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Are You My Nurse? The Effects of Patient-Delivered Gender Microaggressions on Women Trainees' Clinical Work in Integrated Primary Care

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Abstract

Gender microaggressions are a form of sexist discrimination that have detrimental effects on women's psychological well-being. Unfortunately, these sexist occurrences are commonplace in the United States and can be experienced in a variety of ways. As such, there is a need to understand behavioral health providers' experiences with patient-delivered gender microaggressions. In doing so, we may be able to better support women behavioral health trainees' during their clinical development by potentially understanding the ways in which women trainees are affected by sexist patient encounters. Therefore, the present study sought to apply the Social Cognitive Model of Counselor Training and the Multicultural Orientation framework to understand the ways in which women trainees are affected by gender microaggression in the context of their clinical work in integrated primary care settings. It was hypothesized that negative affective reactions may cause decreases in trainees' perceptions of their counseling abilities as well as their evaluation of the impact of the behavioral health interactions wherein gender microaggression occur. It was also hypothesized that women's level of stigma consciousnesses and their cultural comfort would serve as protective factors to the effects of gender microaggressions on women trainees' counseling self-efficacy and their overall evaluations of the behavioral health interaction wherein gender microaggressions occur. Results revealed that participants who experienced gender microaggressions endorsed lower counselor-efficacy beliefs, less session smoothness, and higher arousal states (e.g., anxious, excited, fast). Results also revealed that arousal partially mediated the effects of gender microaggressions on women trainee's evaluations of session smoothness. Implications such as supporting and empowering women trainees in how they choose to respond to gender microaggression, creating dedicated supervision time and mentorship programs to facilitate women trainees' clinical development, and specific supervisory approaches to navigating gender microaggression are discussed. Future directions are also highlighted, including understanding the experiences of trainees' who hold more than one marginalized identity when they encounter patient-delivered discrimination, protective factors that draw on the internal resources and strengths of women trainees, and the complex nuances of integrated primary care training.

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ABSTRACT

Gender microaggressions are a form of sexist discrimination that have detrimental effects on women's psychological well-being. Unfortunately, these sexist occurrences are commonplace in the United States and can be experienced in a variety of ways. As such, there is a need to understand behavioral health providers' experiences with patient-delivered gender microaggressions. In doing so, we may be able to better support women behavioral health trainees' during their clinical development by potentially understanding the ways in which women trainees are affected by sexist patient encounters. Therefore, the present study sought to apply the Social Cognitive Model of Counselor Training and the Multicultural Orientation framework to understand the ways in which women trainees are affected by gender microaggression in the context of their clinical work in integrated primary care settings. It was hypothesized that negative affective reactions may cause decreases in trainees' perceptions of their counseling abilities as well as their evaluation of the impact of the behavioral health interactions wherein gender microaggression occur. It was also hypothesized that women's level of stigma consciousnesses and their cultural comfort would serve as protective factors to the effects of gender microaggressions on women trainees' counseling self-efficacy and their overall evaluations of the behavioral health interaction wherein gender microaggressions occur. Results revealed that participants who experienced gender microaggressions endorsed lower counselor-efficacy beliefs, less session smoothness, and higher arousal states (e.g., anxious, excited,

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CHAPTER ONE: INTRODUCTION

Over the last decade, the United States' healthcare reform has brought health related disciplines together through its integration of behavioral health and medical services (Bridges et al., 2017). As a result of these developments, the growing interest for psychologists to train and practice health psychology (Nicholas & Stern, 2011) is met with a lack of specific health-related training experiences in graduate psychology programs (Bridges et al., 20017). These training gaps may pose challenges to psychology trainees' clinical development in healthcare settings, such as integrated primary care. Considering that women make up 75% of graduate psychology trainees (Clay, 2017), there is a specific need for understanding training experiences unique to women trainees, such as recognizing how common, gender-based discriminatory experiences interact with women psychology trainees' clinical development in healthcare settings.

Unfortunately, discriminatory experiences are not uncommon in healthcare. For example, a recent meta-analysis of 51 studies showed that over half (59.4%) of medical trainees had experienced at least one form of harassment or discrimination during their training, with patients accounting for 34.4% of the source of harassment and discrimination (Fnais et al., 2014). Because there is a lack of research published specifically on women psychology trainees' experiences of patient-delivered offenses, such as gender-based microaggression, it is imperative that we understand the distinct

training experiences and developmental complexities that novice women behavioral health trainees may encounter during their training in healthcare settings.

Integrated primary care (IPC) settings may be a healthcare setting to further explore given the unique training experiences it offers. IPC settings consist of a variety of healthcare workers (e.g., mental health professionals, physicians, social workers, nurses) working alongside each other through team-based care approaches to treat diverse patients' physical and behavioral health needs. However, there are important training considerations that apply specifically to behavior health trainees in IPC such as the brief treatment model (Horevitz & Manoleas, 2013; Dobmeyer et al., 2016), the wide array of presenting patient concerns (Reiter et al., 2018), and the dynamic skillset necessary to meet the demands of the often busy, fast-paced IPC environment. This type of training environment may pose additional challenges for trainees who may need more time to process and discuss difficult training experiences that are related to developmental issues, such as their counseling self-efficacy when working with certain patients and within the medical environment.

Understanding factors that may affect women trainees' view of their counseling self-efficacy within integrated primary care settings may provide insight into how graduate programs and training sites may assist women trainees' during their clinical development. Bandura's Social Cognitive Theory framework and self-efficacy theories have been applied for understanding counselors' development (Goreczny et al., 2015; Kozina et al., 2010; Larson 1998; Larson & Daniels, 1998; Lent et al., 2003). Larson's (1998) social cognitive model of counselor training (SCMCT), derived from Bandura's

(1986) SCT framework, can be used to conceptualize the interdependent relationship between three causal determinants--counselors' actions, personal agency factors, environmental influences—that are thought to interact with one another to influence trainees' counseling self-efficacy (CSE). In addition, there are four principle sources of information that influence CSE beliefs that are embedded within the three causal determinants, including mastery (mastering a skill), modeling (observing peers/supervisor), social persuasion (given encouragement/information to succeed), and affective arousal. Affective arousal, in particular, may be a way of understanding factors that influence women trainee's CSE.

Prior research has found that as trainees' anxious arousal increases, their CSE beliefs decrease (Al-Darmaki, 2004; Barbee et al., 2003; Daniels & Larson, 1998; Goreczny et al., 2015). However, there is a paucity of research that examines other mechanisms that influence trainees' CSE, such as other emotional reactions (e.g., anger, uncertain, confused) when trainees encounter difficult clinical situations. Given the aforementioned prevalence of women trainees in psychology training programs and the prevalence of healthcare providers' experiences with patient-delivered discrimination, it is especially important to consider how women trainees' experiences of clinical challenges, such as those that involve sexist patients, may provoke emotional responses, such as anxiety or uncertainty, and how those responses may be linked to their perceived ability to deliver a set of skills when faced with self-relevant, clinical situations. Furthermore, if we can understand how these complex patient interactions affect women trainees' cognitive and affective processing of such events, then perhaps we may also

gain more insight into potential protective factors, such as stigma consciousness, that could serve as a buffer for preserving or improving women trainees' CSE in the presence of negative patient interactions.

Stigma consciousness, described as the degree to which a person expects to be stereotyped by others based on their group membership, has been connected to ability beliefs (Clark et al., 2015) and psychological responses associated with discriminatory experiences (Wang et al., 2012). While it is suggested that high levels of stigma consciousness among women may serve as a protective factor from the harmful consequences of gender bias, there is a paucity of research focused on understanding how stigma consciousness among women trainees may influence their responses to gender discrimination. It is hypothesized that stigma consciousness may mitigate the harmful effects of patient-delivered offenses, such a gender microaggressions, on women trainees' counseling self-efficacy and evaluations of session impact.

Microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p.271). In its earlier stages, microaggression research aimed to understand and conceptualize the injustices that racial minority groups experience in their daily lives as a result of aversive racism (Sue et al., 2007). More recently, research has extended microaggression theory to include other oppressed identity statuses, including gender, sexual, and religious minorities (Sue, 2010; Torino et al., 2019). Gender microaggressions are defined as "brief and commonplace daily verbal, behavioral, and

environmental indignities that communicate hostile, derogatory, or negative sexist slights and insults toward women" (Capodilupo et al., 2010, p.197). Moreover, gender microaggressions are expressed on a spectrum of actions or behaviors ranging from overt and intentional to covert and unintentional (Sue 2010; Swim & Cohen, 1997). As such, microaggression theory may serve as a complimentary framework to the SCMCT when conceptualizing women trainees' experiences with sexist patients in healthcare settings given the detrimental effects that gender microaggressions have on women.

Gender-based discrimination is known to harm women across multiple life domains, including women's experiences in the workforce as well as their psychological well-being. For example, women who experience sexist discrimination report feelings of anger, fear, anxiety, guilt, shame, depression, and low self-esteem (Capodilupo et al., 2010; Fischer & Holz, 2007; Owen et al., 2010; Swim et al., 2001). In addition, women who hold multiple oppressed identities, such as their race/ethnicity, ability, and sexual orientation, are at risk for negative health outcomes (Branco et al., 2019; Lewis et al., 2017; Syzmanski & Kashubeck-West, 2008). Owen and colleagues (2010) extended this research into the psychotherapy realm by exploring the relationship between women patients' perceptions of gender microaggressions by their therapists and therapy processes and outcomes. They found that gender microaggressions were negatively related to the working alliance between patient and therapist and psychological well-being (Owen et al., 2010). While this study focused on patients' experiences being aggressed, it is expected that whoever experiences gender microaggression in the therapeutic dyad would be negative affected, despite the role of the person being

aggressed. Therefore, theoretically, women trainees who experience discrimination from their patients during their behavioral health interactions would also endorse similar psychological responses that may influence their perceptions of their ability to deliver skills (i.e., CSE) with offensive patients.

Trainees' multicultural orientation (MCO) may be a way to explain the degree to which trainees' perceive their work with patients as effective in challenging clinical situations as well as what therapists actually *do* in session when cultural issues, such as gender microaggressions, arise between themselves and patients. Owen, Tao, Leach, and Rodolfo (2011c) assert that MCO involves "a way of being with clients, particularly when one detects cultural dynamics that may require enhanced awareness, knowledge, and skills" (p.91). Trainees' MCO may be especially important when considering how women trainees' respond to activating experiences of gender microaggressions and how their MCO may be associated with their CSE beliefs as well as their judgments regarding the quality of the patient-provider interaction wherein the gender microaggression occurred. For example, if a patient delivers a gender microaggression towards a woman trainee, the degree to which the woman trainee demonstrates calmness, openness, and willingness to understand the patient's worldview (i.e., the trainee's level of MCO), may provide insight into the trainees' CSE beliefs and how they judged the overall behavioral health interaction.

The proposed study examines how women trainees' counselor self-efficacy (Larson, 1998) is influenced by patient-delivered, gender microaggressions (Sue, 2010) in the context of integrated primary care settings. Given the time-limited treatment

context of IPC (Reiter et al., 2018) and the prevalence of patient-driven discriminatory acts towards medical providers (Fnais et al., 2014), there is a need for understanding the ways in which gender microaggression affects trainees' perceptions of their ability to perform behavioral health skillsets and their evaluations of behavioral health encounters when gender microaggressions occur. Therefore, this study will explore how negative affective reactions may contribute to decreases in trainees' counselor self-efficacy after experiencing gender microaggression. It will also examine how stigma consciousness and trainees' cultural comfort may help lessen the effects of gender microaggression on trainees' counselor self-efficacy.

Counseling Health Psychology

Over the last decade, healthcare reform in the United States has brought health related disciplines together through its integration of behavioral health and medical services (Bridges et al., 2017). As a result of these developments, there is growing interest for counseling psychologists to train and practice clinical health psychology (Nicholas & Stern, 2011). Counseling psychology training offers unique and impactful contributions to the field of health psychology with its core values focused on cultural diversity, health care prevention, and developmental, strengths-based, and positive psychology perspectives (Chwalisz & Obasi, 2008; Maguire et al., 2008; Nicholas & Stern, 2011; Tucker et al., 2007; Tucker, Herman, et al., 2007; Werth, 2008a; Werth et al., 2008b). For example, values such as cultural inclusion and diversity, social justice, holism, prevention, relationships, strengths, and multidisciplinary collaboration are noted as central to training in counseling psychology (Nicholas & Stern, 2011; Packard, 2009).

While trainees from counseling psychology programs may offer significant contributions to the field of health psychology, health-related training settings may pose challenges for those who have not had exposure to training in healthcare environments. In fact, it is not unusual for psychology programs to lack specific training in healthcare settings. Researchers have specifically examined this training gap across counseling psychology programs. Raque and colleagues (2013) surveyed training directors of APA-accredited counseling psychology graduate programs across the United States (n = 22) to understand the extent of health psychology training opportunities within counseling psychology programs. Results from their study revealed that approximately 95% of the training directors identified their students as being somewhat interested in health psychology and approximately 23% of the training directors identified their students as being either very or extremely interested (Raque et al., 2013). Despite students' general interest in health psychology training, results from the study suggest health-related training opportunities may be limited among counseling psychology programs. Seven of the 16 programs that recognized that students were somewhat interest in health psychology and 1 out of the 4 programs that identified their students were very interested had no faculty in their programs with expertise in the topic. These findings suggest that students who have interest in health psychology may be limited in their opportunities to pursue this interest during their graduate training (Raque et al., 2013).

Specific health-related training experiences, such as training in integrated primary care, may be even more limited for counseling psychology graduate students. Bridges and colleagues (2017) identified 306 APA-accredited clinical and counseling psychology

training programs in the United States, with only 29 (9.4%) of those programs providing training in primary care psychology. Further, a phenomenological study that explored behavioral health clinicians' experiences working in integrated primary care (IPC) revealed that all 10 participants from various psychology training backgrounds (i.e., counseling, clinical, marriage and family, social work) gained their foundation in IPC through their clinical work and not through their graduate program (Glueck, 2015). This further emphasizes the importance of identifying the training gaps that may exist for behavioral health trainees interested in integrated healthcare settings.

Moreover, when considering the disproportionate number of women in psychology training programs compared to men, there is a specific need for understanding women's training experiences in IPC and other healthcare settings. For example, according to APA's Center for Workforce Studies (CWS) data, women accounted for 75% of the 70,311 students enrolled in psychology graduate programs in 2014 (Clay, 2017). Further, up to 80% of the students enrolled in psychology graduate training that had an emphasis in health service provision were women (Clay, 2017). This information sheds light on the necessary steps that psychology and other healthcare fields must take to understand training experiences unique to women specifically. For example, research indicates that patient-delivered discriminatory experiences account for 34.4% of the sources of harassment and discrimination experienced by medical trainees (Fnais et al., 2014). As the number of women psychology trainees in healthcare settings continue to grow, it is imperative that we seek understanding of how these common patient-provider interactions affect women trainees, such as recognizing how patient-delivered,

gender-based discriminatory experiences interact with women psychology trainees' clinical development. By gaining a greater understanding of these dynamics, this information may provide contributable insights into the distinct training and developmental complexities that novice women behavioral health trainees encounter during their graduate training. Furthermore, this information may offer training programs and healthcare agencies insight into how to support and protect women pursuing a career or working in health-related disciplines.

Integrated Behavioral Healthcare

Health care professionals, including mental health professionals, are now working alongside each other through team-based care approaches to treat patients' physical and behavioral health needs. Many integrated healthcare settings, such as primary care clinics, specialty care clinics, and academic health centers, offer patients co-located services for their behavioral health needs while simultaneously monitoring their medical needs (Lenz et al., 2018). This type of collaborative care model offers opportunities for multidisciplinary teams to coordinate patient care between providers, provide same-day, in-house referrals, and share conceptualizations of patient concerns while providing multiple opportunities to address cultural barriers regarding patient care (Heath et al., 2013). With this approach, greater emphasis is placed on treating the behavioral aspects that influence well-being, health promotion, and prevention and management of disease (Bridges et al., 2017).

Behavioral Health Setting Characteristics

In general, behavioral health services look much different in integrated healthcare settings compared to traditional psychotherapy settings. For example, behavioral health services within IPC are usually shorter in session length and course of treatment than mental health specialty clinics. In most cases, behavioral health visits last between 15 to 30 minutes and range between one and 10 visits, with one to three visits being the typical case (Dobmeyer et al., 2016; Horevitz & Manoleas, 2013; Reiter et al., 2018). In contrast, sessions within traditional mental health settings (e.g., counseling centers) usually last around 50 minutes (i.e., "a therapy hour") and vary in the number of sessions dependent on the patient's presenting concerns (Horevitz & Manoleas, 2013). Behavioral health providers (BHP) are also presented with an array of patient problems ranging from mental health concerns to chronic disease management (e.g., diabetes) to substance abuse treatment to medically unexplained symptoms (e.g., chronic fatigue; Reiter et al., 2018). As such, BHPs may engage in a variety of counseling-based services with patients including mental health-focused therapies, psychiatric diagnostic clarification or confirmation, health and behavior change processes, psychoeducation, and preventative care approaches (Reiter et al., 2018; Vogel et al., 2012). This type of brief treatment model requires behavioral health providers to be efficacious and efficient with their time when exposed to a variety of patient needs.

Efficiency and efficaciousness also serve value in other aspects of patient care within IPC settings. Often, medical providers need BHPs to step into an exam room with a patient to provide a one-time, brief intervention, known as a "warm handoff," when a

biopsychosocial concern has been identified (Reiter et al., 2018).Warm handoffs are a method for orienting patients to and engaging patients in behavioral health services by helping patients understand the role of BHPs and how behavioral health services may help address patients' presenting concerns (Reiter et al., 2018). They are meant to be delivered on the same day that a patient sees their medical provider, requiring BHPs to quickly respond to a patient needs by obtaining a brief patient history and referral question from the medical provider before entering the exam room (Reiter et al., 2018).

Other times, BHPs may provide consultative services to medical providers regarding the conceptualization of patients' behavioral health needs and recommendations (Horevitz & Manoleas, 2013; Robinson & Reiter, 2016; Fivecoat et al., 2017). In addition, BHPs may be interrupted during a visit with a patient to tend to an urgent patient and/or provider need (Horevitz & Manoleas, 2013; Robinson & Reiter, 2016). In IPC, this is often referred to as an open-door policy, as interruptions during appointments are welcome if there is an immediate patient need (Robinson & Reiter, 2016). These interactions with both patients and medical providers are brief in nature and serve mainly as a supportive role to the medical provider. Moreover, these skills demonstrate the value of BHPs being able to quickly adapt to the demands of their work environment while providing effective services to a variety of patient and provider needs.

Vogel and colleagues (2012) noted working within integrated healthcare settings, specifically IPC, creates a significant shift in the mindset of how to approach patient care and how techniques are used. For example, as an integrated team member, BHPs work with and alongside medical providers as a type of consultant to assist with patient

concerns (Reiter et al., 2018). As such, BHPs may not follow patients until their concern is in remission as this is the medical provider's responsibility as a patient's main provider; instead, BHPs may work with a patient until they show improvements and have a treatment plan in place to continue their improvement (Reiter et al., 2018). This requires BHPs to mold to the culture of the IPC setting in order to maximize their utility as a patient provider and team-member (Vogel et al., 2012).

