, secondary coping, such as avoidance, may provide short-term relief but is associated with poorer long-term outcomes, including elevated distress, substance use, social withdrawal, internalized racism, and reduced sense of agency (28, 34, 38, 39). In a similar study, racial microaggressions in connection with depression and reduced sense of belonging to society were associated with the use of maladaptive coping strategies (40). Deriving from this, racial microaggressions in counseling and the potentially resulting poorer working alliance, diminished health improvement, and termination of treatment (13) may promote secondary coping which could be associated with lower resilience levels due to feelings of helplessness, reduced sense of agency, increased distress, and worsened mental health. Racial microaggressions in psychotherapy could also directly affect resilience, given established associations between racial discrimination and diminished resilience levels (41, 42). Accordingly, one potential approach in psychotherapeutic settings is to strengthen proactive coping strategies, as these are positively connected to resilience and have been identified as a critical factor for further investigation within research on racial discrimination and microaggressions (5, 43).

Other relevant factors relating to resilience are perceived social support and sense of belonging to one’s self-identification group. Both are frequently reported by individuals experiencing racism (26, 44). Social support provides validation, emotional relief, and a feeling that one’s experiences are recognized (Helgeson, 2003). It was also found to be a consistently strong predictor of higher resilience levels

across several studies (Supke et al., 2025). In the context of racial discrimination, this may be particularly important since social support can counteract isolation and provide interpersonal resources. Also, sense of belonging to one's self-identification group may provide an additional source of identity, validation, and collective strength. Affirmation to a self-identification group and group identity showed protective effects under high discrimination stress and were conceptualized within the framework of resilience (46, 48).

When discussing resilience, different coping strategies, and support factors, it is also central to acknowledge that definitions of high and low resilience or adequacy of coping strategies can lead to blaming racialized individuals for not responding well to an oppressing environment. Individuals experiencing racism should not be framed as solely in need of high resilience, while the persistent structural reality of racism as well as barriers to mental health services or discrimination within therapeutic settings is overlooked (21). Research should therefore rather explore how racism can affect resilience and how coping and different support factors can be beneficial with the aim of informing therapeutic practice but keeping the broader sociopolitical frame into account.

Taken together, the present study aims to investigate how racial microaggressions manifest itself in the German mental health care system and how their occurence in psychotherapeutic settings relate to resilience levels of patients. In addition, it will be examined whether proactive and secondary coping strategies mediate this relationship and how social support and sense of belonging to one's self-identification are connected with coping and resilience. It it hypothesized that experiences of racial microaggressions in psychotherapeutic settings are negatively associated with resilience levels (H1) and that proactive and secondary coping strategies mediate this association (H2). It is further hypothesized that social support and sense of belonging to one's self-identification group predict resilience and the use of proactive coping strategies positively (H3). By this, the present study intends to contribute to the growing body of research concerning the occurrence of racial microaggressions in Germany and addresses an important research gap regarding the relation of racial microaggressions in psychotherapeutic settings with resilience and coping behavior as previous research has called for.

2. Methods

The present study was conducted within the scope of the mixed-methods project Racial Discrimination in the Context of Mental Health Care (RaDiGe). RaDiGe is a joint project of the University Medical Center Mainz, Johannes Gutenberg-University Mainz, and the University of Applied Sciences Jena and is funded by the Federal Ministry of Research, Technology, and Space. Qualitative, quantitative, and experimental approaches are applied to assess the relationship between experiences of racial discrimination and mental health as well as access to and experiences in psychotherapeutic care of racialized individuals in Germany. The present study draws data from the quantitative online survey. The project is supported by four practice organisations: Islamic Association for Social and Educational Professions (IASE), Magazine of Color, Information and Documentation Center for Antiracism Work (IDA), and Institute for the Promotion of Education and Integration (INBI). They provide anti-racist guidance throughout the

entire course of the project. For the present study, they advised on recruitment and sampling strategies, selection and translation of items as well as scales, and preparation of the manuscript. Meetings with the practice organisations were held twice a year, but additional consultation could be requested.

