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Envisioning human service organizations free of microaggressions

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ABSTRACT

Microaggressions refer to verbal or non-verbal communications that invalidate those with non-dominant group identities across all dimensions of human diversity. Within human service organizations (HSOs), microaggressions may lower therapeutic alliance, reduce retention, and result in negative outcomes. While understanding the type, frequency, and damaging impact of microaggressions are useful and well established in research, less is known about the organizational policies, practices, behaviors, and values needed to reduce or eradicate microaggressions within human service contexts. Utilizing three focus groups and four individual interviews with adults who received services from HSOs, this qualitative study explored: What would HSOs need to learn, practice, and believe in order to be free of microaggressions? Sixteen participants reported on the provider's knowledge and behaviors, organizational environment, and institutional characteristics needed to create an organization free of microaggressions. Limitations of existing approaches and implications to develop more equitable practices within HSOs are discussed.

1. Introduction

In recent years, there has been a heightened consciousness in the United States about social injustice that manifests at the interpersonal and systemic levels. Historical and present-day studies of discrimination have demonstrated both unambiguous forms, macroaggressions, and ubiquitous forms, known as microaggressions (Pierce, 1974). Given its explicit nature, macroaggressions are widely referenced and largely uncontested by the general population. Microaggressions, however, are the opposite. These harmful verbal or nonverbal communications are difficult to identify which also makes them difficult to address. Although "micro" in name, microaggressions do not refer to the magnitude of discrimination but rather the frequency and normalcy of these experiences in daily life. Microaggressions are comprised of distinct subtypes (i.e., microinsults, microassaults, microinvalidations) in which each have deleterious physical and psychological health impacts on targets (Sue, 2010).

The type, prevalence, and impact of microaggressions are often explored within university or therapeutic settings (Chin & Kameoka, 2019; Owen, Tao, & Rodolfa, 2010). However, fewer studies focus on how to interrupt, reduce, or eradicate microaggressions within human service organizations (HSOs). Given the well-documented racial and ethnic disparities within HSOs, context-specific strategies to reduce discrimination is critical (e.g., Alcendor, 2020). As such, this study seeks to identify the multi-level strategies that HSO clients believe will reduce microaggressions and mitigate the harm caused by inequitable institutional practices and discriminatory behaviors.

1.1. *Microaggression theory*

Microaggression theory was initially conceptualized by psychiatrist, Dr. Chester Pierce. He recognized that ambiguous, everyday interracial interactions, "characterized by white put-downs, done in an automatic, preconscious, or unconscious fashion" were prevalent among racial minorities (Pierce, 1974, p. 515) and conceptualized these interactions as microaggressions. Fundamental to this conceptualization was how power was organized within the United States. How a person was situated within the societal hierarchy as a member of a dominant (those with social power) or non-dominant (those without social power) group informed one's ability to identify a microaggression and interpret its meaning. Specifically, those who perpetrate microaggressions remain largely unaware of their transgressions and experience little emotional response; while those who are targets of microaggression can identify the microaggression (even if only slightly) and report resulting negative psychological and physical health outcomes.

Sue (2010) expanded microaggression theory and developed an

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explanatory framework to explicate the types (i.e., microassaults, microinsults, microinvalidations, environmental) and expected impact on people of color. In the past decade, multiple studies have adopted this framework and made more visible the daily experiences of discrimination among non-dominant communities with histories of marginalization. Researchers have found that Black Americans, Indigenous people of the Americas, Asian and Indigenous Canadian, Asian Americans, and Hispanic Americans all experience microaggressions with both similar and disparate qualities based on their unique social group positionalities (Canel-Çınarbaş & Yohani, 2019; Desai & Abeita, 2017; Johnston-Goodstar & VeLure Roholt, 2017; Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013). Extending beyond racial group categories, people who are poor or working class, LGB people, and transgender people also report experiencing microaggressions (Gray, Johnson, Kish-Gephart, & Tilton, 2018; Swann, Minshew, Newcomb, & Mustanski, 2016; Ylioja, Cochran, Woodford, & Renn, 2018).