Understanding the Medical Culture

Many of these competencies, such as team-based care approaches, navigating the brief treatment model, and treating the variety of mental health and health-related presenting concerns, require a foundation of understanding the medical culture. Edwards and Patterson (2006) note that one of the biggest challenges for trainees is acclimating to this culture as space and time within medical settings look much different than typical mental health settings. Exam rooms are often used as therapy rooms, interruptions in services often occur, and BHPs are heavily utilized to help medical providers address patients' immediate needs (e.g., a patient who is suicidal). These rapidly changing dynamics are seen as chaotic when comparing IPC to traditional mental health settings (Edwards & Patterson, 2006; O'Donohue et al., 2005; Robinson & Reiter, 2016).

Edwards and Patterson (2006) explain that supervisors must be aware that trainees within these settings can often feel alone and isolated. As trainees navigate their experiences of adapting to the medical environment, they may need support related to areas of competency or emotional support regarding the interactions with patients. However, given the busy, fast-paced nature of a primary care office, immediate

supervisory support may be difficult for trainees to find (Edwards & Patterson, 2006) or address at length.

Supervision in primary care settings generally follows the medical precepting model consisting of live supervision of behavioral health appointments and on-the-fly supervision in which the trainee gives 30-60 second case conceptualizations including diagnostic differentials and considerations, treatment planning, and care coordination (Bailey, 2015). Additionally, trainees typically participate in a weekly one-hour supervision meeting that is fast-paced, targeted, and solution-focused as it is normal for trainees to discuss up to 30 patients with their supervisor within the one-hour meeting (Bailey, 2015). This may pose a challenge for trainees who may need more time to process and discuss training experiences that are related to developmental issues, such as their self-efficacy when working with certain patients and within the medical environment.

Self-Efficacy

Self-efficacy theory, a construct developed from Bandura's (1977, 1986) social cognitive theory (SCT), pertains to how a person judges their capabilities of performing a set of tasks within a designated domain (Bandura, 1986; Larson, 1998). From a social cognitive perspective, human functioning is explained through the simultaneous interaction of behaviors, personal factors, and environmental events called triadic reciprocity (Bandura, 1986). Therefore, self-efficacy theory asserts that a person's self-generated beliefs about their ability to perform a certain skill set comes from interactions in their social environment. Researchers have used Bandura's (1986) social cognitive and

self-efficacy theories as a framework for understanding counselors' development (Goreczny et al., 2015; Kozina et al., 2010; Larson 1998; Larson & Daniels, 1998; Lent et al., 2003). Drawing from SCT, counselors' actions (e.g., what they do in session) are influenced by their personal agency, which includes their self-efficacy beliefs as well as cognitive, affective, and motivational processes (Bandura, 1986; Larson, 1998). Through the process of triadic reciprocity, the causal determinants of counselors' actions, personal agency factors, and environmental influences explain counselors' functioning.

Social Cognitive Model of Counselor Training

Larson (1998) posed a social cognitive model of counselor training (SCMCT) to conceptualize the interdependent relationship between the three causal determinants and how their relationship influences the link between counselor trainees' knowledge (e.g., knowing what to do in session) and their actions (e.g., executing skills in session). The three causal determinants--personal agency, counselor actions, and the proximal environment--encompass four principle sources of information that influence counseling self-efficacy (CSE) beliefs.

SCMCT and Self-Efficacy

Bandura (1977, 1993) originally theorized that people can gather self-knowledge from the four sources of (1) performance accomplishments/skills, (2) vicarious experiences of learning (e.g., observations), (3) verbal persuasion and social influences (e.g., feedback, encouragement), and (4) affective arousal. Each are influential in determining one's expectations about their capabilities. For instance, individuals with low self-efficacy (i.e., low belief in their ability) are less likely than those with high self-

efficacy to initiate tasks and consistently maintain behaviors to complete tasks (Goreczny et al., 2015).

The SCMCT tailored these four sources of information that influence self-efficacy expectations from Bandura's theory of self-efficacy to align with CSE beliefs. These sources of information, including mastery (mastering a skill), modeling (observing peers/supervisor), social persuasion (given encouragement/information to succeed), and affective arousal, are the ways that counselor trainees develop their CSE; cognitive appraisal of these sources of information determine the amount of CSE one possesses (Larson, 1998). From this lens, a trainee's perceptions (i.e., their cognitive appraisals) of information obtained from their environment is postulated to be influential in how trainees perceive their self-efficacy.

CSE may be especially important for counseling psychology training programs to consider for students who have or wish to pursue training in integrated health care settings. Trainees with less exposure to learning opportunities within their programs may perceive additional challenges within the integrated care training environment. For example, as trainees evaluate their experiences derived from the four sources of information present in IPC settings, their CSE beliefs may be impacted by the complexities of IPC training environments, such as the unique skillset needed for IPC, the supervision model, the interdisciplinary dynamics, and the psychological responses of the trainee that can occur when treating an array of patients within a brief model. These sources of information are obtained through the process of triadic reciprocity and will be

elaborated on within the context of three causal determinates of counselor actions, the proximal environment, and personal agency.

Counselor Actions

The SCMCT incorporates two domains of counselor actions, effective actions in supervision and effective actions in counseling, through which counselors learn to deliver effective skills. Effective actions in supervision are those behaviors that counselors take in supervision that assist in building efficacy with patients (Larson, 1998). These actions involve direct and indirect learning experiences, such as listening to recorded sessions or being prepared for supervision, that help foster positive CSE beliefs when working with patients (Larson, 1998).

Effective actions in counseling are developmentally appropriate actions that lead to mastery experiences, which is the strongest contributor to increasing CSE (Larson, 1998). These actions require the trainee to demonstrate a pattern of effort and gradual improvement, perform moderately difficult tasks that require little assistance from their supervisor, counsel under optimal conditions (such as maintaining a consistent case load), hold the view that their success is attributable to persevering through challenging tasks, and attend to positive aspects of their performance (Larson, 1998).

While the SCMCT focuses on counselor actions with patients and with their supervisor, the SCMCT does not identify the variety of counseling environments in which these actions transpire, such as counselor actions within IPC settings versus traditional mental health settings. Given that mastery experiences are the main contributor to increasing CSE, it is important to consider how these actions influence

efficacy beliefs of behavioral health trainees in various training environments like IPC. As Bailey (2015) noted, supervision in IPC settings looks different than traditional mental health agencies as trainees are expected to quickly review and conceptualize patient concerns to meet the demands of the fast-paced primary care setting. Trainees within IPC settings are also expected to deliver a variety of counseling-based services with a variety of patient populations under clinical circumstances that are peculiar to IPC such as the immediate need establish rapport and execute goal-oriented tasks aimed to treat patient concerns within a limited timeframe (Horevitz & Manoleas, 2013; Reiter et al., 2018; Vogel et al., 2012). Understanding how these factors may influence trainees' actions within a complex and perhaps unfamiliar training environment may help supervisors and training programs consider ways to promote stronger CSE beliefs during novice trainees' clinical development.

Proximal Environment

A counselor's supervisor and patients create the counselor's proximal environment that, when taken together, assist the counselor with learning how to be efficacious (Larson, 1998). Two direct functions of the supervisor that help build CSE include modeling experiences and social persuasion. Modeling experiences involve the supervisee having multiple opportunities to observe their supervisor, peers, or themselves performing a desired counseling action (Larson, 1998). It is posited that modeling is the second strongest influence in increasing self-efficacy (Bandura, 1977; Larson, 1998). Barnes (2004), who drew concepts from Larson's SCMCT to formulate ways training

and supervision could increase trainees' CSE, noted that modeling behaviors needs to be "clear, purposeful, and moderately difficult" in order the enhance CSE (p. 59).

Social persuasion is defined as the realistic and supportive encouragement from supervisors to their supervisees as well as structured learning situations that contribute to counselors' success (Larson, 1998). When supervisors provide credible, realistic messages regarding specific counseling tasks, supervisees may be more persuaded to process and reflect on those messages, which may ultimately contribute to an increase in CSE. Moreover, trainees may depend more on their supervisors to give them feedback on their performances with patients (Barnes, 2004).

Given that the supervisor and patients create the counselor's proximal environment, it is important to consider how these individuals influence modeling and social persuasion in IPC. While modeling experiences specific to IPC serve as a function of building CSE, there are some clinical situations that may be either unexpected or difficult in terms of "modeling" for the trainee. Although it may not be uncommon for a supervisor to model or provide feedback on a behavioral health encounter with a patient who presents with challenging behavioral health concerns, the unpredictable nature of some patient behaviors, like when a patient makes sexist statements towards a provider, may add a layer of complexity for the supervisor. For example, a supervisor who identifies as a man and a trainee who identifies as a woman may have different experiences with patient encounters on account of their gender; therefore, this may pose challenges for the supervisor in helping a trainee learn to be efficacious when these types of behavioral health interactions occur.

Personal Agency

Within the SCMCT model, counselor self-efficacy (CSE) beliefs are viewed as the primary determinants of counselor action, and they are known to affect counselors' persistence, risk-taking behaviors, and responses to clients (Larson, 1998). *CSE beliefs* pertain to a counselor's beliefs and judgments regarding their ability to effectively counsel a patient in the future (Larson, 1998; Larson et al., 1992). Therefore, CSE beliefs are, in part, responsible for the actions taken by a counselor in session, including the amount of effort they put forth with a patient and whether they choose to persevere under pressure (Bandura, 1986; Larson, 1998). If a person has low self-efficacy beliefs, the influence of these beliefs on the person's persistence and motivation will ultimately affect their ability to achieve their desired outcomes (Kozina et al., 2010). This may be an especially important training consideration for clinical environments, such as IPC, where behavioral health trainees need to be able to quickly respond to patient needs at the request of medical providers, persevere under the fast-paced nature of the environment, treat a variety of patient presentations, and make each behavioral health encounter count within the brief treatment model.

Other components of personal agency that influence counselor actions include counseling-related knowledge and skills, outcome expectations, goals and plans, self-evaluation, and cognitive and affective processes. *Counseling-related knowledge and skills* are the techniques used by novice counselors and are acquired through procedural counseling knowledge, content knowledge (e.g., counseling theories, multicultural counseling), and personal experiences (Larson, 1998; Lent et al., 1998). *Outcome*

expectations refer to the trainee's views on the patient's prognosis in therapy (e.g., believing that the patient will get better after therapy; Barnes, 2004; Larson, 1998). *Goals and plans* are set by the trainee in counseling or in supervision and affect a trainees' motivation and persistence in clinical situations (Bandura, 1988; Larson, 1998). *Self-evaluation* is directly related to CSE beliefs and mastery experiences and involves positive and negative self-judgments about counseling performance (Larson, 1998; Lent et al., 1998).

Cognitive processes relate to the selective attending and weighing of feedback from counselors' own actions and feedback from their patients, peers, and supervisors (Larson, 1998). For example, if a trainee deems themselves as being less efficacious, it may be that they are placing more emphasis on less relevant information specific to the session (Larson, 1998). This may be important for behavioral health trainees to consider given the importance of attending to the most relevant information presented in their behavioral health appointments in a limited timeframe. If a trainee in an integrated care setting labels themselves as being less efficacious, it may be, in part, due to their cognitive processes associated with their patient encounters.

Affective processing is mediated by a trainee's cognitive processes; therefore, the extent to which a trainee interprets their anxiety as debilitating may ultimately impact their actions (Larson, 1998). A counselor trainee's beliefs about their counseling abilities affects the way the trainee experiences their anxiety. As result, their anxiety may be interpreted as self-aiding or self-hindering (Larson & Daniels, 1998; Schendel, 2010), which, in turn, affects the self-regulation of their CSE beliefs (Barnes, 2004). If a trainee

views their anxiety as a personal weakness, they are more likely to have low self-efficacy towards completing tasks in situations when these feelings arise (Bandura, 2004; Schendel, 2010). Therefore, management of psychological responses (e.g., anxiety) influences their CSE beliefs, which in turn affect outcome expectancies (Kozina et al., 2010).

Counselor Self-Efficacy and Affective Reactions

The inverse relationship between anxiety and self-efficacy is well-known; that is, when a person's anxiety increases, their self-efficacy decreases (Bandura, 1993; Erzen & Odaci, 2016; Ghaderi & Rangaiah, 2011; Griggs et al., 2013). Research on the relationship between self-efficacy and anxiety has extended to counselor training research and explored the ways that this relationship influences training experiences and decision-making with novice counselors (Al-Darmaki, 2004; Barbee et al., 2003; Daniels & Larson, 1998; Goreczny et al., 2015). Recently, Goreczny and colleagues (2015) conducted a study with 97 counseling students (21 undergraduates, 76 master's-level graduate students) working in various training settings that examined counselor self-efficacy at various points in students' training. Researchers used the Counselor Self-Efficacy Scale (CASES) and the Counselor Self-Estimate Inventory (COSE) to measure participants' self-efficacy. The CASES measures three dimensions of counselor self-efficacy including self-efficacy related to helping skills, session management, and counseling challenges (Lent et al., 2003). The COSE measures efficacy expectations by assessing counselor trainees' confidence in performing microskills, attending to process, dealing with difficult client behaviors, behaving in a culturally competent way, and being

aware of one's values (Larson et al., 1992). Across all levels of counseling training, there were significant correlations with medium effect sizes among global anxiety questions and most subscales included in the two counselor self-efficacy scales (e.g., CASES – Insight, r = -0.49, p <.01; CASES – Session Management, r = -0.40, p <.01; CASES – Total, r = -0.48, p <.01; COSE – Microskills, r = -0.45, p <.01; COSE – Process, r = -0.36, p <.01; COSE – Total, r = -.37, p <.01). Although direct causations cannot be implied from this information, developing trainees' ability to manage their anxiety could pose additional insights into the relationship between their efficacy beliefs and anxious arousal.

The examination of trainees' CSE serves an integral role in understanding counselor development as novice counselors are expected to learn, build, and implement a unique set of skillsets in training situations that are deemed challenging. However, there is a paucity of research that examines other mechanisms that influence trainees' CSE, such as other emotional reactions (e.g., angry, uncertain, confused) when trainees encounter difficult clinical situations. Given the aforementioned prevalence of women trainees in psychology training programs, it is especially important to consider how women trainees' experiences of clinical challenges, such as those that involve sexist patients, may provoke emotional responses; such as anxiety, confusion, or uncertainty; and how those responses may be linked to their perceived ability to deliver a set of skills when faced with self-relevant, clinical situations. For example, research has not yet examined the effect of offensive patient behaviors (e.g., gender microaggressions, blatant sexism) on women trainees' CSE. Furthermore, current recent lacks specific

understanding of *how* these types of derogatory patient interactions affect women trainees on a psychological level, such as their affective reactions, their confidence in delivering their skillset in the described clinical scenarios, and how these interactions impact work with patients in session. If we can understand how these complex patient interactions affect women trainees' cognitive and affective processing of such events, then perhaps we may also gain more insight into potential protective factors that could serve as a buffer for preserving or improving women trainees' CSE in the presence of negative patient interactions.

Stigma Consciousness

Stigma consciousness is a concept that may help protect women trainees from the deleterious effects of negative and offensive patient interactions. According to Pinel (1999), stigma consciousness is described as the degree to which a person expects to be stereotyped by others based on their group membership. A crucial distinction that is worth highlighting is that stigma consciousness does not involve *awareness* of a person's stereotyped status; rather it describes the degree of focus a person places on their stereotyped identity (Pinel, 2004). This self-consciousness about one's stigmatized group influences how a person interprets discriminatory experiences. For example, individuals who have a greater degree of stigma consciousness are more attentive and concerned about how their group membership is stereotyped and how they have been personally affected by stereotypes (Pinel, 1999). Further, stigma consciousness is "a reliable individual difference variable that affects how disadvantaged group members navigate the often-ambiguous reality surrounding their stigmatized identity" (Wang et al., 2012, p.

241). Therefore, stigma consciousness may be a protective factor for women trainees who possess greater levels of stigma consciousness may be able to externalize the experience of being aggressed by attributing the experience to their stigmatized group membership.

Past research examined the effects of stigma consciousness on marginalized groups, including numerous studies on women's experiences in occupational, social, and performance contexts (Brown & Pinel, 2003; Pinel, 2004; Clark et al., 2016; Doyle & Molix, 2017). In regard to stigma consciousness and performance, Pinel (2004) explored how women interpret negative feedback differently depending on their degree of stigma consciousness when the feedback is given by a man. They found that women with higher levels of stigma consciousness had a greater propensity to attribute negative performance evaluations to gender discrimination compared to women with lower levels of stigma consciousness (Pinel, 2004). Thus, the women participants with high levels of stigma consciousness may have been able to more readily externalize the negative feedback to their stereotyped identity rather than believing the feedback held meaning about who they were as a person (i.e., stereotype validation). This finding evokes the question, "Does stigma consciousness influence how women respond to situations wherein gender bias occurs?"

Earlier research on stigma consciousness suggested that individuals who possess high stigma consciousness may experience negative psychological effects of stereotype threat to a stronger degree than individuals low in stigma consciousness (Brown & Pinel, 2003; Brown & Lee, 2005). However, several studies propose that high stigma consciousness, which may cause one to be more vigilant towards stereotype threat, may

be adaptive in distressing situations as individuals may be more prone to disconfirm bias towards their stigmatized group. Clark and colleagues (2015) conducted a study with a community sample of 336 women and 225 men (M_{age} = 33.68 years) that examined whether high levels of stigma consciousness served as a protective factor from the effects of stereotype validation. The researchers assessed participants' perceived ability beliefs and evaluative certainty of performance associated with business economics after explaining that men performed better than women in this subject. Results from their study indicated that women with low stigma consciousness (-1 *SD*) were more certain that they had performed worse than men (b = 0.38, SE = 0.16, p <.05); this greater certainty predicted more negative beliefs in women's own business economics ability (b = -0.56, SD = 0.05, p < 0.0001) with a significant indirect effect (b = -0.22, SE = -.10, CI -0.4249, −0.0450). On the other hand, the relationship between ability beliefs and gender was not mediated by evaluative certainty among participants with higher stigma consciousness (+1 *SD*). Taken altogether, these findings provide support that stigma consciousness may buffer the consequences of stereotype validation among women. Further, while no known studies have explicitly examined the relationship between stigma consciousness and counselor self-efficacy beliefs, it is hypothesized that stigma consciousness may mitigate the harmful effects of patient-delivered gender microaggressions on women trainees' counselor self-efficacy beliefs and their perceptions of session evaluation.

In further support of this hypothesis, Wang and colleagues (2012) examined the moderating effect of stigma consciousness on women's psychological responses to gender discrimination. Even more interesting is that the researchers were curious how

women's stigma consciousness may influence their responses when gender discrimination is more subtle compared to blatant sexist experiences (Wang et al., 2012). Ninety-six adult women were assigned to either an ambiguous prejudice condition or a blatant prejudice condition in which participants were evaluated by a man interviewer for a job position. Interestingly, women with high stigma consciousness were more likely to attribute their failure of obtaining the job to gender bias and more so under ambiguous discriminatory circumstances ($b = 0.79$, $SE = 0.15$, $p < .001$). This findings suggest that women with heightened vigilance to bias (i.e., high stigma consciousness) may be able to recognize the bias against them and respond adaptively to more subtle forms of gender discrimination (Wang et al., 2015). More information is needed on how stigma consciousness may serve as a protective factor to women in situations where discrimination is more subtle. In alignment with the present study, it may be helpful to understand how stigma consciousness may influence women trainees' perceptions of their skills (i.e., CSE) and their responses to patients after experiencing a discriminatory interaction, such as patient-delivered gender microaggressions.