2.2 Participants

Individuals who self-identified other than White and/ or German without a migration background and who have visited therapeutic care currently or in the past were included in the present study. Thus, of the 2,500 individuals included in the RaDiGe-project, 1,831 were excluded because they self-identified solely as White and/ or German without a migration background and 479 were excluded since they had no experience with psychotherapeutic care. The final sample included 190 participants, of whom 96 (50.5%) identified as a woman, 93 (48.9%) as a man, and one (0.5%) as non-binary. Age ranged from 18–75 years (M = 36.05). Most participants self-described as Muslim or German with a migration background (multiple selection was possible). Further sociodemographic characteristics, including the self-identification, are presented in Tables 1 and 2.

Table 1

Sociodemographic characteristics of the sample (N = 190)

Gender	***N***	**%**
Woman	96	50.5
Man	93	48.9
Non-binary	1	0.5
Education		
High education	82	43.2
Middle education	90	47.3
Low education	18	9.5
Employment		
Employed	113	59.5
Retired	7	3.7
Unemployed	17	9.0
Other	53	27.9
Country of birth		
Germany	132	69.5
Other	58	30.5
	M	*SD*
Age	36.05	12.05
Equivalence income	2,057.25[a]	1,404.69

Note. High education = Bachelor, Master, PhD, or comparable education; middle education = completed apprenticeship or A-level school degree; low education = no school degree, lowest possibler school degree, or no apprenticeship (derived from Hoffmeyer-Zlotnik et al., 2024); [a]43 missing values.

Table 2
Self-identification of participants (N = 190)

Muslim	***N***	**%**
	60	**31.6**
Jewish	9	4.7
Sinti and Roma	10	5.3
Eastern European	31	16.3
Asian	13	6.8
Turkish	23	12.1
Black	8	4.2
Person of Color (POC)	6	3.2
White	30	15.8
German (without migration background)	9	4.7
German (with migration background)	71	37.4
Foreign	36	18.8

Note. Multiple selection was possible. Hence, participants choosing the self-identification groups White or German without migration background were still included when they also indicated another self-identification besides those two.

2.3 Procedure

Data collection was conducted by the market research institute Mindline between June and July 2025. An incidental ratio was first collected to establish the distribution of the quota characteristics gender, age, and region (case number n = 1,452), which was then read off as the basis for reaching the target sample size of 2,500 participants. The sample was controlled according to the distributions of the quota characteristics. Slight deviations were compensated for by weighting. Invitations were sent out strategically based on quota requirements and in several waves via email, but also via the panel website or the mobile app of the panel. Quota cells or subgroups that have been proven to be more difficult to fill were prioritized and invited first. The response rate was 10.0%. In total, 10,038 individuals took part in the online survey of whom 7,538 were excluded due to non-completion of the survey and quality reasons, for example, indiscriminate answers to multiple statement batteries or nonsensical responses. Average survey duration was 15.5 minutes.

The project was approved by the ethics committee of the State Chamber of Physicians of Rhineland-Palatinate (No. 2023–17106) and the study was conducted in accordance with the Declaration of Helsinki. A minimum age of 18 years and consent to the participation were required. The participants

were informed about their right to withdraw from the study at any time. The voluntary nature and purpose of the study were indicated before the start of the survey.

2.4 Materials

Several scales and single items were used to analyze the association between racial microaggressions in psychotherapy, coping behavior, resilience, sense of belonging to one's self-identification group, and social support.

2.4.1 Self-identification

To explore how participants self-describe their group the following item was applied: "People can belong to various groups. How does this apply to you? Please list all the groups to which you feel you belong. The groups listed are just a few examples of possible groups. Please also use the free-text fields if any groups you belong to are not listed." There were 12 preset answer possibilities which are displayed in Table 2. Additionally, participants could use up to four free-text fields to describe self-identification(s) other than the specified. Unlimited multiple selection was possible. In case of multiple selection, it was necessary to choose the most relevant self-description regarding experiences of discrimination for two of the scales described below with the following item: "You have selected several groups. Please select the one that is most important to you in your daily life when it comes to discrimination".