Microaggressions may explain the relationship between oppression and compromised individual health in the absence of overt discrimination. People across numerous marginalized social identities report that microaggressions occur frequently within their everyday lives. Microaggressions, in turn, become daily stressors which routinely compromises physical and emotional health (Hernández & Villodas, 2020; Majeno, Urizar, Halim, Nguyen-Rodriguez, & Gonzalez, 2020). Specifically, experiencing microaggressions can increase physical pain, fatigue, and depression (Choi, Lewis, Harwood, Mendenhall, & Huntt, 2017; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014).

1.2. *Microaggressions within human service organizations*

Microaggressions are often demonstrative of larger power issues within a given context, which can lead to cultural ruptures that can be difficult to repair. *Where* someone experiences discrimination is equally as important as *what* type of discrimination they report and *who* perpetrates it. HSOs are comprised of institutions for children, elderly, disadvantaged populations, physical and mental health facilities, and government-supported organizations. They offer access to vital resources that are both preventative and remedial. HSOs typically utilize various interdisciplinary approaches to enhance a person's quality of life by collaborating with community agencies, organizers, social service systems, community leaders, evaluators, and subject matter experts. HSOs are also responsive to cyclical cultural, economic, social, and political changes within the community (Hasenfeld, 2010).

If organizations intentionally designed to support communities and attend to unmet needs often caused by unequal distribution of social power engage in discriminatory practices, these organizations undermine their mission and limit their utility to the communities they serve. For example, microaggressions within therapeutic contexts were associated with a reduced trust in mental health counselors and lowered likelihood to adhere to therapeutic treatment (Gonzales, Davidoff, Nadal, & Yanos, 2015). Microaggressions can be a source of negative rapport between practitioners and clients (Owen et al., 2010), and can also lead to people not wanting to reach out to HSOs when they need support (Nnawulezi, Godsay, & Bryant, 2020). Therefore, research that seeks to understand how microaggressions manifest within human service organizations (HSOs) and how to attend to them becomes an opportunity to support community well-being more broadly.

1.3. *Multi-level strategies for addressing microaggressions*

For HSOs to efficiently meet the evolving needs of community members, they must adopt new approaches, and acknowledge and amend past transgressions. One way to mitigate the negative impact of microaggressions is the use of diversity training. While studies have identified proximal benefits of cultural intervention that uses intergroup engagement (Wilksin-Yel et al., 2020), these benefits are often not universal. For example, Williams, Kanter, Peña, Ching, and Oshin (2020) investigated an educational and experiential intervention to address racism and microaggression through interracial exchanges. While White participants showed improvement on several domains including reduction in microaggressive thoughts and behaviors, as well as symbolic racism; Black participants only experienced an increase in ethnic identity. These disparate training outcomes demonstrate that while interpersonal training may support some people under certain circumstances, there is a need for institutional interventions that raise the collective consciousness of all organizational members.

Most interventions are constructed at the individual level, seeking to change a single person's behaviors, or the interpersonal level, seeking to change the interactions between two or more people. Individual and interpersonal interventions are important yet limited in their ability to respond to the cultural and operational complexity of HSOs. Nnawulezi et al. (2020) propose that for HSOs to develop interventions that can account for the adaptability of microaggressions and the multi-faceted nature of HSOs, they must get "In View" within their communities. "In View" suggests that HSO must consistently work at self-correcting and disrupting institutional power structures that fosters microaggressions.

The process of getting "In View" aligns with Black feminist, population education, and critical theories that center freedom from oppressive conditions as the primary focus for individual, institutions, communities, and societies (Freire, 2000; Kaba, 2021; Prilleltensky, 2008). Freedom, then, is conceptualized for this study as the ability to move, dream, build, and sustain without threat of violence, humiliation, marginalization, exploitation, coercion, or any dehumanizing practices. The value of freedom within human service organizations means that all people, regardless of their lived experiences, can have access to the necessary resources and be able to receive those resources in a way that supports their full humanity.

1.4. *Current study*

HSO staff are often driven by the desire to reduce microaggressions, deliver high quality services, as well as mitigate harm. However, there is little guidance about the interpersonal and institutional strategies that would specifically work to eradicate microaggressions (see Sue, 2019 for exception). This study seeks to explore the context-specific microaggressions clients experience within the HSOs, and how they envisioned organizations needing to shift to design equitable organizations that perpetuate less harm and promote freedom.