Microaggression Theory

Microaggression research has focused on the subtle and contemporary forms of prejudice behaviors that manifest in everyday social experiences (Dovido et al., 2019; Sue, 2010; Sue et al., 2007). Microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p.271). In its earlier stages, microaggression research aimed to

understand and conceptualize the injustices that racial minority groups experience in their daily lives as a result of aversive racism (Sue et al., 2007). In doing so, researchers were able to identify three forms of microaggressions. *Microassaults* are overt racial derogation intended to hurt the recipient (Sue et al., 2007; Torino et al., 2019). These blatant attacks on racial minority individuals or groups can be verbal or non-verbal and most similar to the term "old-fashioned racism" as they appear to manifest at the conscious level (e.g., using a racial slur against a person of color; Sue et al., 2007; Torino et al., 2019). *Microinsults* are more subtle than microassaults and often operate outside a person's conscious awareness (Sue et al., 2007). These verbal or non-verbal acts of rudeness or insensitivity communicate insulting covert messages about a person's racial heritage or identity (e.g., a White teacher who does not call on a student of color when their hand is raised; Sue et al., 2007). *Microinvalidations* are also typically unconscious or unintentional behaviors or comments that "exclude, negate, or nullify the psychological thoughts, feelings, or experientiality reality of a person of color" (Sue et al., 2007, p. 274). An example of this would be when a White person says they do not see color, only a person (Torino et al., 2019).

Gender Microaggression

Recent research has extended microaggression theory to include other oppressed groups including gender, sexual, and religious minorities (Sue, 2010; Torino et al., 2019). Gender microaggressions are defined as "brief and commonplace daily verbal, behavioral, and environmental indignities that communicate hostile, derogatory, or negative sexist slights and insults toward women" (Capodilupo et al., 2010, p.197).

Similar to racial microaggressions, gender microaggressions are expressed on a spectrum of actions or behaviors ranging from overt and intentional to covert and unintentional (Sue 2010; Swim & Cohen, 1997). Additionally, gender microaggressions share commonalities with other forms of sexism, including overt and covert sexism, modern sexism, everyday sexism, and hostile and benevolent sexism. However, gender microaggressions differ from forms of subtle sexism as gender microaggressions acknowledge sexism through a multitude of manifestations. Rather than focusing on a few specific aspects of sexism, like everyday sexism that focuses on interpersonal discrimination, sexist language, and body objectification (Swim et al., 2001), gender microaggressions include these categories as well as other interpersonal, systemic, and environmental discriminatory events (Nadal et al., 2013).

In particular, gender microaggressions encompass many of the subcategories of sexism including "assumption of physical or intellectual inferiority, second-class citizenship/invisibility, denial of reality of sexism, denial of individual sexism, and environmental microaggressions in the media and general society" (Nadal et al., 2013, p. 195). Further, gender microaggression theory acknowledges that the more subtle forms of gender discrimination are often unconscious and unintentional (Sue, 2010). In fact, gender microaggressions toward women are often delivered by well-intentioned men who are unaware of the negative impact that their behaviors or actions have on women (Sue, 2010). Gender microaggressions also includes a classification system for varying degrees of discriminatory experiences, something that Nadal and colleagues (2013) note has helped advance our understanding of sexism.

Forms of Gender Microaggression

Gender microassaults are most similar to more hostile, overt forms of sexism (e.g., "old-fashioned sexism," Swim & Cohen, 1997) and are delivered with the conscious intentionality to harm (Capodilupo et al., 2010; Nadal et al., 2013). While categorized as a form of gender "microaggression," this deliberate and overt type of sexism is rather "macro" given its manifestation. Examples of gender microassaults are when a woman is called a "bitch" for being assertive, when a man catcalls a woman walking down the street (Nadal et al., 2013), or when a woman is told they dress "too feminine" among men co-workers (Basford et al., 2014). Swim and colleagues' (2001) explored experiences with gender microaggressions in a qualitative diary study involved data collection across a two-week period with 40 women undergraduate students. A woman participant identified the experience of a gender microassault stating, "I was hanging out with some friends when one guy in the apartment said, 'Yo bitch, get me some beer'" (Swim et al., 2001, p.37). Another woman participant described the gender microassault of having a man compliment her on a belt she was wearing while his friend (a man) commented, "Forget the belt, look at her rack" (Swim et al., 2001, p.37). When enactors deliver microassaults, they may not realize the ramifications that these behaviors have on women, yet the ramifications are felt nonetheless (Nadal et al., 2013).

Gender microinsults are often subtle and unconscious or unintentional behaviors and actions that reinforce negative views of women (Capodilupo et al., 2010; Nadal et al., 2013). Microinsults align similarly with benevolent sexism in the way that perpetrators may be viewed as performing well-intentioned, chivalrous acts for women (e.g., a man

offering to carry a heavy box for a woman), when the man's actions actually support the view that women are fragile and inferior to men (Glick & Fiske, 2001). Glick and Fiske (2001) assert that benevolent forms of sexism allow men to maintain the image that they are willing to sacrifice their needs in order to care and protect women. This type of bias sends the message that women need men to be their protectors and providers, which may ultimately influence the way that women view themselves in terms of gender equality.

In an exploration of gender microinsults, Becker and Wright (2011) conducted two consecutive studies that examined whether women's exposure to benevolent sexism reduced their intentions to engage in collective action and examined whether women's exposure to benevolent sexism reduced their actual engagement in collective action. Collective action was defined as actions taken on behalf of the ingroup that aim to improve the conditions of the group (Becker & Wright, 2011). Results revealed that women exposed to benevolent sexism significantly decreased their intentions to engage in collective action, reduced women's tendencies to take flyers associated with gender inequality awareness, and reduced women's tendencies to sign a gender-related petition (Becker & Wright, 2011). These results suggest that benevolent sexism may be associated with women's lack of recognition of the forces needed to change sexist structures in society.

Gender microinvalidations are also covert and often unconscious forms of sexism. Microinvalidations are when enactors invalidate, deny, or ignore the internal and lived experiences of women (Capodilupo et al., 2010; Nadal et al., 2013). For example, when a woman confronts their boss about feeling doubted by their colleague who is a

man, the boss accuses the woman of overreacting, stating the man colleague would not think that way about them (Basford et al., 2014). Another example is the general belief that sexism does not exist anymore (Nadal et al., 2013). Basford and colleagues (2014) conducted a study to investigate gender difference in third-party perceptions of microaggressions against women at work. One hundred and fifty participants (70 women, 80 men) were required to read eight vignettes (two for each form of microaggression and two no-microaggression/control) that depicted interactions between women employees and men supervisors[1]. Results from the study indicated that women (M = 2.98, SD = .45) perceived greater microinvalidation compared to men (M = 2.76, SD = .43), $t(148) = -3.11$, $p < .001$, $d = -.51$; medium effect size) when measured with a 5-point Likert, perceived microaggression scale (Basford et al., 2014). These results suggest that women may be more attuned to the experiences of more subtle forms of microaggressions, such as microinvalidations, than men, perhaps as a result of women's more frequent experiences with microinvalidations (Basford et al., 2014).

Taxonomy of Gender Microaggression

Sue and Capodilupo (2008) originally proposed a theoretical taxonomy on microaggressions to understand the themes of microaggressions that may impact marginalized groups, specifically people of color, women, and LGBT individuals. Within this taxonomy, there are several themes of microaggressions specifically related to gender

[1] It is important to note that this study included vignettes that used "male" and "female" coworkers as the subjects. Because sex refers to biological differences between males and females, and that information cannot be ascertained from the information provided in the article, more inclusive, gender-based language (e.g., women, men) will be used instead when referencing this study and others that do not provide specific rationale for using sex as a participant and/or subject identifier.

including sexual objectification, second-class citizenship, assumptions of inferiority, denial of reality of sexism, assumptions of traditional gender roles, denial of individual sexism, use of sexist language, and environmental microaggressions (Nadal, 2010; Sue & Capodilupo, 2008).

Capodilupo and colleagues (2010) examined the validity of these categories through a qualitative study with 12 women from the community and a large, public university (both in a northeastern metropolitan area) who ranged in age from 18 to 43 years old (mean age = 25). Participants identified as Asian (*n* = 4), White (*n* = 4), Latina (*n* = 3), and Black (*n* = 1). Seven of the women self-identified as heterosexual, and five women did not report their sexual orientation. The researchers found that women's endorsements of sexual objectification and assumption of traditional gender roles were the most prominent themes. An example of sexual objectification came from one 18-year-old, Latina woman who stated, "It happens all the time. I mean, like, you know, sometimes just walking down the street, you hear a guy whistling at you or saying, 'Oh, hey, you look really cute or something. 'Let me know your name'" (Capodilupo et al., 2010, p.202). A White woman communicated how the assumption of traditional gender roles began early in her development. She stated, "When we were girls, we were always put into this image that we're going to be the mother, we're going to have the kids. We're always with our moms, cooking, learning, you know, dressing up like her…it's already pre-arranged for us" (Capodilupo et al., 2010, p. 204). Their study also found that denial of individual sexism (i.e., when a man denies his own gender biases and prejudices) was an underdeveloped theme and they revealed an additional theme called leaving gender at

the door (Capodilupo et al., 2010). The leaving gender at the door theme encompasses incidents that communicate the need for women to keep their feminine aspects out of situations, such as their work environment or in social discussions (Capodilupo et al., 2010). These themes support the concept that microaggressions are expressed in three different forms of microaggressions including microassaults, microinsults, and microinvalidations. Table 1 presents the taxonomy of gender microaggressions with definitions and examples. Themes were also categorized by type of microaggression based on the definitions and examples in Capodilupo et al's (2010) study.

Table 1

Taxonomy of Gender Microaggressions

Theme	Form of Microaggression	Definition	Example
Sexual objectification	Microassault	Verbal and nonverbal messages and behaviors that bring attention to a woman's body and/or their sexuality	Catcalling at a woman, leering at women, deemphasizing a woman's value as a person in verbal and nonverbal ways
Second-class citizenship	Microinvalidation	Men receiving more opportunities and privileges than women	Facing injustices in the workplace, like pay gaps, as a result of a gender
Assumptions of inferiority	Microinsult	Suggests women's physical and intellectual attributes are secondary to men	Purposefully not asking women to carry heavy objects at work
Denial of reality of sexism	Microinvalidation	The invalidation or denial or women's	A man minimizing a women's experience of

		experiences with sexism	sexism by telling them to ignore the incident
Assumptions of traditional roles	Microinsult	The assumption that women should engage in and maintain traditional gender roles and stereotypes	Women being told to “act like a lady,” dress feminine, be a homemaker, take care of children
Use of sexist language	Microassault	Using offensive words to demean a woman	Calling a woman a “slut” or “bitch”
Environmental microaggressions	Microinvalidation	Negative messages to and about women that occur within institutions and systems	Sexually objectifying women in the media; Displaying sexualize images of women in the workplace
Leaving gender at the door	Microinvalidation	Women being directly or indirectly told to leave feminine aspects of themselves out of their work and/or social environments	A woman who is told to avoid discussions of sexism or feminism at work

Note. Definitions and examples were derived from Capodilupo et al’s (2010) and Nadal et al’s (2013) studies.

As mentioned, gender microaggressions vary in their explicitness and the ways in which they are enacted. Women who experience gender microaggressions are likely to experience them on a frequent basis. In fact, Swim and colleagues’ (2001) qualitative diary study found that women experienced an average of 1.38 sexist incidents with a personal impact during the first week of the study. Because of the commonplace

occurrences of gender microaggressions, it is important to understand how these incidents negatively impact women's well-being.

Negative Effects of Gender Microaggression

Gender-based discrimination harms women across multiple life domains, including the workplace. For instance, women's income is compromised as a result of gender inequality (Sue, 2010). In fact, in the fourth quarter of 2019, women's average weekly earnings were only 82.5% of the average weekly earnings of men (U.S. Department of Labor, 2020). Further, in 2017, men earned more money than women in 97% of the 307 occupations surveyed by the Department of Labor. This data represents the continuing pay gap in employment that women endure within the United States. In a nationally representative sample of 4,914 surveyed adults (2,344 of those participants being women) working in STEM-based occupations, women were four times as likely as men to endorse being treated as incompetent because of their gender (23% women, 6% men), and one in 10 women reported being passed over for important assignments because of their gender (Pew Research Center, 2017). Moreover, women in the survey were three times more likely than men to personally experience sexual harassment in their workplace (22% women, 7% men; Pew Research Center, 2017). As women experience sexist events, whether in the workplace or in their everyday lives, it is important to consider how this may ultimately create greater levels of psychological distress.

Psychological Reactions to Gender Microaggression

Women who experience sexist discrimination report feelings of anger, fear, anxiety, guilt, shame, depression, and low self-esteem (Capodilupo et al., 2010; Fischer & Holz, 2007; Owen et al., 2010; Swim et al., 2001). Additionally, the more sexist events that women encounter, the more anger, depression, and lower social state self-esteem women feel (Swim et al., 2001). For example, Swim and colleagues (2001) found that as the number of sexist events in a day increase, the more anxiety women experience (Swim et al., 2001). Similar results were found in Capodilupo and colleague's (2010) qualitative study in which women endorsed themes of feeling angry, guilt, discomfort, humiliation, and fear when they experience gender microaggressions. Theoretically, women trainees who experience discrimination during their training would also endorse similar emotional responses. If women trainees did endorse similar affective responses, then it is likely that they may experience a decrease in their CSE given the literature that supports the relationship between anxiety and CSE (Bandura, 1993; Erzen & Odaci, 2016; Ghaderi & Rangaiah, 2011; Griggs et al., 2013).

Although specific research on women trainees' psychological reactions to discriminatory experiences is lacking, there is literature on cognitive processes associated with women's perceptions of gender microaggressions (Capodilupo et al., 2010). Through a qualitative approach, researchers revealed themes of resiliency, acceptance, and resistance in the cognitive reactions of 14 women from the community when they were asked how they responded to gender microaggressions (Capodilupo et al., 2010). While the study did not explore women's self-efficacy per say, the ways in which

participants cognitively processed experiences of discrimination is helpful when considering women trainees' experiences with discrimination in their training roles. From the aforementioned SCMCT framework, cognitive appraisals of affectively arousing events influence how much self-efficacy a trainee possesses; therefore, information on how women are affected by discrimination may be useful when conceptualizing how women trainees' counselor self-efficacy (CSE) is affected after experiencing gender microaggression. If women trainees' psychological reactions to discriminatory experiences are negative (e.g., resistance), then perhaps the degree to which their (CSE) is affected may be explained through their affective reactions to such events.

Additionally, the effects that gender microaggressions have on women who hold more than one marginalized identity (e.g., race/ethnicity, ability status, sexual orientation) may present additional complexities when understanding women's experiences with discrimination. As such, it is important to keep in mind the ways in which gender microaggressions intersect with women who hold multiple marginalized identities. Women trainees, and women in general, may experience the effects of gender microaggressions differently than women whose gender identity is their sole marginalized identity (i.e., White women).

Intersectionality

Crenshaw's (1989) original work on Black feminism ignited the concept of intersectionality as she spoke about the experiences of Black women and anti-discrimination law. Crenshaw (1989) provided an analysis of the multidimensional experiences of Black women and compared these experiences to that of a single-axis

approach (i.e., exploring one identity of a person). She spoke about experiences of holding two marginalized identities simultaneously and the nuanced and blatant discrimination Black women face. Since then, scholars have taken various approaches to understanding discrimination and intersectionality associated with Women of Color. The study of gendered racism became an area of research focused on understanding how discrimination and oppression impact individuals who hold multiple identities (Lewis et al., 2017). As one example of the importance of an intersectional approach, Thomas and colleagues (2008) conducted a study with 344 African American women and found a significant positive relationship between gendered sexism and psychological distress even when coping mechanisms were utilized.

Equally concerning is the suggested impact that gendered racism has on health outcomes. In a study that examined the relationship between gendered racism and health outcomes among 231 Black women, researchers found that a greater frequency of gendered racial microaggressions is a significant predictor of negative physical health and negative mental health with moderate effect sizes (Lewis et al., 2017). Researchers have also found that microaggressions are associated with negative outcomes across other marginalized groups. For example, researchers have found that racism and heterosexism (Balsam et al., 2011; Szymanski & Sung, 2010) and racism and classism (Allen, 2012, Nadal et al., 2014) are linked to greater psychological distress among people of color.

The detrimental effects of multiple oppressions may extend to other intersecting marginalized identities as well. Previous literature suggests that internalized sexism and internalized heterosexism are predictors of psychological distress (Piggot, 2004;

Syzmanski & Kashubeck-West, 2008). Szymanski and Henrichs-Beck (2013) conducted a study with 473 sexual minority women to extend this research by examining women's experiences of external and internalized heterosexism and sexism and their relationship with psychological distress and coping styles. They found that heterosexist events (β=.21), sexist events (β=.15), internalized heterosexism (β=.15), and internalized sexism (β=.20), when examined concurrently, were all predictors of psychological distress among sexual minority women, R^2 =.25, F (5, 467) = 30.70, p < .001 (Szymanski & Henrichs-Beck, 2013). Additionally, in a study that surveyed discriminatory experiences among individuals with disabilities, researchers found that women with disabilities reported lower health and well-being as a result of discrimination than individuals possessing only one marginalized identity, specifically disabled status (Brancoet al., 2019).

Collectively, the findings across the aforementioned studies of intersectionality suggest that women who hold more than one marginalized identity may experience harm as a result of discriminatory lived experiences. However, given that sexism in these studies was a common thread among participants, it is worthwhile to consider how discriminatory experiences manifest for women, in general, in their everyday lives. Because women face prejudices and discrimination as a result of their gender, the various ways in which these sexist events transpire may provide a deeper understanding into the way women cognitively and affective process these experiences.

Effect of Microaggressions on Therapy

Recently, literature has explored the effect of microaggressions on psychological well-being and therapeutic processes. A recent meta-analysis including 21 studies and over 6,000 participants showed that microaggressions were related to various aspects of psychological functioning, such as self-esteem, depressive symptoms, substance use, rumination, stress, overall psychological well-being, and overall psychological distress (Owen et al., 2019). Moreover, researchers found that individuals' ratings of microaggressions occurring outside of therapy accounted for 8.6% of the variance in their mental health functioning (Owen et al., 2019).