2.4.2 Racial Microaggression in Counseling Scale

For the present study, the original English version of the Racial Microaggression in Counseling Scale (RMCS) (11) was adapted and back-and-forth translated to German by the research team in consultation with the practice organisations. The scale consists of 10 items measuring experiences of racial microaggressions in therapy settings on a three-point Likert Scale "This has never happened" (0), "This has happened but it did not bother me" (1), and "This has happened and it bothered me" (2) (ω = .93). An example item is: "My psychotherapist has sometimes downplayed the significance of racism during our sessions". The authors added the following question at the end of the scale: "In your opinion, is or was this therapist affected by racism?" (yes = 1, no = 2). Participants were asked to think about their current or most recent psychotherapy experience when filling out the scale. For this scale it was necessary to select one self-identification in case of multiple selection. An English version of the adapted and translated scale is presented in the appendix (Figure A).

2.4.3 Brief Resilience Coping Scale

The Brief Resilience Coping Scale (BRCS) ((50) is already available as a validated scale in German (51). It measures resilience with four items on a five-point Likert Scale (1 = not true at all to 5 = completely true) (ω = .81).

2.4.4 Discrimination Coping Strategies Scale

The Discrimination Coping Strategies Scale (DCSS) (24) is a 5-item questionnaire measuring frequently used coping strategies in relation to racial discrimination on a 5-point Likert Scale (1 = never to 5 = very often). For the present study, the original English version of the DCSS was back-and-forth translated to German by the research team in consultation with the practice organisations (ω = .57). The original items were derived from a qualitative study investigating applied coping in reaction to racial discrimination (30). Three strategies are encompassed in the subscale proactive coping style: discuss, self-affirmation, and disprove. The items ignoring the situation and rude verbal retort are comprised in the subscale secondary coping (23).

2.4.5 Social support

The brief three-item form of the perceived social support questionnaire (F-SozU K-3) (52) was used to measure social support on a 5-point scale (strongly disagree = 1 to strongly agree = 5) (ω = .85).

2.4.6 Sense of belonging to one's self-identification group

Participants could answer to six statements regarding sense of belonging to their self-identification group(s) on a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). Example items are: "I feel like I belong to this group" and "I understand what being part of this group means to me". This questionnaire was developed by the authors for the present study in German. For this scale it was necessary to select one self-identification in case of multiple selection. An English language version is presented in the appendix (Figure B).

2.4.7 Single items

One single item was applied to examine diagnosed psychological disorders in participants: "Have you ever been diagnosed with a psychological disorder by a doctor or a psychotherapist?" (Yes, the following disorder(s)…/ No). To analyze structural barriers and racial microaggressions in the German mental health care system, one self-developed item with nine answer possibilities and one free-text field was used asking for reasons why a psychotherapeutic treatment did not happen despite participants' efforts to receive care. Example answers are: Waiting time was too long, a therapist told me that she or he isn't familiar with racism, and a therapist told me that my German language proficiency is not sufficient.

2.5 Data analysis

Data were analyzed using IBM SPSS Statistics (version 29.0; IBM Corp., 2022) and R (version 4.4.1; R Foundation for Statistical Computing, 2024). For the descriptive analysis SPSS was utilized. Sum scores were computed for RMCS, DCSS and BRCS. For the RMCS, the mean was calculated across all 10 items. A higher mean indicates more frequent and bothering experiences of racial discrimination in psychotherapy. For the DCSS, means for the two subscales proactive and secondary coping were computed respectively. A higher mean indicates more frequent use of either proactive or secondary coping. For the BRCS, the total sum score was calculated and then divided into three categories: a total of four to 13 indicates low resilience levels, a total of 14 to 16 shows a medium level, and a total of 17 to 20 was assigned to a high resilience level. Sum scores were also computed for the F-SozU K-3, with

higher scores indicating higher social support (3–15). Mean values were calculated for the six items measuring sense of belonging to one's self-identification group. A higher mean indicates higher sense of belonging.

Internal consistency of the BRCS, DCSS and RMCS was evaluated computing McDonald's omega (ω) in SPSS. The cut-off point for the internal consistency, measured by McDonald's ω , was set at > .7.