2. Methods

2.1. *Participants*

A total of sixteen participants participated in the study, ranging in age from 24 to 48 years old ($M = 32.13$, $SD = 7.95$). In terms of gender, eight participants (50%) identified as women, seven (43.8%) as men and one person (6.3%) did not disclose their gender. Ten participants (62.5%) identified as Black, while four (25%) identified as White, 1 (6.3%) as Latinx, and one (6.3%) as Asian. Participants varied in their educational attainment including an associate degree or partially completed a 4-year college degree (18.8%), a 4-year college degree (37.5%), and completed graduate degree (43.8%).

3. Materials

3.1. *Interview guide*

Prior to data collection, an interview guide was developed. Two people who fit the eligibility criteria participated in a cognitive interview to assess the guide's questions quality (Alaimo, Olson, & Frongillo, 1999). Their feedback was incorporated into interview and focus group protocols.

The interview guide provided a microaggression definition (Sue, 2010), and two brief examples of microaggressions, such as complimenting someone when they speak "good English". Next, participants were guided to share their personal experience of microaggressions. The interview guide included three sections: 1) envisioning characteristics of a microaggression-free HSO; 2) identifying behaviors, values and knowledge that promotes these characteristics; 3) identifying behaviors, values and knowledge that fosters microaggression at HSO. Interviewers invited participants to envision a HSO free of microaggressions and describe their overall emotions ("What would it feel like to you?) and feelings from interacting with HSO's providers and personnel ("How would you interact with your provider" and "How would that interaction make you feel?"). Next, interviewers asked participants to envision an organization free from microaggressions and describe the knowledge, behaviors, and values needed for the organization to actualize this vision ("What do you see? What signs, pictures or magazines might you see in the waiting room?").

3.2. *Procedure*

In order to understand how people perceived a microaggression-free organization, we recruited people who: 1) received services from an HSO within the past two years and 2) were over the age of 18. We defined human service organizations, as any privately-owned or government-sponsored organization that supports individuals or communities, including but not limited to, community centers, public schools, social security offices, health clinics or mental health services, hospitals, courts, or housing services. To explore the research questions, we utilized a combination of purposive and snowball sampling. Participants were recruited via flyers and direct outreach to human service organizations in the Baltimore City area. Interested people were directed to call, text, or e-mail a study investigator. Participants were initially screened to determine whether they met the study criteria, and eligible participants were provided with a location and date for the focus groups. Among the 13 interested people, 12 were eligible to participate in the study.

We initially chose to conduct focus groups in explore the shared experiences of microaggression among clients who received services from HSOs. Focus groups are facilitated group interviews that provide an opportunity for interactive discussion and explore whether there was convergence or divergence in emerging ideas and themes around a phenomenon of interest (Stewart & Sandashami, 2015). We conducted a series of three focus groups, with a total of twelve participants. The focus groups lasted 60–90 min, were facilitated by the lead author and trained notetaker.

During data collection, the research team engaged in an iterative reflexive and analytic process to determine whether the current data collection strategy adequately addressed the questions of interest. We reached saturation after the focus groups, because upon reflection and discussion among both authors after each group, when we had both rich (intricate, detailed) and thick (several personal experiences) that shared the same characteristics and nuances. However, we sought detailed and nuanced data about simulation experiences. Consequently, the team recruited and conducted in-depth interviews with four additional participants who fit the eligibility criteria. Interviews were between 60 and 90 min and were conducted by the lead author. We utilized the same process, iterative reflection and discussion, to assess whether we had reached saturation. After the fourth and final interview, we reached saturation because we were not hearing new themes or ideas.

Focus groups and interviews were audio-recoded between December 2018 and February 2019 in private space at a local community center. Prior to the start of the focus groups and interviews, the facilitator explained informed consent procedures and obtained verbal consent. Participants were then given a short demographic survey before the start of the group. All participants were compensated $20 for their participation and provided a $5 travel stipend. Focus groups and interviews were transcribed verbatim by the first and second author and checked for accuracy. Identifying information was removed during transcription. This study was approved by the university institutional review board.