Additionally, the effect of microaggressions in therapy with patient populations, like racial-ethnic minorities (REM), LGBQ individuals, and women, has gained more recent attention in the literature (Constantine, 2007; Davis et al., 2016 Owen et al., 2010; Owen et al., 2011, 2015; Shelton & Delgado-Romero, 2011). Owen and colleagues (2019) used seven studies that involved REM patients' experiences of racial/ethnic microaggressions, two studies that examined women patients' experiences with gender microaggressions, and one study that analyzed LGBQ patients' experiences with sexual orientation microaggressions in therapy to explore the relationship between microaggressions and process variables. All studies aimed to understand patients' experiences with microaggressions committed by their therapists in therapy. Taken collectively, these studies revealed a negative association between microaggressions delivered by therapists toward patients and therapy outcomes (i.e., satisfaction, improvement, psychological well-being; r = -0.24, small effect size) as well as

therapeutic processes (i.e., alliance, cultural humility; r = -0.45, moderate effect size; Owen et al., 2019).

Findings from a scale development study that focused on assessing the relationship between women patients' perceptions of gender microaggressions by their therapists and therapy processes and outcomes found that gender microaggressions were negatively related to the working alliance between patient and therapist and psychological well-being (Owen et al., 2010). These findings suggest that women patients who perceived more microaggressions had a lower working alliance and worse therapy outcomes (Owen et al., 2010).

As previously mentioned, discrimination against women has been linked to women's experience with negative affective states (e.g., depression, shame, guilt) and lower self-esteem (Capodilupo et al., 2010; Owen et al., 2010; Swim et al., 2001). The findings from Owen et al's (2010) study that suggest an association between microaggressions against women in therapy and psychological distress is especially important given that therapy is supposed to be a place where support and safety of patients are held in high regard. While more research is needed to understand how manifestations of sexism in therapy can be detrimental to women patients, it is also worthwhile to consider how gender microaggressions delivered by patients may affect women behavioral health providers' responses to sexist experiences when they occur in therapy. Further, more research is needed on how women providers' react to gender microaggressions when they occur and how these reactions may influence treatment.

Multicultural Orientation Framework

Trainees' multicultural orientation (MCO) may be a way to explain the degree to which trainees perceive their work with patients as effective in challenging clinical situations as well as what therapists actually *do* in session when cultural issues, such as gender microaggressions, arise between themselves and patients. Owen and colleagues (2011c) assert that MCO involves "a way of being with clients, particularly when one detects cultural dynamics that may require enhanced awareness, knowledge, and skills" (p. 91). This may be especially important when considering how women trainees' view and respond to patient-delivered gender microaggressions when they occur in behavioral health interactions.

The MCO framework consists of three components: cultural humility, cultural opportunities, and cultural comfort (Owen et al., 2011c). *Cultural humility* serves as an organizing principle of the MCO framework and is defined as an ability to maintain an other-oriented stance in which the therapist is respectful and attuned to the patient's needs while also being curious and open to the patient's views and identities (Davis et al., 2018; Hook et al., 2017; Mosher et al., 2017; Owen, 2013). In other words, a therapist demonstrating cultural humility remains open to understanding the patient's most salient cultural identities, even in situations that may evoke defensiveness (Davis et al., 2018). As such, humility requires the therapist to be aware of their reactions (e.g., biases, assumptions) to patients in a variety of clinical situations, such as those that may be interpersonally or emotionally challenging. While there is no current research that examines the relationship between a trainee's cultural humility and microaggressions

expressed by their patient, it is hypothesized that when patient-delivered microaggressions occur in behavioral health interactions, trainees who display cultural humility (e.g., remaining open to understanding the patient's worldview, values, beliefs), may also feel more efficacious in being able to effectively treat the patient despite the patient's perceived insensitive behavior.

Cultural comfort refers to the therapist's ability to react calmly and maintain at ease when culture is discussed with their patients (Owen et al., 2013). Therapist's reactions (e.g., thoughts, feelings) associated with discussing culturally-focused content in session can happen before, after, or during these conversations (Owen et al., 2017). Therefore, a therapist with cultural comfort will demonstrate self-regulation of discomfort or anxiety by maintaining an open, calm, and relaxed demeanor when cultural topics are discussed with diverse patients (Davis et al., 2018). This may be especially important when considering the degree to which trainees' feel efficacious treating a patient who exhibits discriminatory behaviors towards the trainee, and how trainees manage their affective reactions in those moments. A trainee who demonstrates cultural comfort by maintaining calm and at ease after experiencing a patient-delivered microaggression may feel more equipped to treat the patient in subsequent sessions.

Cultural opportunities occur when therapists provide opportunities in session to discuss and explore aspects of a patient's cultural identity, such as their values or beliefs (Owen et al., 2016). Additionally, cultural opportunities do not necessarily have to be provoked by a patient bringing up salient pieces of their cultural background. When a therapist chooses to pursue cultural opportunities from an MCO lens, they may initiate

cultural discussions when they are warranted without coming off as disingenuous or forced (Davis et al., 2018). In the example of a patient who delivers a microaggression towards a trainee, the trainee's ability to discuss cultural differences in an attempt to understand the patient's cultural views and beliefs may perceive their work with the patient as more valuable and may feel more confident in their ability to treat the patient's presenting concerns.

In general, therapy processes and outcomes have been associated with therapists' positive multicultural orientation (Hook et al., 2016; Owen et al., 2011; Owen et al., 2017). For example, Owen and colleagues (2011) found that patients' (N = 176) perceptions of their therapists' MCO were positively related to the real relationship (r = .65, p < .001; large effect size) and working alliance (r = .73, p < .001; large effect size). Additionally, they found that therapists' MCO was a significant predictor of REM and White patients' psychological well-being after controlling for patients' perceptions of their pretherapy distress (Owen et al., 2011). To some extent, these therapy processes (e.g., working alliance, the real relationship) may be suggestive of patients' evaluations of session impact (e.g., whether patients thought the session was good or bad, whether patients felt good or bad after a session; Stiles, 1994) perhaps as a result of their therapists' MCO. If a therapist demonstrates positive MCO and their patients endorse positive therapy processes and outcomes, then it might be possible that those patients may evaluate their sessions with their therapists as being more impactful.

It may be likely that therapists with more positive MCO also evaluate their sessions as more impactful and, therefore, beneficial for the patient. While MCO and

session impact (e.g., the value of the session, the comfortability of the session; Stiles, 2002) has not been studied together, theoretically, it would make sense that therapists' MCO and patient and provider evaluations of session qualities would be related. For example, if therapists are able to provide opportunities for culturally-focused discussion while maintaining a sense of openness and calmness (Davis et al., 2018), then perhaps those therapists would also evaluate those interactions as having more beneficial effects for the patient (Stiles, 1994, 2002) regarding their treatment outcomes. As such, therapy interactions that are deemed as challenging, such as an offensive patient, may be perceived as more impactful when a therapist is able to maintain an other-oriented stance while acknowledging cultural dynamics with a sense of smoothness and depth.

Because findings from Owen et al's (2011) study suggest that therapists' MCO may be connected to treatment outcomes, the MCO framework may be particularly important to consider in clinical settings, such as IPC, where trainees treat diverse populations of patients with a variety of presenting concerns. Given the time-limited dynamics of the integrated behavioral healthcare model, treatment outcomes take priority, thus placing emphasis on the behavioral health provider's ability to work efficiently and effectively with a patient who may possess values, beliefs, or identities that might be different from the provider. This raises several important questions: What happens when a trainee is confronted with a patient whose behaviors, as a result of their worldviews, are considered insensitive and offensive to the provider? Are therapists with more positive MCO less likely to experience negative perceptions of their ability to counsel a patient who offends them? Additionally, do therapists with more positive MCO evaluate their

behavioral health interactions as having greater session impact even when a patient presents with offensive behaviors? As mentioned, microaggressions are known to provoke a variety of psychological and emotional reactions. Therefore, it is important to understand how trainees, and behavioral health providers in general, respond to patients who deliver microaggressions and how these responses may connect to the provider's perceived ability to deliver a set of skills with that specific patient as well as their overall evaluation of the behavioral health interaction. More specifically, if a patient delivers a gender microaggression towards a woman trainee, the degree to which the woman trainee demonstrates calmness, openness, and willingness to understand the patient's worldview (i.e., the trainee's level of MCO), may provide insight into the trainees' CSE beliefs and how they judge the overall behavioral health interaction.

Healthcare and Microaggressions

To date, there has been no research published on therapists' perceptions of patient-delivered gender microaggressions, and research on other forms of microaggressions from patients toward healthcare providers is limited. Because microaggressions affect a broad range of individuals across multiple life domains, understanding how microaggressions affect workers in helping professions may provide insight for those preparing for a career in the healthcare field and for those currently working in healthcare settings. Furthermore, training programs and healthcare organizations may be able to utilize the information from this study to help maintain or improve the well-being, job satisfaction, and retention of trainees and employees. Additionally, implications drawn from this study may highlight a need for improving

structures within healthcare systems as a means of protecting employees and trainees from gender-based discrimination.

This budding area of research has started to gain steam in the medical field. A meta-analysis of 51 studies showed that over half (59.4%) of medical trainees experienced at least one form of harassment or discrimination during their training, with patients accounting for 34.4% of the source of harassment and discrimination (Fnais et al., 2014). Further, a recent Medscape report from more than 6200 physicians revealed that 27% of physicians reported being sexually harassed by patients at least once in the last three years, further highlighting the common occurrence of patient-delivered gender discrimination, such as gender microassaults, in healthcare settings. Providers in medical settings, such as IPC, who hold various marginalized identities, including LGBTQ physicians, physicians of color, international medical graduates, and women physicians are all at risk of discriminatory experiences (Overland et al., 2019). Overt forms of racism and sexism as well as more subtle microaggressions are known to contribute to physicians' burn out, moral distress, and other associated forms of physical and psychological harm (Jain, 2013; Montenegro, 2016; Wheeler et al., 2018; Wolf et al., 1991).

Research pertaining to the experiences of other healthcare workers, including nurses, social workers, and mental health counselors is scarce (Estacio & Saidy-Khan, 2014; Hernández et al., 2010; Ross-Sheriff, 2012). The few studies conducted have explored healthcare professionals' experiences of racial microaggressions within the workplace, and more research is needed on how these professionals, including behavioral

health providers experience other types of microaggressions, including gender microaggression, when working with patients. Moreover, there have been no studies published on behavioral health providers' or trainees' experiences of gender microaggressions delivered by their patients in the workplace. It is worthwhile to consider how gender microaggressions influence behavioral health providers' work with their patients given the frequent occurrence and harmful impact that medical providers experience from patients. Moreover, understanding providers' psychological reactions to gender microaggressions when they are delivered by their patients may provide more insight into the ways these reactions are and can be managed when treating patients. This information may also contribute to behavioral health providers' development, including their self-efficacy, as they encounter a variety of patient populations throughout their training.

The Present Study

The proposed study examines how women trainees' counselor self-efficacy (Larson, 1998) is influenced by patient-delivered, gender microaggressions (Sue, 2010) in the context of integrated primary care settings. Given the time-limited treatment context of IPC (Reiter et al., 2018) and the prevalence of patient-driven discriminatory acts towards medical providers (Fnais et al., 2014), there is a need for understanding the ways in which gender microaggression affects trainees' perceptions of their ability to perform behavioral health skillsets and their evaluations of the impact of behavioral health encounters when gender microaggressions occur. Negative affective reactions may serve as a way to explain decreases in counselor self-efficacy and evaluations of session

impact after the experience of gender microaggressions. The current study also examines trainees' level of stigma consciousnesses and their observer-ratings of cultural comfort as potential protective factors against decreases in trainees' counseling self-efficacy and overall evaluations of session impact of the behavioral health interaction. This study tests the following hypotheses:

Hypothesis 1a: Participants who are assigned to the gender microaggression condition will demonstrate significantly lower counselor self-efficacy compared to participants in the control condition.

Hypothesis 1b: Participants who are assigned to the gender microaggression condition will report lower evaluations of session impact (i.e., less depth and smoothness) compared to participants in the control condition.

Hypothesis 1c: Participants who are assigned to the gender microaggression condition will demonstrate significantly higher negative affective reactions than participants in the control condition.

Hypothesis 2a: The relationship between experiences of gender microaggression and counselor self-efficacy will be partially mediated by negative affective reactions, such that the mediation will yield increases in negative affective reactions and, as a result, decreases in counselor self-efficacy in women trainees.

Hypothesis 2b: The relationship between experiences of gender microaggression and lower evaluations of session impact will be partially mediated by negative affective reactions, such that the mediation will yield increases in negative affective reactions and, as a result, lower evaluations of session impact.

Hypothesis 3a: The association between stigma consciousness and counselor self-efficacy will differ based on the condition assignment, such that stigma consciousness will be more strongly associated with counselor self-efficacy for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 3b: The association between stigma consciousness and evaluations of session impact will differ based on the condition assignment, such that stigma consciousness will be more strongly associated with evaluations of session impact for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 4a: The association between trainees' cultural comfort and counselor self-efficacy will differ based on the condition assignment, such that trainees' cultural comfort will be more strongly associated with counselor self-efficacy for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 4b: The association between trainees' cultural comfort and evaluations of session impact will differ based on the condition assignment, such that trainees' cultural comfort will be more strongly associated with evaluations of session impact for those in the gender microaggression condition compared to those in the control condition.

CHAPTER TWO: METHOD

Participants

Ninety-six participants were recruited for the study, and 58 of those participants consented to the study and completed both the video portion and survey portion of the study. It was determined that there was no missing data after reviewing the 58 participants; therefore, the 58 participants were included in the final analyses. Based on an a priori power analysis, the sample size of the present study fell within the targeted range. Data collection began in August 2020 following the approval of the study by the University of Denver's IRB. Recruitment information was circulated via email to local and national institutions with clinically-oriented psychology graduate training programs across the United States. A total of 76 graduate programs were contacted to distribute the recruitment information. The recruitment email was also sent to national Listservs connected to the American Psychological Association, including Division 17 and Division 35. The inclusion criteria for the study were that participants 1) must identify as women, 2) be enrolled in a clinically-oriented psychology graduate training program at the masters-level or doctoral level, 3) have access to a computer with audio and webcam accessories and 4) access to Internet. Participants were able to respond to the surveys

using Qualtrics and the videos using Theravue, now known as Skillsetter (an online program that allows psychotherapists and trainees to practice their psychotherapy skills).

All 58 participants self-identified as women as this was part of the inclusion criteria. Regarding race and ethnicity, 70.7% identified as White/European American, 10.3% identified as Hispanic/Latinx, 6.9% identified as Black/African American, 5.2% identified as Asian/Asian American, 3.4% identified as Middle Eastern, and 3.4% identified as Multiracial. The majority of participants identified as heterosexual (72.4%) with 17.2% who identified as bisexual, 6.9% who identified as queer, 1.7% who identified as gay or lesbian, and 1.7% who identified as demisexual. Participants ranged in age from 21-years-old to 49-years-old with the majority of participants being in their twenties (84.5%). Approximately 72% of participants were pursuing a master's degree and approximately 28% were pursuing a doctoral degree. Most participants were enrolled in counseling psychology programs (65.5%), while other participants were enrolled in clinical mental health counseling programs (19%), clinical psychology programs (12.1%), school psychology programs (1.7%), and neuropsychology programs (1.7%). Regarding clinical experiences, 22.4% of participants had experience in private practice, 19% of participants had experience in community mental health settings, 6.9% in specialty care clinics (e.g., weight loss clinic, sleep clinic), 6.9% in college counseling settings, 5.2% in integrated primary care, and 5.2% in hospital settings (e.g., VA, public, state). Approximately 35% of participants endorsed having other clinical experiences not listed in the survey including residential treatment facilities, correctional facilities,

schools, sports psychology clinics, domestic violence shelters, counseling training clinics, and role-plays in class.

Video Vignettes

Video Creation

Video vignette scripts were created by the primary researcher and vetted by three psychologists familiar with microaggression research and one familiar with the integrated primary care clinical setting. Once final vignette scripts were solidified, the primary researcher contacted an acting studio to recruit actors for the video vignettes. One actor was recruited to conduct the voiceover portion of the first and second videos, which helped set the clinical context for the vignettes. A second actor portraying a White, able-bodied man in his 30s was recruited for the second and third videos in the modules to reflect clinical scenarios with patients who are men with no explicit marginalized identities. The primary researcher and the actors recorded several versions of each video vignette then the primary researcher consulted with two psychologists to choose the final videos that were used for the video modules in Theravue.

Theravue[2]

Theravue is an online program designed to enhance the psychotherapy education experience by providing psychotherapists and trainees an electronic platform to practice psychotherapy skills. With Theravue, psychotherapists and trainees are able to implement and improve their clinical skills with a variety of patient scenarios. Psychotherapists and trainees can watch clinical video vignettes then immediately submit their responses to the

[2] Developers of the online program, Theravue, changed the name to Skillsetter during the process of this study.

scenario (e.g., what they would do as the therapist in a given situation) as soon as the video ends. A similar process using Theravue was utilized for the study. Each participant was assigned a module of three videos that they watched in a particular order. For every participant, there were two standard videos that provided clinical context and information for the third video in the module; that is, the first two videos were the same for every participant while the third video was either the control condition or the experimental condition.

The first video in the module helped set the clinical context of an integrated primary care clinic. All participants watched a video clip that displayed several images of an integrated primary care clinic while a narrator described the clinical setting. This helped "set the stage" of an integrated primary care clinic environment to help familiarize participants with this type of clinical setting.

The second video vignette was the patient responding to their primary care provider (PCP) after their PCP recommended that the patient speak with a behavioral health provider regarding their depressive symptoms. Before the second video began, a narrator provided background information on the patient including patient demographics and reason for the behavioral health referral. The PCP was not visible and did not speak in the video; however, information on the PCP's gender identity (i.e., a man) was disclosed in the background information. This video vignette served as another contextual video to assist with preparing the participant with information for either the experimental or control video (the third video in the module).

The third video in the module was either a control video vignette or a gender microaggression video vignette. Both video vignettes depicted a brief behavioral health appointment between the behavioral health trainee and the patient to reflect a typical clinical scenario in which behavioral health providers interact with patients in IPC. The actor (i.e., the patient) discussed his current experiences with depressive symptoms and his ambivalence about engaging in behavioral health services in IPC in both the control video vignette and the gender microaggression video vignette. The control video vignette did not involve any gender microaggressions. The gender microaggression video vignette encompassed elements of different gender microaggressions to reflect the way that gender microaggressions manifest in everyday interactions (Sue, 2010; Capodilupo et al., 2010) and perhaps in clinically-oriented exchanges between a patient and their provider. Because the videos were abbreviated, instead of portraying an entire behavioral health appointment, the gender microaggressions were delivered by the actor within three minutes.