Missing values accounted for less than 5% and were classified as missing at random. These were imputed using scale means, given that at least half of the values for a scale was available for each participant. If a case did not meet this criterion, it was excluded from the analysis (listwise deletion).

To further evaluate coping behavior, a paired samples t-test was conducted with the means of the proactive and secondary subscales of the DCSS to compare which coping dimension is used more frequently.

To analyze whether experiences of racial microaggressions in psychotherapy are negatively associated with resilience (H1), whether proactive and secondary coping strategies mediate this association (H2), and whether social support and the sense of belonging to one's self-identification group predict resilience and the use of proactive coping strategies positively (H3), a structural equation analysis was conducted in R. Proactive and secondary coping measured by the DCSS functioned as two mediators separately, experiences of racial microaggressions in therapy measured by the RMCS was the independent variable, and resilience measured by the BRCS was the outcome. Social support and sense of belonging to one's self-identification group were analyzed as covariates predicting resilience and both respective coping dimensions. Age, gender (woman), education (high), and unemployment were included as control variables. Bootstrapping with 5,000 iterations was conducted with the package lavaan 0.6–21. Effects were deemed statistically significant when the bootstrap confidence interval (CI) did not include the null effect. The CI of choice is the bias corrected and accelerated bootstrap CI (Bca CI), which is a more robust estimate for when the data is skewed (53). The significance level for the entire analysis was set at $\alpha < .05$.

3. Results

Regarding mental health, 43.2% of the participants reported having been diagnosed with a psychological disorder at some point in their life. The most frequently reported diagnoses were depression (24.3%), anxiety disorder (6.5%), and post-traumatic stress disorder (PTSD) (4.6%). Concerning experiences within the German mental health care system, 62.6% stated that they were interested in a psychotherapeutic treatment but were unable to access it. Reported access barriers included long waiting times (30.5%), being informed by a physician or psychotherapist that treatment was not necessary (12.6%), therapists being unavailable after an initial consultation (14.7%), therapists reporting insufficient knowledge of the participant's culture or religion (11.1%), not knowing how to access psychotherapeutic services (10.5%), therapists lacking familiarity with racism and its psychological impact (10.0%), the unavailability of a therapist sharing the participant's primary language (7.9%),

therapists considering the participant's German language proficiency insufficient (7.4%), and the unavailability of therapists with personal experience of migration or racial discrimination (5.8%). Despite these barriers, all participants reported having received psychotherapeutic treatment at some point in one or more mental health care settings. Specifically, 60.5% received outpatient psychotherapy, 31.1% had been treated in a psychosomatic clinic, 20.5% in a psychiatric clinic, and 14.7% in a rehabilitation clinic.

Overall, 58.7% of the participants stated to have already experienced racial microaggressions during their current or most recent therapeutic treatment. The most frequently endorsed experiences were the perception that the therapist held stereotypical assumptions about the participant (58.7%), followed by feeling over- or underestimated by the therapist due to the participants' group identity (57.1%), insensitiveness regarding the participants' self-identification group (56.5%), and that the therapist seemed to find the participant overly sensitive regarding racist issues (54.8%). The average RMCS score (M = .80) indicates that participants experienced racial microaggressions in psychotherapy, although these experiences were generally occurring infrequently and were perceived as not bothersome. To the question "In your opinion, is or was the therapist affected by racism?", 24.7% responded affirmatively. Further results are presented in Table 3.

The paired-samples t-test revealed that participants employ proactive coping strategies significantly more often than dysfunctional coping strategies $t(183) = 2.58$, $p = .011$, $d = 0.19$. A mean of 14.57 for the BRCS indicates on average middle resilience levels.

Table 3
Descriptive Statistics for the analyzed scales (N = 190)

RMCS	***M***	***SD***
	.80	**.63**
BRCS	14.57	3.31
DCSS		
Proactive Coping	3.33	.81
Secondary Coping	3.14	.85
Social support	11.08	3.18
Group identification	4.67	2.62

Note. To facilitate readability, the variable sense of belonging to one's self-identification group was abbreviated as group identification in this table.