3.3. *Analysis*

Prior to analysis, transcripts were imported into a qualitative data analysis software package Dedoose, for coding. An inductive thematic analysis was conducted due to the exploratory nature of the study, which allowed us to capture themes that were shared and unique across groups and interviews (Braun & Clarke, 2012). Thematic analysis involved six steps: 1) reviewing the data and documenting initial thoughts; 2) generating initial codes through extensive review and discussion; 3) applying the coding framework to all focus group and interview transcripts; 4) sorting and mapping all coded data excerpts into themes; and 5) refining themes by reviewing the coded data excerpts for each theme to determine whether they form a coherent narrative; and 6) naming and describing the theme. In step three, both authors coded the same interview and focus group, and reviewed alignment and discrepancies to find consensus in coding. In steps four through six, the first two authors met on a regular basis to discuss and understand how codes were distinct or similar. Finally, we examined co-occurrences in our coding and reviewed our memos to develop themes, before they were named.

3.4. *Trustworthiness*

Multiple strategies were employed to enhance the trustworthiness of the study data and findings: a) participant responses between focus group and interviews were cross-checked and multiple investigators were involved during data collection and analysis (triangulation); b) the third author reviewed the data and interpretations (peer review); c) the investigators actively searched for information that did not fit emerging patterns and themes (negative case analysis). Further, the research team met regularly and maintained a reflexive journal to reflect on our positionality in the research (reflexivity).

4. Results

4.1. *Accessing HSOs: identity-based microaggressions that compromised services*

Participants first discussed the types of microaggressions that comprised their experiences at HSOs. They cited racial microaggressions as the most common type of microaggression experienced when they entered HSOs, followed by microaggressions based on sexuality, social class, gender, body type and weight.

4.1.1. *Racial microaggressions*

Racial microaggressions are experiences of subtle discrimination that are based on racial identity. The perpetrators of these microaggressions held provider, manager, and director roles. Microaggressions often occurred when people were receiving services from a community-based organization, social services or visiting medical providers. Participants referred to microaggressions that were based on racist stereotypes which assumed the target's cultural, intellectual, and moral inferiority. Several participants indicated that perpetrators expressed surprise – often delivered in the form of a praise or compliment – that people of color were educated or well-spoken. Imani[1] shared her experiences of racial microaggressions including: "Oh, you speak so well" or "Oh, you went there?" after sharing she attended a prestigious university.

4.1.2. *Sexuality-based microaggressions*

Sexuality-based microaggressions are brief and everyday negative

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[1] Pseudonyms were used to protect the identity of study participants.

affronts that target a person's sexual identity and sexual practices. Participants described experiencing these types of microaggressions when visiting a medical provider. This was especially true when discussing sexual history, practices, and preventative testing. Sarah, a focus group participant who was in an open relationship, shared:

When I asked to get screened for sexual transmitted infection and HIV … [the provider] said well "You're married. Why do you need this?" [The provider] didn't even go into sexual behaviors and pushing me to not get these tests that I really wanted. I have not seen a regular primary care provider since. But it also helped me navigate what I should and shouldn't tell providers, which is probably not good.

Non-verbal cues from providers such as visual discomfort communicated a microaggression. This was highlighted when Malik's stated: "Once I told my doctor I'm a homosexual, like her face just froze. She was just so shocked about it and I left it a little disturbed. I never went back again and that slightly traumatized me." Dre discussed a related experience after he visited a care provider for an STI screening, Dre was informed by the health department that he has been exposed to an STI. He quickly returned to the same provider who, upon seeing him in the examination room, stated, "Oh, it's you again." This microaggression discouraged Dre from seeking future care and treatment from the HSO. After experiencing a sexuality-based microaggression at HSO, participants felt they had to make decisions whether to conceal their queerness or educate providers. Sarah explained:

I hide health history, or just be very much upfront and explain [that] there are different way fluids are entering in-and-out of my body, and this is why I need "this" [test]. So it is either I overshare, or I don't share at all; depending on what I need, just to get what I need.