Coders

Coders were utilized to code participants' responses to the third video vignette (control and gender microaggression conditions). The coders were trained using a modified version of the MCO-PT manual (Haywood Stewart, 2019) which was adapted to align with MCO (multicultural orientation) variables in the context of gender microaggressions. The MCO variables in the adapted manual included Cultural Humility, Cultural Comfort, and Cultural Opportunities, as well as an additional construct, Orientation (i.e., other-oriented, relationally-oriented, self-oriented), associated with

Cultural Humility. Coders first read several articles on MCO as well as the coding manual then met with the primary researcher to discuss the constructs. Next, coders met as a group to review and discuss several written vignettes that were coded by the primary researcher. Coders then met to practice coding several video vignettes that demonstrated varying degrees of the MCO constructs. During this meeting, coders watched several videos, coded their responses independently, then discussed and compared their codes as a group. Thorough discussions took place when there were discrepancies between coders and a consensus was reached. To help differentiate between rating options for each of the MCO dimensions, especially when discrepancies in codes were identified, the primary researcher had coders conceptualize each video response as being "high," "medium," or "low," for each of the items in each MCO dimension (e.g., "high" Relaxed item within the Cultural Comfort domain). Discussions were had to clarify why a response was considered high, medium, or low for the respected item. Then, the primary researcher helped coders identify where the coding rating fell within the high, medium, and low categories to help coders decide on a numerical rating (1-6) for each item. Each time these discussions took place, the primary researcher updated the coding manual to help provide coders with direction and clarity during independent coding. A final round of coding took place in which coders rated videos alone then came together for a meeting to discuss reliability among the teams. Additional meetings were held as a team or with individual coders as questions arose during the coding process. In all, a total of approximately 11 hours were involved in coder training.

There were two coding teams comprised of master's and doctoral graduate students. Team 1 included two first-year doctoral students and the primary researcher; Team 2 included a second-year master's student and the primary researcher. The primary researcher coded all videos involved in the study. Participants were mostly assigned randomly to coding teams; however, given that coders and many of the participants were recruited from the same university, participants had the option to indicate any coders they did not want to watch their videos. In this case, those participants were assigned to a different group based on their preference.

All coding was completed independently in assigned spreadsheets. Coders sent in their spreadsheets roughly halfway through coding so the primary researcher could run intraclass correlation analyses (ICCs) to assess the status of inter-rater reliability for each team. Once all videos were coded, ICCs were run again for each item of the MCO-PT and were found to be in the excellent range (see Results section). However, Team 1 recoded five videos (out of 28) associated with the Relationally-Oriented item to improve reliability. The five videos that were recoded were based on coders' scores that deviated by three or more codes. For example, if one coder rated the item as a 2 and another rated the item as a 5, that particular video was selected to be recoded. This process involved Team 1 meeting to re-watch the selected videos together then each coder blind rated the score for the Relationally-Oriented item without looking at their original scores for that item.

Measures

Session Evaluation Questionnaire (SEQ)

Participants' evaluation of the behavioral health encounter and their affective reactions to the behavioral health encounter was measured using the Session Evaluation Questionnaire (SEQ - Form 5; Stiles et al., 2002) and was completed by participants immediately after they recorded their responses to the third video vignette (see Procedures). The SEQ consists of 21 bipolar adjectives that participants rated on a seven-point scale (1 to 7) to capture the dimensions of Depth, Smoothness, Positivity, and Arousal. Participants were directed: "Please circle the appropriate number to show how you feel about this session" (Stiles et al., 2002). The wording of instructions was modified to fit more appropriately with the video vignette task; therefore, instructions were changed to: "Please circle the appropriate number to show how you feel about this behavioral health encounter." The items are divided into two sections, session evaluation and post-session mood.

Ten items measuring post-session mood were used to assess participants' affective reactions to the behavioral health encounter. The stem "Right now I feel" precedes the post-session mood items, happy-sad, angry-pleased, moving-still, uncertain-definite, calm-excited, confident-afraid, friendly-unfriendly, slow-fast, energetic-peaceful, and quiet-aroused (Stiles et al., 2002). An additional two items assessing post-session mood were added to the questionnaire to help capture a wide variety of affective reactions to the behavioral health encounter. The two items included: at ease-anxious and certain-confused. The second ten items measuring session evaluation were used to assess

participants' judgments regarding how they evaluated the behavioral health encounter; that is, participants will judge the behavioral health encounter as good or bad by rating the encounter as deep (powerful, effective) or shallow (weak, worthless) and as smooth (relaxed, comfortable) or rough (tense, distressing; Stiles et al., 2002). The stem "This session was" preceded the 11 items, bad-good, difficult-easy, valuable-worthless, shallow-deep, relaxed-tense, unpleasant-pleasant, full-empty, weak-powerful, special-ordinary, rough-smooth, and comfortable-uncomfortable. In the SEQ, session evaluation items are listed before post-session mood items. However, because affective reactions were more time sensitive for assessment, post-session mood items were administered first.

To calculate the four SEQ dimension scores (i.e., Depth, Smoothness, Positivity, Arousal), the items are first grouped by their dimensions. Depth includes the items: deep-shallow, powerful-weak, full-empty, special-ordinary, valuable-worthless. Smoothness includes the items: smooth-rough, comfortable-uncomfortable, relaxed-tense, pleasant-unpleasant, easy-difficulty. Positivity includes the items: confident-afraid, happy-sad, pleased-angry, definite-uncertain, friendly-unfriendly. Positivity includes the additional item, certain-confused. Arousal includes the items: aroused-quiet, energetic-peaceful, fast-slow, moving-still, excited-calm. Arousal will also include the additional item, at ease-anxious. Item scores for scales that have negative connoted adjectives (e.g., worthless, uncomfortable) on the right-hand side were reverse scored with higher scores indicating greater Depth, Smoothness, Positivity, or Arousal (Stiles et al., 2002). The sum of item scores for each Depth and Smoothness dimensions were then divided by 5 and the

sum of item scores for Positivity and Arousal were then divided by 6 (which is the number of items for each dimension), so that scores laid on the same 7-point scale as the individual items (Stiles et al., 2002). It is important to note that only 20 out of 21 original items of the SEQ (five for each of the four dimensions) were given to participants to assess their evaluations of and affective reactions to the behavioral health encounter in addition to the additional two items that were added to further assess post-session mood. The first item of the SEQ (bad-good) is a global evaluation index; therefore, it does not fall within the four indexes. This item was scored by external coders to capture the general effectiveness of participant responses and was not be administered to participants (see Multicultural Orientation-Performance Task in Measures). The SEQ has demonstrated high internal consistencies for all SEQ indexes across various conditions and settings (Depth: $\alpha = .93$, Smoothness: $\alpha = .90$, Positivity: $\alpha = .81$, Arousal: $\alpha = .81$; Stiles et al., 2002). The Good-Bad index was moderately to strongly correlated with SEQ Depth, Smoothness, and Positivity (Stiles et al., 1994).

In this study, Cronbach's alpha for the Arousal dimension (including the at ease-anxious item) was estimated to be .85. The internal consistency for the six Positivity items (including the certain-confused item) was in the acceptable range ($\alpha = .70$). Additionally, Cronbach's alpha for the Smoothness dimension was excellent at .90 and was in the acceptable range ($\alpha = .71$) for the Depth dimension.

Counselor Self-Efficacy Self-Reflection Items

In addition to capturing participants' counselor self-efficacy using the CASES (see below), participants were also asked to reflect on their experiences with the patient

in the video vignettes after they complete the SEQ. Participants were given three items that assessed components of personal agency, a causal determinant that is theorized to contribute to trainees' counseling self-efficacy (Bandura, 1986; Larson, 1998). Participants were given the following statements: "My emotional reactions to the patient make it challenging to feel effective with the patient," "I believe that I would be effective when working with this patient," and "I believe that my work with this patient would be successful in achieving the patient's treatment goals." Participants were asked to rate their responses on a five-point Likert agreement scale ranging from (1) strongly disagree to (5) strongly agree.

These items were administered to participants in addition to the Helping Skill and Session Management subdomains of the CASES to capture dimensions of personal agency factors (i.e., affective processing, CSE beliefs, outcome expectations) that are thought to contribute to trainees' overall counseling self-efficacy (Larson, 1998). The first statement, "My emotional reactions to the patient make it challenging to feel effective with the patient," assessed the degree to which trainees believed their affective processes affected their perceived abilities. The second statement, "I believe that I would be effective when working with this patient," assessed the trainees' CSE beliefs associated with a specific patient, which, in turn, may affect the actions that trainee takes in future sessions, including the amount of effort they put forth with a patient and whether they choose to persevere under pressure (Bandura, 1986; Larson, 1998). The third statement, "I believe that my work with this patient would be successful in achieving the patient's treatment goals," directly related to the trainees' view of the

patient's expected outcome in treatment. The first statement regarding participants' emotional reactions to the patient was reverse scored. Higher scores on the three self-reflection items indicated higher ratings of counselor self-efficacy. The reliability of the three items were low ($\alpha = .46$); however, the items "I believe that I would be effective when working with this patient" and "I believe that my work with this patient would be successful in achieving the patient's treatment goals" were found to be correlated ($r = 0.66$).

Counselor Self-Efficacy Scale

Participants rated their level of counselor self-efficacy using the Counselor Activity Self-Efficacy Scale (CASES; Lent et al., 2003). Hill and O'Brien's (1999) helping skills model in addition to the social-cognitive model of counselor self-efficacy (Bandura, 1986, 1997; Larson & Daniels, 1998) were used as frameworks in developing the CASES. The CASES measures self-efficacy across three broad subdomains including Helping Skill Self-Efficacy, Session Management Self-Efficacy, and Counseling Challenges Self-Efficacy. The Helping Skill Self-Efficacy subdomain integrated Hill and O'Brien's (1999) helping skills training model by incorporating 15 items based on the three stages of basic helping skills including insight skills, exploration skills, and action skills. The second subdomain, Session Management Self-Efficacy, has 10 items that focus on counselors' perceived ability to use basic helping skills when managing session tasks (Lent et al., 2003). This subdomain extends basic helping skills to session scenarios rather than just the counselors' perceived ability to perform basic helping skills (Lent et al., 2003). The third subdomain of the CASES is Counseling Challenges Self-Efficacy,

which involves counselors' perceived ability to work with a client through challenging session scenarios (e.g., a client who has been sexually abused, a client who is suicidal; Lent et al., 2003). The Counseling Challenges Self-Efficacy subdomain was not used in the current study due to inapplicability of most of the listed counseling challenges. Instructions on the CASES were changed to reflect participants' view of their ability to implement skills effectively with the patient in the video vignette; therefore, the instructions were change from "in counseling most clients" to "in counseling this patient." Trainees rated their confidence for each question on a 10-point scale from "no confidence" (0) to "complete confidence" (10). Scores from each subdomain were calculated by averaging the item responses within that subdomain; higher scores indicate higher levels of self-efficacy for that particular subdomain.

The strengths of the measure are reflected in the psychometric properties of the measure. The CASES has demonstrated excellent overall internal consistency ($\alpha = .97$) and high internal consistency for each of the subscales (Exploration Skills: $\alpha=.79$, Insight Skills: $\alpha=.85$, Action Skills $\alpha=.83$, Session Management: $\alpha=.94$, Client Distress: $\alpha=.94$, and Relationship Conflict $\alpha=.92$; Lent et al., 2003). During the scale validation study, two-week test-retest reliability and internal consistency estimates were measured in a separate sample of 48 participants; the CASES demonstrated good test-retest reliability at .75, great overall internal consistency ($\alpha=.96$), and relatively stable internal consistency for each subscale (Exploration Skills = .71, Insight Skills = .75, Action Skills = .59, Session Management = .76, Client Distress = .75, and Relationship Conflict = .66; Lent et al., 2003). In the scale's validation study, the Counseling Self-Estimate Inventory

(COSE) was used to examine convergent validity with the CASES as the COSE also measures counseling self-efficacy. High correlations were found between scales that measured similar constructs as well as the scales' total scores. Additionally, discriminant validity was supported by small, nonsignificant correlations found between the CASES and social desirability (Lent et al., 2003). The norming sample used for the CASES reflects significantly more women than men (266 women, 76 men), which aligned strongly with the sample of the study.

In the present study, the Cronbach's alpha was estimated to be .91 for the Helping Skills subdomain and .90 for the Session Management domain. The overall internal consistency for the two subscales combined to represent one total CASES score was estimated to be in the excellent range (α=.94).

Stigma Consciousness Questionnaire (SCQ) for Women

Stigma consciousness was measured using the Stigma Consciousness Questionnaire (SCQ) for Women (Pinel, 1999). The SCQ for Women is comprised of 10 items rated on a seven-point Likert scale (0-strongly disagree to 6-strongly agree) that measures the degree to which women feel as though stereotypes about their gender group influence their daily life (Pinel, 1999). First, seven of the 10 items on the SCQ for Women are reversed scored (e.g., "Stereotypes about women have not affected me personally"). Scores are calculated by averaging all the item responses; higher scores indicate higher levels of stigma consciousness.

In the validation study, internal consistency of the SCQ for Women was acceptable (α = .77; Pinel, 1999). Validating the SCQ for Women occurred in two phases.

Phase 1 consisted of collecting information about convergent and discriminant validity. The SCQ for Women was positively correlated with the Public subscale of the Self-Consciousness Scale and negatively correlated with the Modern Sexism Scale. Also as predicted, there were no correlations between stigma consciousness and the Attitudes Towards Women Scale, the Personal Attributes Questionnaire for Self and Stereotypes, indicating good discriminant validity. In Phase 2, the SCQ for Women produced a stable test-retest reliability at 0.76 over a 1-month period. Additionally, construct validity of the measure was supported by statistically significant correlations that indicated women high in stigma consciousness were more likely to believe women as a group were discriminated against (Group $r = 0.48$), the average woman was discriminated against (Average $r = 0.50$), and the woman, herself, was discriminated against (Personal $r = 0.48$). In the present study, Cronbach's alpha was estimated to be good at .75.

Multicultural Orientation Performance Task (MCO-PT)

The Cultural Comfort subscale of the MCO-PT was used as a predictor for participants' ratings of the counselor self-efficacy and evaluations of session impact as cultural comfort, specific to gender, may capture participants' level of ease in patient-provider discussions after experiencing gender microaggression (i.e., reacting calmly, maintaining comfort, being relaxed; Owen et al., 2017). Coders served as external raters to evaluate participants' responses regarding their ability to be culturally humble, their ability to create opportunities for discussions of culture, their level of comfort with these discussions, and the general effectiveness of their responses (Haywood Stewart, 2019). Additionally, participants' responses regarding their orientation in session (i.e., other-

oriented, relationally-oriented, self-oriented) was also evaluated. The Other-Oriented item related to the trainee's level of attunement to the patient's experience and/or the patient's needs in treatment. The Relationally-Oriented item was defined as the therapist's focus on the therapeutic relationship and its dynamics, placing emphasis on collaboration (e.g., working together) and/or trying to understand one another for a common goal. The Self-Oriented item was defined as the trainee responding in a way that puts the trainee's needs as a focus, which may involve what the trainee can do or wants to do to help the patient or may include boundary setting with the patient (e.g., "I do not feel comfortable with you talking to me that way"). Given the extent of adaptations made to the MCO-PT coding scheme for the purposes of this study, only the Cultural Comfort domain was used in primary analyses and will be reported in this dissertation. However, coders rated participants across all MCO-PT domains. The MCO-PT's coding scale was inspired by the Session Evaluation Questionnaire (SEQ) as it requires coders to rate participant responses by choosing a number on a continuum of bipolar adjectives (e.g., Relaxed (1) to Tense (7); Stiles et al., 2002). The MCO-PT consists of three subscales associated with the three components of MCO as well as an item that that measures general psychotherapy responses. Level of cultural comfort in a participant's response is assessed by rating three items on the following scales: (1) Uncomfortable to (6) Comfortable, (1) Nervous to (6) Calm, and (1) Tense to (6) Relaxed (Haywood et al., 2019). Level of cultural humility is measured by ratings on three items including (1) Disrespectful to (6) Respectful, (1) Close-minded to (6) Open-minded, and (1) Superior to (6) Non-superior (Haywood Stewart, 2019). The third pillar of MCO, cultural

opportunities, is assessed by rating one item from (1) No cultural discussion to (6) Definitive cultural discussion (Haywood Stewart, 2019). The last item on the MCO-PT is derived directly from the SEQ and assesses the general effectiveness of participants' responses to the gender microaggression vignette. Coders rated participants' responses from (1) Good to (7) Bad.

The MCO-PT was implemented with a sample of psychotherapists-in-training who were asked to respond to several video vignettes depicting challenging clinical situations involving the intersection of cultural identities (Haywood Stewart, 2019). A team of coders then rated the participants' responses to video vignettes using the MCO-PT (Haywood Stewart, 2019). Internal consistency estimates in prior research were .94 for Cultural Comfort, .97 for Cultural Humility, and .77 for Cultural Opportunity (Haywood Stewart, 2019). The MCO-PT demonstrated moderate ratings of concurrent validity with measures of multicultural competence, colorblind racial attitudes, and dehumanization (Haywood et al., Stewart). Additionally, higher ratings of multicultural orientation were significantly associated with greater multicultural competence (Haywood Stewart, 2019). Further, the subscales of cultural humility and opportunity were significantly negatively associated with colorblind racial attitudes across the entire sample (Haywood Stewart., 2019). Information on the inter-rater reliability of the Cultural Comfort domain of the MCO-PT for this study is included in the Results section.

Procedures

Participants were first asked several demographic questions regarding their age, gender identity, racial/ethnic identity, and sexual orientation. Next, participants were

directed to the Theravue website to complete a series of video vignettes. Participants were randomly assigned to two different video modules (each including three videos in a specific order). One module was the control group, and the other module was the gender microaggression group. All participants received the first two videos vignettes in the same order (Video 1 then Video 2) in their modules. All participants watched Video 1 and were not required to respond. The purpose of this video was to help set the clinical context for participants. Then, all participants watched Video 2. The purpose of this video was to also help set the clinical context for participants as well as allow them to practice using the Theravue system before recording their actual responses to the third video. Participants then watched the final video in the module, Video 3. Video 3 was either the control video vignette condition or the gender microaggression video vignette condition depending on the random assignment. After each participant watched the third video in their module, they were prompted to record themselves responding to the patient in the video via their personal webcam. Participants were given one opportunity to respond to the patient in Video 3 so that the study could capture trainees' initial, unrehearsed responses to a patient in this particular type of clinical scenario. Participants were then asked to complete the Session Evaluation Questionnaire (SEQ), the Counselor Self-Efficacy Reflection Items, the Helping Skills and Session Management subdomains of the Counselor Activity Self-Efficacy Scale (CASES), the Stigma Consciousness Questionnaire for Women (SCQ-W), and post-assessment demographic questions. Once data was cleaned and coder training was completed, coders evaluated all video responses and data analyses began, which examined the following hypotheses:

Hypothesis 1a: Participants who are assigned to the gender microaggression condition will demonstrate significantly lower counselor self-efficacy compared to participants in the control condition.

Hypothesis 1b: Participants who are assigned to the gender microaggression condition will rate their responses with lower evaluations of session impact (i.e., less depth and smoothness) compared to participants in the control condition.

Hypothesis 1c: Participants who are assigned to the gender microaggression condition will demonstrate significantly higher negative affective reactions than participants in the control condition.

Hypothesis 2a: The relationship between experiences of gender microaggression and counselor self-efficacy will be partially mediated by negative affective reactions, such that the mediation will yield increases in negative affective reactions and, as a result, decreases in counselor self-efficacy in women trainees.

Hypothesis 2b: The relationship between experiences of gender microaggression and lower session evaluation ratings will be partially mediated by negative affective reactions, such that the mediation will yield increases in negative affective reactions and, as a result, lower evaluations of session impact.