3.1 Structural equation model

The RMCS was not significantly associated with proactive or secondary coping. Social support significantly predicted proactive coping. Sense of belonging to one's self-identification group was positively associated with proactive but not with secondary coping. High education, age, unemployment, and female gender were not significantly associated with proactive or secondary coping.

Proactive coping was a significant positive predictor of the BRCS. In contrast, secondary coping was not significantly associated with resilience. The direct effect of RMCS on BRCS was also not significant. Social support was positively associated with the BRCS while belonging to one's self-identification group were not significantly related. Among the covariates, unemployment was negatively associated with the BRCS. Age, female gender, and high education were not significantly related.

Neither proactive nor secondary coping significantly mediated the association between RMCS and BRCS. Consequently, neither the total indirect effect nor the total effect of RMCS on BRCS reached statistical significance. Overall, the findings do not support proactive or secondary coping as mediators of the association between RMCS and BRCS. Instead, the BRCS was primarily associated with higher levels of proactive coping and social support, whereas unemployment was associated with lower BRCS levels. Because the model was just-identified ($df = 0$), global fit indices were not interpreted. Further results are presented in Table 4. Results inclduding covariates are depicted in the appendix (Table A).

Table 4

Structural equation model examining racial microaggressions, resilience, coping, and covariates (N = 190)

Path	*B*	*SE*	β	*z*	*p*
Predicting proactive coping					
RMCS → Proactive coping (a_1)	− .064	.091	− .049	− .71	.481
Social support → Proactive coping	**.212**	**.053**	**.280**	**3.99**	**< .001**
Group identification → Proactive coping	**.227**	**.070**	**.227**	**3.25**	**.001**
Predicting secondary coping					
RMCS → Secondary coping (a_2)	.059	.101	.043	.58	.560
Social support → Secondary coping	.201	.059	.251	.79	.241
Group identification → Secondary coping	.072	.077	.068	.93	.351
Predicting BRCS					
Proactive coping → BRCS (b_1)	**1.965**	**.234**	**.479**	**8.40**	**< .001**
Secondary coping → BRCS (b_2)	.181	.211	.047	.86	.391
RMCS → BRCS (c')	− .252	.283	− .047	− .89	.374
Social support → BRCS	**1.063**	**.176**	**.342**	**6.05**	**< .001**
Group identification → BRCS	− .089	.224	− .022	− .40	.691
Indirect effects					
RMCS → Proactive coping → BRCS	− .126	.179	− .024	− .70	.483
RMCS → Secondary coping → BRCS	.011	.022	.002	.48	.630
Total indirect effect	− .115	.184	− .022	− .63	.532
Total effect	− .367	.337	− .069	-1.09	.275

Note. B = unstandardized regression coefficient; *SE* = standard error; β = standardized regression coefficient. Significant effects ($p < .05$) are presented in bold. Bootstrapping was conducted with 5,000 iterations. To facilitate readability, the variable sense of belonging to one's self-identification group was abbreviated as group identification in this table.

4. Discussion

The present study investigated how racial microaggressions manifest itself in the German mental health care system and how their occurrence in psychotherapeutic settings relates to resilience levels of patients. In addition, it was examined whether proactive and secondary coping strategies mediate this relationship and how social support and sense of belonging to one's self-identification group are

connected with coping behavior and resilience. Overall, participants experienced access barriers to mental health care. Racial microaggressions in psychotherapeutic treatment occurred but rather seldom and were on average not perceived as bothering. Contrary to the hypothesis, racial microaggressions experienced in psychotherapy were neither directly nor indirectly associated with resilience levels through proactive or secondary coping. Instead, resilience was primarily predicted by higher levels of proactive coping and perceived social support. Furthermore, social support and sense of belonging to one's self-identification group were positively associated with proactive coping.