4.1.3. *Social class microaggressions*

Social class microaggressions, experiences of class discrimination based on perceptions of indicators such as clothing, education and wealth, were commonly described by participants when they utilized social services at HSOs. Perpetrators communicated suspicions of participants abusing social services. Imani shared that she needed food assistance and said: "It's like, going and asking for help and somebody making you feel weird for it. Someone [is] making you feel uncomfortable for receiving your service that you should be receiving." Targets of class microaggressions at HSOs noted that perpetrators often required more proof that the target needed access to social services. Dre shared:

The process seems so crazy. It feels like you would do not this to any other population. It was just the way she was looking at my clothes, and looking at me, and the questions she was asking me. It felt like, because I don't look poor or my clothes aren't raggedy, or whatever the case may be, that I shouldn't be getting food stamps?

Like other microaggressions, social class microaggressions communicated to participants that they are less than and less deserving of resources because of their socioeconomic status.

4.1.4. *Gender microaggressions*

Gender microaggressions, based on how external people perceived the gender of the targets, often encouraged and reinforced traditional binary gender expectations. Specifically, women participants indicated being questioned about physical ability. Olivia stated that she was often encouraged to carry out secretarial tasks by her employer at a HSO, despite being hired to also perform physical labor. She stated: "If you give me a task and I felt like I was unable to do it, I would just say it. You [don't] have the autonomy to say, 'I can' or 'I can't' based on [the] perception of gender."

Morgan, who identified as transgender, shared how perpetrators at a HSO emphasized "passing" was a gender microaggression that upheld gender conformity. Morgan shared how their physician approvingly stated: "'You look really masculine, like your body, your shoulders are broad, and your voice sounds really deep.' I just thought it was weird because I didn't necessarily want to be told that's what I should look like."

Microaggressions also attacked a target's intersecting identities. Prasoona, who works for an HSO, shared her experience of microaggressions that were both racialized and gendered while conducting a training at an HSO with her White colleague for an audience of mostly Black men. She described:

There will be older men who are saying, "Well, I don't know, darling" or, "Okay, what do you know about that?" Then also, like, "Well, hold on, young miss. Hold on, young miss." There's like that stuff and interrupting me. Then, I think there is some horizontal hostility. Something happening when it's older Black men and me as like a young Brown woman. [The] ways that they're interacting with me in a way they're not interacting with my White woman co-facilitator who is the Executive Director. She and I do this together and she's not being interrupted in the same way that I'm being interrupted or talked down to. We're both talked down to as young women, but it's different.

4.1.5. *Body type and weight microaggressions*

A few participants described experiencing microaggressions that targeted body type and weight that were deviant from societal body ideals. Adagio recalled an experience with her health provider when she requested to have her blood pressure checked:

The nurse got a cuff and the cuff was too small for my bicep, I have a beefy bicep, and so, she then said, "Oh well, let me go get the elephant cuff." I will never forget it. Of course, I didn't think I heard her right. And she did. It was, you know, just the biggest cuff. It probably was like a thigh cuff.

4.2. *Envisioning freedom: identifying organizational characteristics*

Participants found it difficult to imagine an organization free of microaggressions and believed that it was an unachievable goal. Olivia explained: "My existence is under so many intersectionalities, that it's hard for me to fathom that. If I'm not being ostracized by gender, it's about race, and then if in your own race it's more layers. So, it's really hard to describe how that would feel." Moreover, Brianna added that there may be unrealistic expectations:

My first thought is that a [microaggression-free organization] sounds like so peaceful and lovely. Then I think about an environment absent of microaggressions means that I will never commit a microaggression and I think that's unlikely. I feel really like, back on eggshells, like nervous about how I'm going to [mess] it up.

Allen stated that since microaggressions were fundamentally about power, it would be difficult to imagine any organization without power dynamics: "If there was an organization or a place where microaggressions didn't exist, it would mean that power couldn't be a currency. [Group affirms] Which is almost impossible to imagine [Group affirms]." While many participants shared the belief that a microaggression-free organization was not realistic, they still described the pathways that organizations could take to become more equitable in their organizational and interpersonal practices.