Hypothesis 3a: The association between stigma consciousness and counselor self-efficacy will differ based on the condition assignment, such that stigma consciousness will be more strongly associated with counselor self-efficacy for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 3b: The association between stigma consciousness and evaluations of session impact will differ based on the condition assignment, such that stigma consciousness will be more strongly associated with evaluations of session impact for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 4a: The association between trainees' cultural comfort and counselor self-efficacy will differ based on the condition assignment, such that trainees' cultural comfort will be more strongly associated with counselor self-efficacy for those in the gender microaggression condition compared to those in the control condition.

Hypothesis 4b: The association between trainees' cultural comfort and evaluations of session impact will differ based on the condition assignment, such that trainees' cultural comfort will be more strongly associated with evaluations of session impact for those in the gender microaggression condition compared to those in the control condition.

CHAPTER THREE: RESULTS

Interrater Reliability

Intraclass correlations (ICCs), a statistical method for assessing reliability of multiple coders (Hallgren, 2012), were calculated to estimate interrater reliability among coders using the MCO-PT. In general, ICCs range from 0 to 1.0 with higher scores reflecting greater accuracy of coding between coders. They are categorized by their level of significance with ICCs below .40 indicating poor interrater reliability, values between .40 and .59 indicating fair agreement, values between .60 and .74 indicating fair agreement, and .75 to 1.00 suggesting excellent agreement (Cichetti, 1994; Cicchetti & Sparrow, 1981). A two-way random effects model was used to calculate interrater ICCs. The two-way model was chosen because new coders were not assigned to each participant (e.g., coders stayed the same across their designated participants for all MCO ratings) and this approach considers any systematic deviations that may exist among each coder (Hallgren, 2012). Random effects were selected because coders were randomly selected with the intent of generalizing reliability results across all coding teams (Koo & Li, 2016). The consistency definition was chosen because it could account for any systematic errors while calculating consistency among coders (Koo & Li, 2016). Lastly, the average measures equation was used because participants were scored by multiple

coders and the average score for each MCO-Performance Task (PT) item among the coders was used (Hallgren, 2016).

ICCs were calculated for each item in the Cultural Comfort domain as well as each item in the other domains of the MCO-PT during preliminary coding to gauge initial interrater reliability; ICCs were also calculated roughly halfway through coding for all MCO-PT variables and after all participants were coded. This approach helped ensure high interrater reliability as coding progressed which also created the ability to use specific items singularly for any post-hoc analyses. Ratings for ICCs by cultural comfort item and the overall cultural comfort domain fell in the excellent range for both teams (see Table 2).

Table 2

Intraclass Correlations by Coding Team and Cultural Comfort Items

Teams	Cultural Comfort			
	Comfortable	Calm	Relaxed	Total Comfort
Team 1	.78	.82	.79	.92
Team 2	.91	.89	.88	.95

Preliminary Analyses

Descriptive statistics were run for predictor and outcome variables to identify any abnormalities, missing data, and outliers. No missing data or outliers were found. Regression assumptions, including normality, linearity, autocorrelation, and homoscedasticity, were tested using visual examination of histograms, P-P plots, plots of

residuals, Levene's test for equality of variance, and via bootstrapping. The means and standard deviations of key study variables across all participants appear in Table 3 and bivariate correlations among key study variables across all participants are presented in Table 4 and Table 5.

Table 3

Descriptive Statistics for Key Study Variables

	Range of Scores	*M*	*SD*
Counselor Self-Efficacy Beliefs			
CSE - Effect	1-5	3.50	0.80
CSE - Success	1-5	3.41	0.80
CSE - Affect	1-5	3.22	1.19
CASES	0-9	6.60	1.26
SEQ-			
Arous	1-7	3.87	0.91
Posit	1-7	4.03	0.81
Depth	1-7	4.39	0.82
Smooth	1-7	3.44	1.16
SCQ-W	1-7	5.33	0.74
MCO-CC	1-6	3.78	1.15

Note. CSE -Effect, -Success, -Affect = Counselor Self-Efficacy Self Reflection Items; CASES = Counselor Activity Self-Efficacy Scale (Total Score across Helping Skills and Session Management domains); SEQ = Session Evaluation Question (domain scales include Arousal, Positivity, Depth, and Smoothness); SCQ-W = Stigma Consciousness Questionnaire for Women, MCO-CC= Cultural Comfort domain of Multicultural Orientation – Performance Task.

Table 4

Bivariate Correlations Among Key Study Variables for Control Condition

	1	2	3	4	5	6	7	8	9	10
1. CSE -Effect	-									
2. CSE -Success	0.60**	-								
3. CSE -Affect	0.42*	0.39*	-							
4. CASES	0.51**	0.47*	0.30	-						
5. SEQ-Arous	-0.23	-0.26	-0.19*	0.11	-					
6. SEQ-Posit	0.54**	0.64**	0.48**	0.35*	-0.56**	-				
7. SEQ-Depth	0.04	0.47*	0.23	-0.15	-0.28	0.43*	-			
8. SEQ-Smooth	0.34	0.43*	0.35	0.18	-0.66**	0.78**	0.48*	-		
9. SCQ-W	-.12	-0.29	-0.21	-0.17	0.23	-0.38*	-0.18	-0.35	-	
10. MCO-CC	0.18	0.20	0.23	0.39*	-0.03	0.41**	0.05	0.37	-0.34	-

Note. CSE -Effect, -Success, -Affect = Counselor Self-Efficacy Self Reflection Items; CASES = Counselor Activity Self-Efficacy Scale (Total Score across Helping Skills and Session Management

domains); SEQ = Session Evaluation Question (domain scales include Arousal, Positivity, Depth, and Smoothness); SCQ-W = Stigma Consciousness Questionnaire for Women, MCO-CC= Cultural Comfort domain of Multicultural Orientation – Performance Task.

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

Table 5

Bivariate Correlations Among Key Study Variables for Gender Microaggression Condition

	1	2	3	4	5	6	7	8	9	10
1. CSE -Effect	-									
2. CSE -Success	0.72**	-								
3. CSE -Affect	-0.16	-0.14	-							
4. CASES	0.36	0.46**	-0.12	-						
5. SEQ-Arous	0.43	0.37	-0.13	0.41*	-					
6. SEQ-Posit	0.12	-.01	0.11	0.27	-0.17	-				
7. SEQ-Depth	0.22	0.21	-0.08	0.30	0.46*	0.26	-			
8. SEQ-Smooth	0.12	0.04	0.44*	-0.59	-0.40*	0.23	-0.37*	-		
9. SCQ-W	0.20	-0.05	0.10	-0.07	0.16	0.44*	0.05	0.19	-	
10. MCO-CC	0.27	0.50**	-0.08	0.39*	0.14	0.20	0.06	-0.17	-0.20	-

Note. CSE -Effect, -Success, -Affect = Counselor Self-Efficacy Self Reflection Items; CASES = Counselor Activity Self-Efficacy Scale (Total Score across Helping Skills and Session Management domains); SEQ = Session Evaluation Question (domain scales include Arousal, Positivity, Depth, and Smoothness); SCQ-W = Stigma Consciousness Questionnaire for Women, MCO-CC= Cultural Comfort domain of Multicultural Orientation – Performance Task.

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

Hypothesis 1a

It was predicted that participants assigned to the gender microaggression (GM) condition would demonstrate significantly lower counselor self-efficacy (CSE) beliefs compared to participants in the control condition. To test this hypothesis, independent samples *t* tests were conducted to compare CSE beliefs in the gender microaggression and control condition groups. The dependent variable, CSE beliefs, was measured four separate ways using the CASES total score in addition to three individual CSE self-reflection items that were developed to measure components of personal agency; therefore, the primary researcher conducted four independent-samples *t* tests to test Hypothesis 1a. Regarding CSE beliefs measured by the CASES total score, the results failed to reject the null hypothesis, suggesting that there was not a significant difference in the scores for the GM condition ($M = 6.64$, $SD = 1.45$) and control condition ($M = 6.55$, $SD = 1.04$); $t(56) = 0.28$, $p = 0.78$ (See Table 5). Similarly, results about CSE beliefs pertaining to effectiveness (CSE-Effect) and outcome expectations (CSE-Success) each ran separately also failed to reject the null hypothesis, which suggested that there

were no significant differences between the means of the two condition groups. Next, the final independent samples *t* test was run using the CSE self-reflection question pertaining to affective processing (CSE-Affect). Interestingly, there was a significant difference in the scores for the GM condition ($M = 2.60$, $SD = 1.04$) and control condition ($M = 3.89$, $SD = 0.96$), indicating participants in the GM condition demonstrated a significantly lower CSE belief, $t(56) = -4.93$, $p < .001$. In other words, those assigned to the GM condition believed their emotional reactions made it challenging to feel effective with patient more so than those assigned to the control condition.

Table 6

Differences Between Control Condition versus Gender Microaggression Condition

	Control		GM				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Counselor Self-Efficacy							
CSE -Effect	3.50	0.79	3.50	0.82	0.00	1.00	0.00
CSE -Success	3.46	0.74	3.37	0.85	-0.46	0.65	-0.12
CSE -Affect	3.89	0.96	2.60	1.04	-4.93	**<.001**	-1.29
CASES	6.55	1.04	6.64	1.45	0.28	0.78	0.07
SEQ-							
Arous	3.60	0.86	4.13	0.89	2.33	**0.02**	0.61
Posit	4.24	0.83	3.83	0.75	-1.98	0.053	-0.52
Depth	4.31	0.76	4.46	0.88	0.67	0.50	0.18
Smooth	3.90	1.04	3.00	1.11	-3.18	**<.01**	-0.84

Hypothesis 1b

It was predicted that participants who were assigned to the GM condition would rate their responses with lower evaluations of session impact (i.e., less depth and smoothness) compared to participants in the control condition. To test this hypothesis, the independent-samples *t* test was conducted to compare evaluations of session impact in the GM and control condition groups using SEQ Depth and SEQ Smoothness as the dependent variables. Regarding evaluations of session depth, the results failed to reject the null hypothesis, suggesting that there was no significant difference between the condition groups, $t(56) = 0.67$, $p = 0.50$. Conversely, the results pertaining to smoothness rejected the null hypothesis, indicating that those who were assigned to the GM condition (M =3.00, SD = 1.11) demonstrated significantly less smoothness in their evaluations of the behavioral health encounter than those in the control condition (M = 3.90, SD = 1.04), $t(56) = -3.18$, $p < .01$.

Hypothesis 1c

It was predicted that participants who were assigned to the GM condition would endorse significantly higher negative affective reactions than participants in the control condition. Like Hypothesis 1a and 1b, the independent-samples *t* test was conducted to compare affective reactions (i.e., post-session mood) in the two condition groups using SEQ Arousal and SEQ Positivity as the dependent variables. Regarding aroused mood, the results of the *t*-tests rejected the null hypothesis. This suggested those who were assigned to the GM condition (M = 4.13, SD = 0.89) demonstrated significantly higher aroused mood than those who were assigned to the control condition (M = 3.60, SD =

0.86), $t(56) = 2.33$, $p < .05$. Regarding positivity, results failed to reject the null hypothesis, albeit barely, suggesting that there was no significant difference between the GM condition ($M = 3.83$, $SD = 0.75$) and the control condition ($M = 4.24$, $SD = 0.83$), $t(56) = -1.98$, $p = .05$. Therefore, only aroused mood will be used in the following hypotheses as a measure of affective reactions.

Hypothesis 2a

It was expected that negative affective reactions would partially mediate the relationship between women trainees' experiences of gender microaggression and their counselor self-efficacy (CSE) causing a decrease in their CSE. To test this prediction, Hayes' PROCESS macro v4 was used to conduct a simple mediation (Model 4); results are reported in Table 6. In Step 1 of the mediation model, the results showed that there was a significant negative association between the gender microaggression (GM) condition and the CSE belief regarding affective processing when disregarding the mediator ($b = -1.29$ 95% CI [-1.81, -0.77], $t = -4.93$, $p < .001$). Step 2 showed that there was a positive significant association between the GM condition and arousal ($b = 0.54$, 95% CI [0.08, 1.00], $t = 2.33$, $p < .05$), indicating that participants assigned to the GM condition experienced an increase in arousal. Step 3 showed that there failed to be a significant association between arousal and the CSE belief when controlling for condition group, $\beta = -0.14$, 95% CI [-0.48, 0.12], $t = -1.19$, $p = 0.24$, suggesting there were no significant differences between arousal and the CSE belief. Step 4 indicated that there was a significant negative direct effect between GM condition and the CSE belief when controlling for arousal ($b = -1.20$, 95% CI [-1.75, -0.65], $t = -4.37$, $p < .001$), indicating

that participants in the GM group experienced a decrease in the CSE belief. However, the indirect effect of the GM condition on CSE via arousal was failed to be significant, (*IE* = -0.08, *SE* = 0.09, 95% CI [-0.29, 0.06]). Thus, the results failed to reject the null hypothesis, indicating that there was no significant difference in CSE among the two condition groups as a result of affective arousal.

Table 7

Model Coefficients for Mediation of Arousal between Condition Group and Counselor Self-Efficacy

		Consequent								
		M (Arous)				Y (CSE Affect)				
Antecedent		Coeff.	*SE*	*p*	95% CIs		Coeff.	*SE*	*p*	95% CIs
X (COND)	*a*	0.54	0.23	0.02	0.08, 1.00	*c'*	-1.20	0.27	<.001	-1.75, -0.65
M (Arous)		---	---	---	---	*b*	-0.18	0.15	0.24	-0.48, 0.12
Constant	i_M	3.60	0.17	<.001	3.26, 3.93	i_Y	4.54	0.58	<.001	3.39, 5.69
		$R^2 = 0.09$					$R^2 = 0.32$			
		$F(1,56) = 5.43$,					$F(2,55) = 12.93$,			
		$p = 0.02$					$p < .001$			

Although it was found in Hypothesis 1a that there were no differences in the means between condition groups and the other CSE variables, including CASES total, CSE–Effect, and CSE-Success, separate simple mediation models were run with each of the CSE variables as the dependent variable to examine whether indirect effects existed when arousal was the mediator (i.e., full mediation). The indirect effect of the GM condition on CASES total via arousal failed to be significant (*IE* = 0.17, *SE* = 0.12, 95% CI [-0.01, 0.45]. Similarly, the indirect effect of the GM condition on CSE-Effect via arousal (*IE* = 0.08, *SE* = 0.11, 95% CI [-0.12, 0.31] and the indirect effect of the GM condition on CSE-Success via arousal (*IE* = 0.05, *SE* = 0.10, 95% CI [-0.14, 0.27] failed to be significant.

Hypothesis 2b

It was expected that negative affective reactions would partially mediate the relationship between women trainees' experiences of gender microaggression and their evaluations of session impact. Similar to Hypothesis 2a, Hayes' PROCESS macro v4 was used to conduct a simple mediation; results are provided in Table 7. In Step 1 of the mediation model, the results showed that there was a significant negative association between the GM condition and session smoothness when disregarding the mediator (*b* = -0.90, 95% CI [-1.47, -0.33], *t* = -3.18, *p*<.01). Step 2 showed that there was a significant positive association between GM condition and arousal (*b* = 0.54, 95% CI [0.08, 1.00], *t* = 2.33, *p*<.05, and Step 3 demonstrated that there was a significant negative association between arousal and session smoothness (β = -0.50, 95% CI [-0.92, -0.36], *t* = -4.54, *p*<.001). Step 4 indicated that there was a significant negative direct effect between GM

condition and session smoothness when controlling for arousal (*b* = -0.56, 95% CI [-0.04, -0.48], *t* = -2.18, *p* <.05), indicating that participants evaluated their session as being less smooth after experiencing gender microaggressions. Additionally, the results also showed that the indirect effect of the GM condition on session smoothness via aroused mood was also negative and significant (*IE*= -0.30, *SE* = 0.14, 95% CI [-0.60, -0.05]); therefore, the results rejected the null hypothesis indicating that aroused mood partially mediated the relationship between GM condition and session smoothness.

Although it was found in Hypothesis 1b that there were no differences in the means between condition groups and session depth (SEQ-Depth), a simple mediation was run to examine whether indirect effects existed when arousal was the mediator (i.e., full mediation). Results indicated that the indirect effect of GM condition on session depth via arousal failed to be significant (*IE* = 0.09, *SE* = 0.12, 95% CI [-0.16, 0.34].

Hypothesis 3a and 3b

It was predicted that there would be a statistically significant interaction between GM condition and stigma consciousness such that stigma consciousness would be more strongly associated with counselor self-efficacy (CSE-Affect) for those in the GM condition compared to those in the control condition. To test this prediction, a simple moderation analysis (Model 1) using Hayes' PROCESS macroV4 with the predictors of condition group (Control versus GM), stigma consciousness (centered), and the Condition Group X Stigma Consciousness interaction term was conducted. The results failed to reject the null hypothesis, indicating that there were no significant differences in

the CSE belief pertaining to affective processing based on the interaction of the condition group and stigma consciousness (β = 0.39, 95% CI [-0.34, 1.13], t = 1.78, p = 0.29.

Table 8

Model Coefficients for Mediation of Arousal between Condition Group and Session Impact

		Consequent								
		M (Arous)					Y (Smoothness)			
Antecedent		Coeff.	*SE*	*p*	95% CIs		Coeff.	*SE*	*p*	95% CIs
X (COND)	*a*	0.54	0.23	.02	0.08, 1.00	*c'*	-0.56	0.26	0.03	-0.04, -0.48
M (Arous)		---	---	---	---	*b*	-0.50	0.14	<.001	-0.92, -0.36
Constant	i_M	3.60	0.17	<.001	3.26, 3.93	i_Y	6.20	0.54	<.001	5.13, 7.28
		R^2 = 0.09					R^2 = 0.38			
		F(1,56) = 5.43,					F(2,55) = 17.10,			
		p = 0.02					p <.001			

It was also predicted that there would be a statistically significant interaction between GM condition and stigma consciousness such that stigma consciousness would be more strongly associated with evaluations of session impact (i.e., smoothness) for those in the GM condition compared to those in the control condition. Like Hypothesis 3a, a simple moderation analysis using PROCESS with the predictors of condition group (Control versus GM), stigma consciousness (centered), and the Condition Group X Stigma Consciousness interaction term was conducted. The results suggested that the interaction between GM condition and stigma consciousness was approaching statistical significance; however, ultimately, the results failed to reject the null hypothesis indicating that there were no significant differences in evaluations of session smoothness based on the interaction of the condition group and stigma consciousness (β = 0.76, 95% CI [-0.02, 1.53], t = 1.97, p = 0.054).