The findings regarding barriers occurring in the German mental health care system underscore the mental health burden carried by participants in demand of therapeutic care. While nearly half of the participants were diagnosed with a psychological disorder at one point in their life, most commonly depression, anxiety, or PTSD, the majority reported a prior unmet need for psychotherapeutic treatment. Long waiting times or timely unavailability of therapists after an initial consultation were reported alongside therapists' unfamiliarity with racism, a lack of therapists who shared participants' primary language or lived experience of migration or racism, and therapists stating that German language proficiency of the participants was not sufficient for treatment. These results align with existing literature suggesting that structural and interpersonal barriers to mental health care disproportionately affect racialized individuals, potentially compounding existing mental health disparities and delaying help-seeking (4, 9, 40). When participants of the present study did manage to access care, the therapeutic relationship itself was partially marked by experiences of racial microaggressions. More than half of the participants experienced at least one microaggression during their current or most recent therapy, most commonly stereotyping, over- or underestimation, insensitivity toward their self-identification group, and telling participants they are too sensitive regarding racist issues. This is also in line with prior research documenting the high prevalence of racial microaggressions within therapeutic dyads and their detrimental impact on the therapeutic alliance as well as treatment outcomes (12, 13). Taken together, these findings suggest a troubling pattern in which the structures meant to provide relief from psychological distress constitute an additional source of strain for racialized individuals. In this context it is important to consider that psychotherapists exerting racial microaggressions are often not marginalized and have lower awareness of their priviliges. Furthermore, discrimination is not thematized sufficiently in psychotherapy training in Germany (54). Additionally, Germany possesses its own distinct history of racism shaped by National Socialism and historical ignorance of its colonial past, leading to social discourses that rather try to deny racism and treat it as an external phenomenon (55, 56) eventhough it has a huge structural impact. This raises important implications for racism-sensitive care: Beyond improving structural access to mental health services, there is a clear need for therapist training that addressess, among, others, establishing knowledge about racism, self-reflection regarding own racism, and awareness of privileges.

4.1 Racial microaggressions in psychotherapy, resilience, and coping

Racial microaggressions experienced in psychotherapy were neither directly nor indirectly associated with resilience through proactive or secondary coping. This partly contrasts previous research finging that racial discrimination is associated with lower resilience levels (41, 42) and that facing racial microaggressions can promote maladaptive coping behavior (40). The absent mediation effect suggests that the impact of racial microaggressions in psychotherapeutic settings might be more complex than initially assumed and cannot be sufficiently explained by coping behavior and resilience alone. Rather than representing a direct pathway, the relation between racial microaggressions occuring in therapy, resilience, and coping may depend on additional contextual or psychological mechanisms that were not assessed in the present study. Also, contextual discussion is necessary. Previous studies reporting negative associations between racism, resilience, and coping examined everyday discrimination and microaggressions across multiple life domains (40–42), whereas the present study focused exclusively on psychotherapeutic settings. Although psychotherapy represents a particularly sensitive context due to expectations of safety and trust, it may constitute a relatively small part of participants' overall experiences with racism. Racial microaggressions in therapy were possibly not sufficiently influential on participants' general coping style or overall resilience level in the present study. A further explanation concerns the evaluation of discriminatory experiences itself. According to the transactional model of stress and coping (22), stressful events do not inevitably result in psychological distress. Rather, their impact depends on how individuals cognitively evaluate the event and the resources they perceive as available to manage it. This theoretical perspective is especially relevant given the structure of the RMCS which distinguishes between experiences "did not bother me" and "did bother me." Surprisingly, many participants indicated that the experiences of racial microaggressions in therapy did not bother them. Perhaps, many participants interpreted the therapist's behavior as not intentional or malignant. Hence, if individuals evaluate such experiences as not bothering then it may not affect them as negatively. Another factor concerns the therapeutic context itself. Unlike many everyday interactions, psychotherapy is characterized by repeated contact with the same professional and offers opportunities for clarification, reflection, and repair. Addressing racial microaggressions within therapy can substantially attenuate the negative effects on the therapeutic alliance and perceived treatment improvement (13, 57). Since the present study did not assess whether therapists acknowledged or repaired discriminatory incidents, it is possible that experienced racial microaggressions were subsequently discussed and resolved. Other methodological aspects may also explain the findings. Current states of resilience and coping behavior were assessed alongside retrospective reports of therapy experiences. However, resilience represents a relatively broad psychological construct that can develop over time through repeated interactions between risk and protective factors (16). Some participants may have experienced racial microaggressions a certain amount of time before the survey thus, it potentially did not correspond to their current resilience levels.