4.3. *Understanding freedom: the development of critical awareness*

Several participants described that, overall, providers at an HSO free of microaggressions would not have predetermined expectations or make judgements about clients based on their lived experiences. Participants believed that providers and those in leadership positions required a heightened level of critical consciousness, which included an awareness of their personal assumptions. Imani shared:

I think one of the biggest things is the judgment. I think if you have an organization that was truly free of judgment, I think [there] would be a lot less microaggressions. Even when you don't say it, it's your body language, how you approach someone, because you've made a judgment already.

Participants also shared that providers would take a personal interest to "unpack" and re-evaluate their assumptions and biases to understand its source. In addition to being aware of personal biases, participants believed that HSO providers would need to be actively aware about the multitude of ways systemic oppression manifests within society. This included: knowledge about diverse social identities, historical systemic oppressions, and an awareness of how social power is wielded to maintain the status quo. Prasoona described that an HSO free of microaggressions would work to understand that vulnerable populations were targeted by policies like the "War on Drugs" and often they simultaneously were targets of institutions that often penalized more than served communities. She commented:

As part of that work and as an organizer, it is imperative that we are working with people who are actively targeted by the war on drugs [policies] and anti-sex work policies. So, those are people who have, more often than not, criminal histories, who might be using substances right now as we speak that are illegal or whatever. I think about the folks I work with who are used to the institution being designed against them or being targeted by it. Then I say something like, "Hey, we're gonna have a coalition meeting that's gonna be at the state health department building. You need to have a valid ID." People are like, "I don't have a valid [ID]. Why are we having it at the state health department?' 'Cause they're our funders, so they want us to have it—they want us to come to them.' I think about all of those logistical rules that we—or not even rules—just these logistical issues that come up, it defeats the goal.

HSO providers would also gain a historical perspective of systemic oppression. Olivia described the importance of "mending the generations of mistrust between community and services." While cultural competency training was suggested as a tool for building awareness, Maria cautioned that this learning could occur at the expense of individuals who are marginalized. She went on to say that "learning must not be at the expense of other oppressed groups. Learning is not achieved by a game or theater." Dre echoed this sentiment in saying: "I don't want any diversity training; I want folks to work on anti-oppression. If we're not having a more specific conversation after that session about power, white supremacy, and capitalism, then it's surface." Overall, participants expressed that an awareness of oppression is an important component of building a microaggression-free organization because it helps HSOs and their providers identify what aspects of their consciousness enables microaggressions.

4.4. *Practicing freedom: encourage behaviors that emphasize kindness, respect, and wholeness*

Participants believed that providers would demonstrate a sense of positive receptiveness in organizations that were free of microaggressions. Providers who center the client's needs by being good listeners, kind, transparent about their actions, and open to collaboration would exhibit a positive receptiveness. Charlene stated: "It's more of a back and forth so it's more of a conversation rather than just 'here are some resources.'" Together, these provider qualities indicated a level of respect for clients, a trust that the clients know themselves best, and try to equalize the power dynamics that exist in a provider and client relationships. For example, Tyler explained that providers should treat clients like "they're humans before they are a patient" and Latoya also said: "Respect is a big factor. Respect, just treating people like a human." Several other participants stated that a HSO free of microaggression would make them feel "validated," "acknowledged" and where their "authentic self can be on a whole range of places and expressions every day, not conditional." Tonya further explained:

You can be your 100% self and not navigating through a space in a certain way or having to check yourself in any type of manner based on who you just are. Sometimes it's not even like who you are, it is how people perceive you based on being a woman, being a Black woman. If [microaggressions] were minimal, my true personality and character could be exposed much sooner.

4.5. *Structuring freedom: create equitable and collaborative policies and procedures*

4.5.1. *HSOs would reflect diverse community*

In addition to provider behavior, participants identified that it was important for a HSO to ensure that they were reflective of the communities they served. Participants agreed that aspects within the HSO environment including staff demographic composition as well as tangible items such as artwork, magazines, pamphlets and posters represent the local community. Charlie noted: "I wanna see different people as soon as I walk in. I would like it if there's someone who looks like me in the space." Imani emphasized that she looked for diversity across the organizational hierarchy. She said: "Who are the managers? How monolithic is the management? How White is the management?" She also cautioned: "We don't want them [individual staff reflective of the local community] to be tokens." Overall, the ability for an HSO to reflect diversity in the environment and employees, served as cues of an inclusive space. As Adagio commented, "If [there is no representation], then I'm just assuming this place is not for me."