Hypothesis 4a and 4b

It was predicted that there would be a statistically significant interaction between GM condition and cultural comfort such that cultural comfort would be more strongly associated with counselor self-efficacy (CSE-Affect) for those in the GM condition compared to those in the control condition. To test this prediction, a simple moderation analysis (Model 1) using Hayes' PROCESS macroV4 with the predictors of condition group (Control versus GM), cultural comfort (centered), and the Condition Group X Cultural Comfort interaction term was conducted. The results failed to reject the null hypothesis, indicating that there were no significant differences in the CSE belief related to affective processing based on the interaction of the condition group and cultural

comfort (β = -0.30, 95% CI [-0.81, 0.22], t = -1.16, p = 0.25). It was also predicted that there would be a statistically significant interaction between GM condition and cultural comfort such that cultural comfort would be more strongly associated with evaluations of session impact (i.e., smoothness) for those in the GM condition compared to those in the control condition. Like Hypothesis 4a, a simple moderation analysis using PROCESS with the predictors of condition group (Control versus GM), cultural comfort (centered), and the Condition Group X Stigma Consciousness interaction term was conducted. The overall moderation was significant, indicating that the association between cultural comfort and smoothness was stronger for the control group (β = -0.59, 95% CI [-1.10, -0.02], t = -2.07, p <.05). Probing of the moderation revealed that the association of cultural comfort and smoothness failed to be significant for the GM condition, β = 0.40, 95% CI [-0.03, 0.83], t = 1.88, p = 0.07, indicating there was no significant relationship between cultural comfort and smoothness for participants in the GM condition (see Figure 1).

Secondary Analyses

Several secondary analyses were conducted to explore additional questions sparked by results of the initial findings. To further explore factors that influenced trainees' counselor self-efficacy, a simple linear regression analysis was run to examine the relationship between cultural comfort and counselor self-efficacy (CSE) using the CASES measure. Cultural comfort was found to be a significant positive predictor for counselor self-efficacy in both the GM condition (β = 0.47, t = 2.20, p <.05) and the control condition (β = 0.42, t = 2.12, p <.05). This finding suggests that the degree of

cultural comfort a trainee had when experiencing gender microaggression predicted how they viewed their ability to counsel the offensive patient.

Additionally, a secondary analysis was run to determine how women trainees evaluate their sessions when they demonstrate cultural humility with a patient who aggresses them. For the GM condition, a regression analysis was conducted with session smoothness as the outcome variable and the Other-Oriented item of the MCO-PT as the predictor. Other-oriented, which draws on the MCO construct of cultural humility, refers to the trainee being attuned to the patient's experience and/or the patient's needs in treatment (see Appendix F for information on the ICCs of this observer-rated item). Other-oriented was a significant negative predictor of session smoothness (β = -0.50, t = -3.04, p <.01) and accounted for 25% of the variance in session smoothness scores. This finding suggests that when a woman trainee who experiences gender microaggression is more other-oriented (and therefore demonstrating cultural humility) the less smooth (e.g., more difficult, uncomfortable, rough) they evaluate the session to be.

A final secondary analysis was run to examine how the behavioral health encounter was impacted by trainees who choose to explicitly or implicitly address the gender microaggressions and/or the gender dynamics with their patient. If a participant directly addressed the gender microaggressions (e.g., specifically naming the patient's offensive actions) and/or the gender dynamics then their response was coded as "Explicitly Addressed;" if a participant indirectly addressed the gender microaggressions and/or the gender dynamics (e.g., using the patient's own words to create an opportunity for discussion) then their response was coded as "Implicitly Addressed." The observer-

rated Overall Effectiveness item of the MCO-PT was used to capture the effectiveness of trainees' responses to the video vignettes (see Appendix F for information on the ICCs of this observer-rated item). Fascinatingly, for the GM condition, participants who explicitly addressed the gender microaggressions (M = 3.54, SD = 0.96) during the behavioral health encounter had significantly higher overall effectiveness scores compared to those who did not explicitly address the gender microaggressions (M = 2.33, SD = 1.20), $t(30) = 2.92$, $p < .01$. There was no significant difference in overall effectiveness scores between participants who implicitly addressed the gender microaggressions (M = 3.10, SD = 1.39) and those who did not (M = 2.73, SD = 1.22), $t(30) = 0.67$, $p = 0.25$.

CHAPTER FOUR: DISCUSSION

The purpose of this study was to understand how women trainees may be affected by gender microaggression in the context of their clinical work in integrated primary care (IPC) settings. Specifically, the study examined the influence of affective reactions to patient-delivered gender microaggressions on women trainees' perceptions of their counselor self-efficacy and their evaluations of their behavioral health encounters. A unique aspect of this study was the creation of video vignettes to simulate the experience of a warm handoff scenario (i.e., a behavioral health patient encounter in IPC) in which women trainees were asked to provide behavioral health services to a patient who identified as a man who microaggressed against the provider. The experimental video condition, which involved a sexist patient encounter, was tactfully created to encompass elements of different gender microaggressions to reflect the way that gender microaggression manifests in everyday interactions (Sue, 2010; Capodilupo et al., 2010) and perhaps in patient-provider exchanges.

The hypotheses in this study aimed to understand how patient-provider interactions wherein gender microaggression occurs influence trainees' perceptions of their clinical skills and their evaluations of session impact. Additionally, the study intended to identify possible protective factors that may serve as buffers against the effects of these sexist experiences. In summary, counselor self-efficacy (CSE) beliefs and

evaluations of session impact (i.e., depth and smoothness) were hypothesized to be lower for participants in the gender microaggression (GM) condition while negative affective reactions were hypothesized to be higher for those in the GM condition. Furthermore, negative affective reactions were hypothesized to explain decreases in counselor self-efficacy and their evaluations of session impact. For participants assigned to the GM condition, a positive association was expected between stigma consciousness and CSE beliefs and between stigma consciousness and evaluations of session impact. Lastly, for participants assigned to the GM condition, a positive association was expected between cultural comfort and CSE beliefs and between cultural comfort and evaluations of session impact.

Emotional Reactions and Perceptions of Effectiveness

The analyses of these hypotheses yielded interesting results. To start, there was a statistically significant relationship between participants assigned to the GM condition and the CSE belief pertaining to affective processing. Therefore, participants in the GM condition believed that their emotional reactions made it challenging to feel effective with the sexist patient more so than those assigned to the control condition. This finding bridges previous literature on counselor trainees' self-efficacy with women's experiences of sexist discrimination. For example, Goreczny and colleagues (2015) found correlational relationships between increases in anxiety and decreases in trainees' self-efficacy beliefs. Additionally, it is well known that women who experience sexist discrimination report affective reactions such as anger, fear, and anxiety in addition to lower self-esteem (Capodilupo et al., 2010; Fischer & Holz, 2007; Owen et al., 2010;

Swim et al., 2001). The results provide preliminary evidence that suggests women trainees who have emotional reactions to gender microaggressions delivered by their patients report feeling less effective with those patients. Yet, there was no statistically significant relationship between participants assigned to the GM condition and counselor self-efficacy measured by the CASES. These findings suggest that the experience of gender microaggressions may influence women trainees' perceptions of effectiveness but may have a more complicated and less direct association with their overall counseling self-efficacy.

Another noteworthy finding was that there may be other emotional processes besides the more common negative affective reactions (e.g., anger, fear) that may be associated with trainees' perceptions of their clinical skills and the how they evaluate their interactions with offensive patients. For instance, there was no statistically significant difference between condition groups for positive mood. The null results were unexpected given the previous literature regarding women's negative emotional reactions when sexist discrimination occurs. Moreover, the Positivity index provided the opportunity for participants to endorse negative mood states following the experience of gender microaggression, such as feeling more sad, afraid, angry, unfriendly, confused, or uncertain. Therefore, it was expected that participants in the GM condition would demonstrate significantly lower positive mood following a sexist patient encounter. However, of note, the results of this analysis were approaching clinical significance (p = 0.053), and it may be that a larger sample size could have demonstrated a significant effect. Regardless, because of the null results, it is postulated that there could be other

affective states, such as anxiousness or excitement, that arise during these clinical situations.

A thought-provoking finding was that aroused mood was found to be significantly higher for the trainees who experienced gender microaggression than those in the control group. The Arousal index involved items that captured how activated and energized the trainee felt following the patient-provider interaction (e.g., moving, fast, excited). This finding suggests that when trainees experience an offensive patient, they feel more moved and energized. Some researchers found that therapists feeling vitalized after a session may be beneficial to treatment processes. For example, Kivlighan and colleagues (2014) found a positive relationship between the therapeutic alliance and therapists' arousal when clients made change in treatment. In this regard, aroused mood implies a more positive connotation when characterizing trainees' affective reactions compared to mood states such as anger and fear. However, it is theorized that perhaps the Arousal index may have captured internal affective processes similar to anxious arousal. Recall that for the aims of the study, the at ease-anxious item was added to the Arousal index as neither the Arousal index nor the Positivity index included an item explicitly specific to anxiety. Moreover, anxiousness can be state-like in that it can be a transitory emotional state that can fluctuate in its intensity (Gros et al., 2007). This is very similar to how Stiles and colleagues (1994) described arousal via the Arousal index due to its high proportion of variance during the validation study of the Session Evaluation Questionnaire. In conclusion, the finding that aroused mood was higher among women

trainees who experienced gender microaggression yields the question, “How does feeling aroused after being aggressed by a patient influence treatment processes?”

An important finding in this study that may help answer this question is related to women trainees’ evaluations of session impact. Participants in the GM condition endorsed significantly less smoothness regarding their evaluations of session impact than participants in the control condition. This suggests that the women trainees who experienced gender microaggression judged their clinical exchange with a sexist patient to be more uncomfortable, tense, and difficult than the women trainees who did not have a sexist patient encounter. Put simply, women trainees in the GM condition perceived the behavioral health encounter went worse than those in the control condition. Further, this study found that when participants became more aroused after experiencing gender microaggression, they evaluated their session as having less smoothness. These findings provide support for the notion that the experiences of patient-delivered gender microaggressions not only cause a rise in women trainees’ arousal but that their aroused mood is somewhat responsible for them perceiving their patient-provider interactions as having less impact. This is an important consideration for psychotherapy and integrated primary care (IPC) training. For instance, it is well-known through past research that smoothness of a session is related to psychotherapy effectiveness (Mallinckrodt, 1993; Stiles et al., 1988, 1990). Therefore, in a time-limited clinical setting such as IPC where effectiveness is highly valued, knowing how situations, like sexist patient experiences, may interrupt the smoothness, and potentially the effectiveness, of the behavioral health encounter is an important clinical and training consideration. For example, in some

clinical instances, behavioral health providers in IPC provide one-time, brief interventions (e.g., warm handoffs) when a biopsychosocial concern is identified (Reiter et al., 2018). In this regard, providers and trainees alike, must demonstrate effectiveness in their ability to perform a functional assessment, deliver an intervention, and/or discuss various treatment options with a patient (Reiter et al., 2018). If a derogatory patient encounter influences how difficult or uncomfortable a trainee perceives the encounter to be, then this may potentially disrupt the fluidity and effectiveness of the one-time patient interaction.

Conceptualization of Null Moderation Results

This study also sought to understand potential protective factors that may assist trainees with the effects of offensive patient interactions. It was predicted that stigma consciousness would be more strongly associated with evaluations of session smoothness for those in the GM condition. While the moderation yielded null results for this hypothesis, the interaction between GM condition and stigma consciousness was approaching clinical significance ($p = 0.054$). While it is difficult to say with certainty, a larger sample size may have produced statistically significant results. If this were the case, the results would align with previous research related to women with high stigma consciousness and their experiences of subtle discrimination. Wang and colleagues (2012) found that women high in stigma consciousness were able to recognize ambiguous gender discrimination and responded adaptively as a result of their heightened vigilance to the discriminatory experiences. Therefore, despite the null results in this study, stigma

consciousness may serve as a protective mechanism for women trainees who experience covert forms of discrimination, though more research is needed to explore this theory.

It was also predicted that women trainees' cultural comfort would be more strongly associated with evaluations of session smoothness. Though the results from the moderation analysis were null, the findings were incredibly interesting. The association between cultural comfort and session smoothness was stronger for the control group. This is noteworthy given that the control group *did not experience* gender microaggression in this study. The interaction between GM condition and cultural comfort failed to be significant; even more interesting is that there was no significant relationship between cultural comfort and session smoothness for participants in the GM condition. This suggests that women trainees report difficulties with the smoothness of their patient interactions when they experience patient-delivered gender microaggressions, and the degree of cultural comfort the trainee possesses in these situations is unrelated to their evaluations of session smoothness. While being a multiculturally oriented clinician is undoubtedly important, this finding may imply that there are more nuances involved in practicing from an MCO framework when the trainee holds one or more marginalized identities.

This concept aligns with a recent critique of the multicultural orientation constructs (cultural humility, cultural opportunity, cultural comfort) that discusses the complexities involved with the MCO framework for trainees of color (Moon & Sandage, 2019). Moon and Sandage (2019) assert that the MCO framework should not increase pressure for trainees of color to adjust to unjust dynamics. Further, they emphasize that

cultural discomfort should not be incorrectly combined with the affective reactions that trainees of color feel as a result of their experiences of racism (Moon & Sandage, 2019). In the current study, 29.3% of the participants identified with a race/ethnicity other than White, and 28.6% of participants identified with a sexual orientation other than heterosexual. It may be likely that the affective processes of participants that influenced their perceptions of session impact were unrelated to their cultural comfort/discomfort and perhaps related to their experiences of discrimination and owning multiple marginalized identities. However, in accordance with Moon and Sandage (2019), this postulation is not to suggest that trainees who hold multiple marginalized identities cannot manage strong affective reactions to prejudice; rather it suggests that practicing from an MCO stance and leaning into conversations that are offensive to the trainee can be challenging, and perhaps harmful.

This idea is further fueled by the secondary analysis that found being other-oriented was a significant negative predictor of session smoothness for participants in the GM condition. In other words, when a woman trainee who experienced gender microaggression was more other-oriented (and therefore demonstrating cultural humility), the less smooth (e.g., more difficult, uncomfortable, rough) they evaluated the session to be. This result makes sense in that it further supports Moon and Sandage's (2019) idea that being an other-oriented clinician when the clinician is the "other" is much more nuanced and requires there to be more support for the marginalized trainee who is providing clinical services from an MCO framework. Additionally, training

programs and institutions should further consider associations between MCO constructs and counselor training for individuals who experience offensive patient encounters.

For example, cultural comfort was a significant positive predictor for counselor self-efficacy in the GM condition and the control condition. The degree of cultural comfort a trainee had when experiencing gender microaggression predicted how they viewed their ability to counsel the offensive patient. From the Social Cognitive Model of Counselor Training (SCMCT) perspective, this finding makes sense; internal affective processes are thought to contribute to trainees' CSE beliefs (Larson, 1998). Years ago, Larson (1998) suggested that even trainees with sufficient multicultural coursework may experience heightened arousal when they work with individuals from different ethnic groups than their own and that trainees' knowledge of cultural processes may not be the same as their affective comfort with different ethnic groups. Therefore, this finding aligns with the SCMCT in that the degree of cultural comfort (i.e., the level of ease) a trainee has with a patient influences trainees' CSE beliefs. At the same time, this finding provides preliminary support that cultural comfort does matter in the context of counselor trainees' self-efficacy in clinical situations where gender microaggression occurs. From a developmental standpoint, it is important that training programs further explore ways to support trainees who are wanting to do right by their patients by practicing from an MCO stance, but who also may need additional support in their training, such as in supervision, and at the institutional level.

Addressing Gender Microaggressions with The Aggressor

In a secondary analysis, it was found that trainees who chose to *explicitly* address the patient after experiencing gender microaggressions were rated by external coders as having higher overall effectiveness in their behavioral health encounters compared to those who did not explicitly address the gender microaggressions. Conversely, there was no significant difference in overall effectiveness scores between participants who *implicitly* addressed the gender microaggressions and those who did not. Therefore, the findings suggest that when a trainee directly addressed the patient's offensive actions they were viewed as having more overall effectiveness in the behavioral health encounter. One possibility for this finding may be that women trainees who chose to explicitly address the gender microaggressions may have felt less aroused which could have assisted them in their direct attempts to address the offensive patient. Although, more research focused on how trainees approach or acknowledge offensive patient remarks and how that may be related to their overall effectiveness during brief behavioral health encounters would be a useful area to further explore. Nonetheless, these findings provide helpful information in the context of integrated primary care where there is a great amount of emphasis on the treatment outcomes and effectiveness of each patient encounter in the time-limited clinical environment (Reiter et al., 2018). However, there are important training implications to consider involving the nuances of women trainees leaning into explicit cultural discussions with sexist patients and how historical and current events, like the oppression of women's rights, and sexualized trauma may affect women trainees (Moon and Sandage, 2019).

Clinical Implications for Training, Practice, and Supervision

There are several implications that can be drawn from the results of this study. In regards to practicing from a multicultural oriented stance, supervisors and training programs must keep in mind the complexities involved with providing cultural opportunities for discussion of gender microaggression and/or gender dynamics with sexist patients. For example, women trainees who are other-oriented with a sexist patient may find themselves in a conversation that could be affectively activating for the trainee and potentially harmful to their well-being. It is important that training programs and supervisors understand why women trainees may choose or not choose to lean into the discomfort of understanding patients' sexist views and belief systems (Moon & Sandage, 2019). Therefore, programs and supervisors should provide support and empowerment for women trainees who navigate unjust dynamics between themselves and their patients regardless of how they choose to respond to sexist interactions.

Women trainees who experience gender microaggression should be afforded the time and space to process their internal reactions to sexist patients. As Kivlighan and colleagues (2014) pointed out, aroused mood following a session may lead to beneficial treatment outcomes. If women trainees are afforded the space to identify and process their experiences with sexist patients in settings, such as in group, individual, or peer supervision and/or practicum classes, then perhaps this may help them work through their affective arousal and ways to navigate future behavioral health encounters with those patients who have aggressed them. In turn, this supportive experience may assist women trainees with using their affective experiences in ways that help inform their clinical

approach with sexist patients, which may ultimately benefit the trainees and perhaps the patients regarding treatment outcomes. However, this may require modifications to supervision at training and institutional levels, specifically in integrated primary care, where supervision may be "on the fly," fast-paced, and/or solution-focused (Bailey, 2015). Creating intentional supervisory experiences that balance the dynamics of the IPC environment with the arousal states of trainees following these patient encounters should be considered.

Moreover, trainees within IPC settings are expected to quickly establish rapport and execute goal-oriented tasks within a brief timeframe (Horevitz & Manoleas, 2013; Reiter et al., 2018; Vogel et al., 2012). Based on the findings of this study that suggest affective reactions influence session impact and trainees' views of their effectiveness with sexist patients, it is worthwhile for supervisors and IPC training environments to consider how complex, dynamic IPC settings may impact trainees' clinical skills and development, especially when offensive patient interactions occur, and what supports are needed to assist trainees in navigating these brief exchanges. One suggestion that may help support trainees' adjustment to the demands of the IPC environment while tending to their own reactions to patients is the use of an elective interdisciplinary mentorship program that includes various healthcare professionals in addition to behavioral health providers. Given the common occurrence of patient-delivered harassment in medical settings (Fnais et al., 2014), other healthcare professionals may have also encountered these discriminatory experiences throughout their training and careers. It would be worthwhile to explore how adopting an elective mentorship program within the IPC

training environment could provide trainees additional supports to discuss their experiences with difficult patient encounters with other professionals who may have had similar experiences.