Nevertheless, the results should not be interpreted as evidence against the harmfulness of racial microaggressions in psychotherapy. Instead, it is suggested that the relationship between racial microaggressions in psychotherapy, coping, and resilience is likely more indirect and context-dependent than initially hypothesized. Racial microaggressions in psychotherapy rather seem to directly affect

factors of treatment success or other outcomes such as sense of belonging, self-esteem, or depressiveness (4, 40).

4.2 Social support and sense of belonging to one's self-identification group

Participants reporting greater perceived social support also reported substantially higher resilience. This outcome is highly consistent with recent empirical research identifying social support as one of the most consistent predictors of resilient adaptation across different populations and adverse life circumstances (47). Similarly, social support is described as an enhancing factor of individuals' ability to recover from stressful experiences by fostering emotional security and psychological flexibility (19). Interestingly, social support was also positively associated with proactive coping, suggesting that supportive relationships may encourage more active responses to discriminatory experiences. This interpretation also aligns with the transactional model of stress and coping (22), emphasizing that available social resources influence both the appraisal of stressful events and the selection of coping strategies. Consequently, social support may not only strengthen resilience directly but may also promote proactive behavioral responses that facilitate long-term psychological adjustment.

The observed positive association between sense of belonging to one's self-identification group and proactive coping aligns with the Social Cure approach (58) which proposes that group memberships provide psychological resources extending beyond social belonging. Shared social identities can foster collective efficacy, strengthen self-esteem, and provide access to emotional and informational support, thereby potentially facilitating adaptive coping responses. This mechanism is supported empirically in discrimination contexts where intragroup support has been shown to buffer the effects of stigmatisation by shaping coping responses such as stigma resistance (59). Stronger connection to one's self-identification group may also reduce the tendency to internalize experiences of racial microaggressions by attributing them externally, potentially attenuating their adverse mental health effects.

On the other hand, sense of belonging to one's self-identification group was not significantly associated to resilience. This is in contrast to other research arguing that sense of belonging is a source of resilience helping racialized individuals to recover from adversitiy caused by racial discrimination (46, 48). However, none of those studies investigated resilience as a direct outcome of sense of belonging but rather analyzed it as a buffering effect of racism concluding that it is a resilient function. Thus, sense of belonging to a group may primarily exerts its influence indirectly through mechanisms such as social support, collective efficacy, or adaptive coping rather than directly affecting resilience itself.

4.3 Clinical implications

Although the hypothesized mediation model was not supported, the study highlights several clinically meaningful factors associated with resilience. In particular, proactive coping, social support, and sense of belonging to one's self-identification group emerged as important protective resources, underlining that strengthening patients' existing psychological and social resources can be a psychotherapeutic

approach. Simultaneously, the absence of significant associations between racial microaggressions and resilience should not be interpreted as evidence that racial microaggressions in psychotherapy are clinically irrelevant. Even though many participants evaluated their experiences of racial microaggressions in psychotherapy as not bothering, their presence is an indication for racist structures in the German mental health care system. Psychotherapists should remain aware that even subtle forms of racial invalidation may undermine trust and emotional safety within the therapeutic relationship. Hence, anti-racism training, self-reflection, knowledge about racism, and rupture repair are essential mechanisms in psychotherapist training to improve experiences of racialized individuals. There are, in fact, several guidelines for racism-sensitive psychotherapy in the German context that should be implemented as central components in psychotherapy training and supervision (e.g., Kluge, 2026; Kreß, 2025; Otyakmaz, 2024).

4.4 Strengths and limitations

The present study contributes to a growing body of international and German research regarding racial microaggressions in mental health care and is one of the first to investigate racial microaggressions in a German sample inlcuding participants with experiences of psychotherapeutic treatment. Further, it extends the work of other studies (9) acknowledging that racial discrimination is independent of migration status. Additionally, the current study integrated resilience theory and coping research into one conceptual framework intead of examine only one or the other. The inclusion of perceived social support and sense of belonging to one's self-identification group allows for a more comprehensive understanding of protective factors associated with resilience and proactive coping.