Additionally, it may be beneficial for supervisors and training programs to consider the possible benefits of using modalities like modeling with their trainees as a means of supporting their clinical development during challenging patient encounters. Bandura (1977) and Larson (1998) assert that modeling is the second strongest influence in increasing self-efficacy (mastery being the strongest influence). Further, Barnes (2004) indicated that intentional and clear modeling behaviors by supervisors may help increase trainees' counselor self-efficacy. In this regard, supervisors and clinical instructors may consider modeling ways that they may respond to a sexist patient (e.g., setting boundaries), seek help from a supervisor, or how they may approach regulating their discomfort in-the-moment with the patient and/or following the patient encounter. In doing so, the supervisor may be able to help the trainee navigate and identify the trainee's personal reactions and help the trainee develop ways to address those reactions during and following sexist patient encounters. It is important to keep in mind that modeling does not imply role playing with the trainee; therefore, supervisors and instructors who demonstrate how they may approach and process a sexist patient encounter and help women trainees explore and identify their own processes and approaches to these situations may help empower the trainee without potentially invalidating their experiences or re-aggressing them. This may require the supervisor to take a non-dominant, collaborative stance with the trainee so the trainee can self-identify ways they

would feel most comfort navigating clinical exchanges with a sexist patient. It should also be noted that this likely requires the establishment of a safe supervisory relationship, and the identities of the supervisor should be considered to ensure that the supervisor recognizes issues of power and privilege within the supervisory relationship. In this regard, supervision that incorporates a feminist framework may be useful for attending to contextual factors, empowering the trainee, modeling a non-expert stance, and focusing on the trainees' strengths (Degges-White et al., 2012).

Degges-White and colleages (2012) define feminist supervision as "the application of feminist theory and values to the supervisory process, content, and relationship. It places a central emphasis on the use of a sociological lens to explain how different experiences of self and relationships are formed" (p. 92). From this lens, feminist supervision recognizes variables such as gender, diversity, oppression, and power differentials and incorporates collaboration, empowerment, and strengths-based approaches to support the trainee during their clinical development (Degges-White et al., 2012). Further, feminist supervisors use modeling to reflect a professional relationship that involves trust, respect, self-disclosure, and shared decision making. Therefore, supervision shifts from being prescriptive and deficit-based to collaborative and strengths-based (Lyness & Helmeke, 2008; Edwards & Chen, 1999). This type of supervisory approach may be useful for women trainees who experience gender microaggression as it may help draw upon the internal resources and strengths of the trainee who is navigating these experiences and may facilitate an environment where

women trainees can discuss factors that impact their clinical development, like sex-role stereotypes and socialization (Degges-White, 2012).

Limitations

There are several limitations in the present study. The sample size is considered to be small. While 58 participants completed the study, 96 potential participants initially expressed interest during recruitment. It may be that candidates chose to decline study participation or complete the study in its entirety after they learned they would need to record themselves responding to clinical video vignettes. Additionally, it may be that those who felt willing to record themselves responding to the clinical video vignettes were those who felt confident in their counseling abilities (i.e., higher CSE beliefs). Second, the generalizability of the findings is limited due to participant demographics such as ethnicity/race and sexual orientation. Based on prior literature, there is a significant relationship between women who hold multiple marginalized identities and psychological distress. In this study, 70.7% of participants identified as White or European American and 72.4% of participants identified as heterosexual. It would have been beneficial to have a more representative sample of women participants who hold more than one marginalized identity as this would have allowed the dissemination of more inclusive research.

Another limitation was the use of one self-reflection item to capture participants' counselor self-efficacy beliefs regarding affective processing. While significant results were produced using the single CSE item, the validity of those results may have been stronger, and therefore more generalizable, if a full measure was used to capture CSE

beliefs related to affective processes. However, to the study's defense, there are no known measures that capture this construct specifically. Additionally, the CASES measure was developed to assess counseling self-efficacy beliefs of *counselor* trainees and the measure was validated using students in counseling-related programs (Lent et al., 2003). Therefore, the terminology and constructs used within the Helping Skills and Session Management domains of the CASES may have been unfamiliar to approximately 15% of the participants who were not enrolled in a counseling-specific graduate degree program (i.e., participants who were enrolled in neuropsychology, clinical psychology, or school psychology programs). Finally, the video vignettes used to simulate a behavioral health encounter was a unique addition to the study, though it posed a set of limitations. Participants were only given one opportunity to record themselves on a webcam to capture trainees' initial, unrehearsed responses to a patient in this type of clinical scenario. Because trainees knew this expectation before watching the video vignette, this may have produced performance-based anxiety. In turn, this may have impacted trainees video responses in general and could have influenced their state of arousal, which was one of the main study variables. Additionally, participants were given a set of background videos to watch to help set the context of the integrated primary care (IPC) environment. Trainees who have never trained or worked in IPC settings may have had a more difficult time understanding the warm hand-off scenario. For instance, 5.2% of participants reported having training experiences in IPC. As a result, the series of video vignettes that explained the clinical environment, the patient's presenting concern with their primary care provider, and the warm hand-off scenario wherein the participants

were required to respond to the patient may have not provided enough context for some participants. Additionally, this unfamiliarity with the IPC environment may have also influenced trainees' responses to the post-measures, such as their affective arousal and their evaluations of session impact, following the video vignettes. Further, the series of video vignettes are not able to realistically capture all the environmental, training, and patient dynamics involved in this type of clinical environment. Therefore, there are some limitations in the ecological validity of using video vignette responses over real clinical exchanges.

Future Directions

The outcomes of this study provide initial evidence to suggest that the experiences of gender microaggression affect women trainees' evaluations of their session impact, specifically regarding their affective reactions on session smoothness. This finding adds to psychotherapy research involving the occurrence of microaggressions in therapy. However, unlike the majority of research that has focused on patients' experiences of microaggressions, the results in this study examined how women trainees respond to gender microaggressions from their patient and how those reactions influenced treatment. Future studies may benefit from further examination of the experiences of trainees who hold one or more marginalized identities, and the impact that subtle and overt discrimination has on their clinical development as well as their well-being. This is an important consideration for future research given that prior research established that people who hold multiple marginalized identities may experience greater psychological distress after experiencing discrimination (Piggot, 2004; Syzmanski & Kashubeck-West,

2008; Szymanski & Henrichs-Beck, 2013). Additionally, the experience of discrimination towards individuals with intersecting minoritized identities is linked to lower well-being and negative mental and physical health outcomes (Lewis et al., 2017; Branco et al., 2019). The findings from this study support the notion that women trainees report uncomfortable, rough patient encounters and greater aroused mood following the experience of gender microaggression. Therefore, understanding the deleterious effects that these offensive patient interactions have on trainees who hold marginalized identities is essential to their development beyond the clinical realm; this understanding could pose important implications for their overall well-being during training. Further, future studies that use an intersectional framework to examine which trainee variables (e.g., salient identities, level of training) coupled with other contextual factors (e.g., the clinical training setting, patient variables, supervision experiences) are most important to the trainee during their clinical development may help supervisors and training programs better understand the intricacies involved in trainees' awareness of and responses to microaggressions. In doing so, training programs may be able to offer more inclusive guidance and supervision to help support trainees who live through discriminatory experiences inside and outside of the clinical training environment.

Moreover, future research focused on understanding the experiences of women trainees and how to best support them in their clinical development when issues like patient-delivered gender microaggression occurs is necessary given the common occurrence of microaggressions in everyday life (Dovido et al., 2019; Sue, 2010; Sue et al., 2007). More research is needed on how accessible internal resources and strengths of

the trainee such as adaptive cognitive and affective processes may be able to help trainees in the moment and following sessions wherein offensive patient interactions occur. In a similar vein, it would be worthwhile to further consider the complexities that exist for trainees with marginalized identities who practice from a multicultural orientation stance (Moon & Sandage, 2019). Studies can further explore the intersection of MCO virtues and trainee identities and develop ways to support culturally responsive trainees on individual and institutional levels.

Additionally, the clinical context of this study was tailored to focus on training experiences in integrated primary care settings. The findings of this study highlight how patient-delivered, gender-based discriminatory experiences interact with women psychology trainees' clinical development in the setting of brief patient encounters within a medical setting. However, future research should further examine trainees' experiences providing services to patients in the integrated primary care setting to better understand more of the nuances involved in this training environment. It may also be beneficial to examine patients' perceptions of session effectiveness during these behavioral health encounters in IPC to better understand how their perceptions may or may not align with trainees' views of their clinical effectiveness after a difficult patient encounter, and how this may be related to treatment outcomes and the IPC training environment. Moreover, only a small percentage of participants in this study had training specific to the integrated primary care environment (5.2%); therefore, future studies that can incorporate how this time-limited, dynamic environment may contribute to patient-provider dynamics, like their views of session effectiveness, would be worthwhile. Nonetheless, knowing that

patient-delivered discriminatory experiences account for over a third of the sources of harassment and discrimination experienced by medical trainees (Fnais et al., 2014), this research offers training programs and healthcare agencies insight into the ways in which women pursuing a career or working in health-related disciplines are impacted by these experiences.

Based on the results that gender microaggressions influence trainees' internal and clinical processes, it may be beneficial for future studies to explore frameworks to help support trainees in dynamic clinical environments such as integrated primary care where they must transition quickly from one patient need to another. For example, on the individual level, it may be worthwhile to consider how supportive supervision that holistically focuses on the intersection of trainees' identities, their cognitive and affective reactions to offensive patients, and their clinical experiences and development may serve as a protective factor against the impacts of gender microaggression. The supervisory experience that encompasses these important elements would be interesting to explore in the context of the integrated primary care environment where supervision is often fast-paced, targeted, and solution-focused (Bailey, 2015). Although clinical supervision in IPC may be packed with treatment planning, case conceptualizations, and care coordination (Bailey, 2015), this may be an area worth further examining to see how trainees with marginalized identities respond when they experience a supervision space that respects and validates their experiences and reflects institutional support for their personal and clinical development. Additionally, further examination of how to utilize the brief supervisory encounters in IPC in addition to incorporating supervisors own

personal experiences of difficult patient encounters could help strengthen the training experience while providing the support and validation needed to navigate these difficult clinical experiences. By expanding research on supervisory experiences in IPC, especially in the context of offensive patient encounters, we may be able to understand how to use the supervisory experience and relationship as a means of trainee advocacy to create a buffer against the negative effects of patient-delivered discriminatory experiences.

Because this study's findings incorporate personal reactions of trainees likely rooted in their lived experiences with sexism, future research should examine individual trainee factors, like their personal agency, in the context of discriminatory experiences. This may help both training programs and trainees understand more about external factors (e.g., trainee behaviors), internal factors (e.g., cognitive, affective, and biological processes), and environmental influences that affect trainees' views of themselves as clinicians, their skillset, and patient interactions. By understanding more about these processes, training programs may be able to help trainees holistically explore and integrate the multiple dimensions of themselves into their training, self-reflection, and clinical work (Mutchler & Anderson, 2010). For example, Mutchler and Anderson (2010) tested a model of Therapist Personal Agency during marriage and family therapy training with 236 counseling graduate students. They found that using an integrated approach to trainee development (i.e., model of Therapist Personal Agency) allowed training programs and supervisors to attend to the whole person of the trainee, including trainees' family of origin and the combined effects of internal factors and external-environmental

factors, to help support trainees' clinical and personal development. Taken altogether, there may be training models and supervisory frameworks that could provide trainees with the space to holistically explore and process the multifaceted aspects of themselves during their development, which may ultimately serve as protective factors against negative patient experiences.

Conclusion

In summary, a main finding of this study is that there is evidence to suggest that women trainees who experience patient-delivered gender microaggressions may also experience affective processes that, in turn, influence how they evaluate the impact of their behavioral health encounters. Additionally, the findings indicate that there is there may be an affective component influencing women trainees' counselor self-efficacy in the context of experiencing gender microaggression. This provides the opportunity for future studies to explore how trainees are affected by patient-delivered offenses during clinical experiences. As mentioned, the integrated primary care setting poses its own set of complexities; as such, further exploration of women trainees' experiences with offensive patients in the context of brief patient encounters and a dynamic training environment may extend support to trainees pursuing a career in the healthcare setting. Finally, no evidence was found to support adaptive cognitive processes and affective reactions as protective factors against the effects of patient-delivered gender microaggression. Future studies may consider alternative methods and/or frameworks that will help women trainees navigate the complexities of patient-provider dynamics in order to best support women during their clinical development.

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APPENDIX A: SESSION EVALUATION QUESTIONNAIRE – FORM 5

DIRECTIONS: Please circle the appropriate number to show how you feel about this behavioral health encounter.

Right now I feel:

at ease	1	2	3	4	5	6	7	anxious
happy	1	2	3	4	5	6	7	sad
angry	1	2	3	4	5	6	7	pleased
moving	1	2	3	4	5	6	7	still
uncertain	1	2	3	4	5	6	7	definite
calm	1	2	3	4	5	6	7	excited
confident	1	2	3	4	5	6	7	afraid
friendly	1	2	3	4	5	6	7	unfriendly
slow	1	2	3	4	5	6	7	fast
energetic	1	2	3	4	5	6	7	peaceful
quiet	1	2	3	4	5	6	7	aroused
certain	1	2	3	4	5	6	7	confused

This session was:

bad	1	2	3	4	5	6	7	good
difficult	1	2	3	4	5	6	7	easy
valuable	1	2	3	4	5	6	7	worthless
shallow	1	2	3	4	5	6	7	deep
relaxed	1	2	3	4	5	6	7	tense
unpleasant	1	2	3	4	5	6	7	pleasant
full	1	2	3	4	5	6	7	empty
weak	1	2	3	4	5	6	7	powerful
special	1	2	3	4	5	6	7	ordinary
rough	1	2	3	4	5	6	7	smooth

comfortable	1	2	3	4	5	6	7	uncomfortable

APPENDIX B: COUNSELOR SELF-EFFICACY SELF-RELFECTION ITEMS

DIRECTIONS: Please mark each statement according to how much you agree or disagree with it. Please do not leave any blank. Use the numbers on the following scale to indicate your response.

1	2	3	4	5
Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**

1. I believe that I would be effective when working with this patient.

2. I believe that my work with this patient would be successful in achieving the patient's treatment goals.

3. My emotional reactions to the patient make it challenging to feel effective with the patient.

APPENDIX C: COUNSELOR ACTIVITY SELF-EFFICACY SCALE

DIRECTIONS**:** The following questionnaire consists of two parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling with the patient you interacted with in the video. We are looking for your honest, candid response that reflects your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions. Select the number that best reflects your response to each question.

Part I. Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling **the patient in the video vignette**.

How confident are you that you could use these general skills effectively with the patient in the video over the next week?	**No confidence At all**				**Some Confidence**				**Complete Confidence**	
1. **Attending** (orient yourself physically toward the client)	0	1	2	3	4	5	6	7	8	9
2. **Listening** (capture and understand the messages that clients communicate)	0	1	2	3	4	5	6	7	8	9
3. **Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear)	0	1	2	3	4	5	6	7	8	9
4. **Open questions** (ask about questions that help clients to clarify or explore their thoughts or feelings)	0	1	2	3	4	5	6	7	8	9
5. **Reflection of feelings** (repeat or rephrase the client's statements with an emphasis on his or her feelings)	0	1	2	3	4	5	6	7	8	9

6.	**Self-disclosure for exploration** (reveal personal information about your history, credentials, or feelings).	0	1	2	3	4	5	6	7	8	9
7.	**Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings).	0	1	2	3	4	5	6	7	8	9
8.	**Challenges** (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).	0	1	2	3	4	5	6	7	8	9
9.	**Interpretations** (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).	0	1	2	3	4	5	6	7	8	9
10.	**Self-disclosures for insight** (disclose *past* experience in which you gained some personal insight)	0	1	2	3	4	5	6	7	8	9
11.	**Immediacy** (disclose *immediate* feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).	0	1	2	3	4	5	6	7	8	9
12.	**Information giving** (teach or provide the client with data, opinions, facts, resources, or answers to questions)	0	1	2	3	4	5	6	7	8	9
13.	**Direct guidance** (give the client suggestions, directives, or advice that imply actions for the client to take)	0	1	2	3	4	5	6	7	8	9

14. **Role-play and behavior rehearsal** (assist the client to role-play or rehearse behaviors in session)	0	1	2	3	4	5	6	7	8	9
15. **Homework** (develop and prescribe therapeutic assignments for clients to try out between sessions)	0	1	2	3	4	5	6	7	8	9

Part II. Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling **the patient in the video vignette**.

How confident are you that you could use these specific tasks effectively with the patient in the video over the next week?	**No confidence At all**				**Some Confidence**				**Complete Confidence**	
1. Keep sessions "on track" and focused.	0	1	2	3	4	5	6	7	8	9
2. Respond with the best helping skill, depending on what your client needs at a given moment.	0	1	2	3	4	5	6	7	8	9
3. Help your client to explore his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
4. Help your client to talk about his or her concerns at a "deep" level.	0	1	2	3	4	5	6	7	8	9
5. Know what to do or say next after your client talks.	0	1	2	3	4	5	6	7	8	9
6. Help your client to set realistic counseling goals.	0	1	2	3	4	5	6	7	8	9
7. Help your client to understand his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
8. Build a clear conceptualization of your client and his or her counseling issues.	0	1	2	3	4	5	6	7	8	9

9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.	0	1	2	3	4	5	6	7	8	9
10. Help your client to decide what actions to take regarding his or her problems.	0	1	2	3	4	5	6	7	8	9

APPENDIX D: STIGMA CONSCIOUSNESS QUESTIONNAIRE FOR WOMEN

DIRECTIONS: Please indicate the extent to which you agreed with each of the following statements.

0	1	2	3	4	5	6
Strongly Disagree	**Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**

1. Stereotypes about women have not affected me personally.
2. I never worry that my behaviors will be viewed as stereotypically female.
3. When interacting with men, I feel like they interpret all my behaviors in terms of the fact that I am a woman.
4. Most men do not judge women on the basis of their gender.
5. My being female does not influence how men act with me.
6. I almost never think about the fact that I am female when I interact with men.
7. My being female does not influence how people act with me.
8. Most men have a lot more sexist thoughts than they actually express.
9. I often think that men are unfairly accused of being sexist.
10. Most men have a problem viewing women as equals.

APPENDIX E: MULTICULTURAL ORIENTATION PERFORMANCE TASK CODING

DIRECTIONS: Please circle the appropriate number to show how you perceive this response.

Comfort

This response was:

Uncomfortable	1	2	3	4	5	6	Comfortable
Nervous	1	2	3	4	5	6	Calm
Tense	1	2	3	4	5	6	Relaxed

Humility

This response was:

Disrespectful	1	2	3	4	5	6	Respectful
Close-minded	1	2	3	4	5	6	Open-minded
Superior	1	2	3	4	5	6	Non-superior

Opportunity

There was:

No cultural discussion	1	2	3	4	5	6	Definitive cultural discussion

Overall

This response was:

Bad	1	2	3	4	5	6	Good

APPENDIX F: INTRACLASS CORRELATION COEFFICIENTS FOR OTHER MCO-PT ITEMS

Intraclass Correlations by Coding Team and MCO-PT Items

Teams	Multicultural Orientation – Performance Task Items	
	Other-Oriented	Overall Effectiveness
Team 1	.81	.87
Team 2	.82	.89