Concerning limitations of the study, it was not surveyed whether participants were undergoing therapeutic treatment currently or whether it had already been terminated. Duration and reason of therapy termination as well as the therapy-patient relationship were also not assessed which could have provided insightful information. Furthermore, some participants could have experienced racial microaggressions in psychotherapy a certain amount of time before the present survey and thus, potential negative effects might not corresponded to current resilience levels. Also, the assessment of secondary coping strategies was limited to two items: "ignoring the situation" and "responding rudely". This may have produced an insufficient representation of this coping dimension. The internal consistency of both subscales of the DCSS, measured by McDonalds Omega, showed lower results. This might be due to the shortness of the scale and in relation to this the diversity of the items (63). Another explanation is that participants may did not respond coherently to the scale since using, for example, one proactive strategy frequently does not indicate that the other proactive strategies are also applied in the same way. Nevertheless, the scale incorporates important coping behaviors related to racism which are also frequently reported in other studies (e.g., 26, 28, 29, 31).

4.5 Future research

Future studies should examine the complex relationship between racial microaggressions, coping, and resilience incorporating other factors such as therapeutic alliance, resolvement of microaggressions

within therapy, and therapy success. Further, reasons for evaluating experiences of racial microaggressions as not bothering should be assessed. To enhance methodological quality, translated and adapted scales as the RMCS should be validated and standardized. Qualitative research may complement quantitative findings by exploring how clients interpret racial microaggressions in psychotherapy and how these experiences influence their perceptions of safety, trust, and the therapeutic relationship. Such approaches may uncover mechanisms that remain difficult to capture using quantitative methods.

4.6 Conclusion

The present study shows that racial microaggressions and structural barriers occur within the German mental health care system. Although no significant association between racial microaggressions in psychotherapy and coping or resilience could be established, social support and proactive coping emerged as strong predictors of resilience. Further, social support and sense of belonging to one's self-identification group were possitively related to proactive coping. These findings highlight the benefit of fostering proactive coping strategies and resilience in therapeutic settings. At the same time, resilience and coping should not be understood as solely an individual's responsibility to adapt well to a discriminatory environment. Especially, mental health care providers are responsible for creating structures that do not increase the burden of those experiencing racism. More broadly, the results underscore the need for greater awareness and structural improvement to address racist practices in mental health care.

Abbreviations

RaDiGe
Racial Discrimination in the Context of Mental Health Care
IASE
Islamic Association for Social and Educational Professions
IDA
Information and Documentation Center for Antiracism Work
INBI
Institute for the Promotion of Education and Integration
RMCS
Racial Microaggressions in Counseling Scale
BRCS
Brief Resilience Coping Scale
DCSS
Discrimination Coping Strategies Scale
F-SozU K-3
Brief Three-Item Perceived Social Support Questionnaire
PTSD

Post-Traumatic Stress Disorder

Group identification

Sense of belonging to one's self-identification group

Declarations

Ethics approval and consent to participate

The project was approved by the ethics committee of the State Chamber of Physicians of Rhineland-Palatinate (No. 2023-17106) and the study was conducted in accordance with the Declaration of Helsinki. All respondents were required to be at least 18 years old and gave consent to their participation. The participants were informed about their right to withdraw from the study at any time. The voluntary nature and purpose of the study were stated before the start of the survey.

Consent for publication

Consent for publication of study results was obtained from the participants before the beginning of the survey. If consent to publication was not given, the survey was terminated.

Availability of data and materials

The dataset supporting the conclusions of this article is currently not available for sharing in a publicly accessible repository. The research team is currently debating when and where the dataset can be accessed in the future.

Competing Interests

The authors declare that they have no competing interests.

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Author Contributions

This study is part of a project and researcher group from different sites and disciplines who worked together continuously in a process to discuss and drive forward the preparation and elaboration of the manuscript. All authors were involved in the design of the quantitative study and interpretation of data for the addressed issue, as well as drafting and revising the article, giving final approval, and are accountable for the content.

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