4.5.2. *HSOs would attend to diverse needs*

According to participants, a HSO free of microaggressions would be attentive to the individuals' diverse needs within the physical environment. Specifically, organizations that were clean, provided refreshments, accessible for differently abled persons, and provided comfortable seating conducive to different body types were cited as ways HSOs could communicate their respect for diverse people. Sarah stated: "[I don't want] those medal folding chairs or the other chairs. They are really small, and they have the wooden arms [and] not all body types can fit [them]." Some participants added that ill-kept HSOs serving predominately marginalized people inadvertently communicated that underserved communities were not deserving of a quality environment.

4.5.3. *HSOs would understand how hierarchy influences well-being*

Participants shared that HSOs free of microaggression would be supportive of their staff, especially those were lower in the organizational hierarchy. Organizations who could provide a decreased case load, preemptively engaged in tactics to avoid worker's burnout, and develop accountability systems that ensured equal treatment of workers would be ideal. Brianna mentioned that stricter supervision over minority employees was a form of microaggressions. She stated:

I can't help but notice that I'm also a little bit younger, I'm White, and I have a master's degree and those things are the reasons that I don't have to be scrutinized even though she [Brianna's Black colleague] works a lot harder and more diligently than I do.

Brianna also suggested that a HSO free of microaggression would provide universal healthcare and different needs-based methods for handling employee mental health accommodations. She said:

We have a really hard time in work allowing for people to have a body and have a mind that are troubled. The message to me [from management] is that my body and my mind are weaknesses, and in fact, will cause a threat to my livelihood.

4.5.4. *HSOs would use mandated training for accountability and repair*

Participants stated that organizational awareness, specifically how microaggressions manifested, was critical to responding to it. HSOs would be open to community feedback and engage in "reflection, rather than defense." Reflection on and responsiveness to the concerns and experiences of clients would contribute to a culture that did not gas light, was not defensive, would seriously consider feedback. By extension, HSO providers would engage in regular trainings and develop accountability mechanisms to respond to microaggressions. Mandatory trainings were repeated by participants as an accountability mechanism to address complex issues like white supremacy and oppression. Imani expressed that trainings are often optional, infrequent, and reactive instead of proactive. In her vision of an HSO free of microaggression, she desired ongoing supports: "This is not one training every 10 years. This is something consistent, every few months we're going to do a workshop or something to just revisit it."

Brianna reflected on the need for accountability measures as a path forward towards structured reconciliation. She believed that reconciliation included perpetrators redressing their microaggressions: "[Use] a learning buddy, or a supervisor, or some way that [the perpetrator could] work out what might have happened [and] how I might address the person to find out if something's up or make atonement." Brianna also shared that healing for the target is critical:

How do I, as someone who is on the receiving end of a microaggression, tell [someone] that [this is] what happened to me. I really avoid this word in the world because it's so charged, but how do I articulate what has occurred? How do I find words to describe the experience, that feels kind of murky, was real? And my harm is real. And I need some kind of healing around this.

4.5.5. *HSO's would reevaluate mission and develop collective values*

Participants believed that all members should understand organization's values and principles. Olivia reflected on the importance of a HSO understanding the origins of its mission:

I feel like sometimes the very foundation and the ground, the roots, of the organization is based off of bias. Our morality and our moral compass are based on biases. [HSO] just being able to analyze where [their] values and missions are coming from before we can even talk about implementing training or holding our staff to a certain standard.

Prasoona described being frustrated with policies especially within organizational hierarchies that do not have accountability practices. "When those rules and policies suddenly change to protect [those in power]— [it is] at the expense of the folks who are marginalized." Denouncing policies and guidelines, Prasoona instead emphasized the importance of collective values:

I mean, definitely having shared collectively developed values and principles. I actually really feel more like values or principles are better [than policies] because in itself, that's like, I'm gonna respect you as an adult, or as my colleague, or someone who I've chosen to work with or be with, to also value these statements, [and] these concepts are a way that I do.

4.5.6. *HSO's would share power with the community*

Organizations that were free of microaggressions would use a client-centered approach to service provision which means valuing clients' input and autonomy. Participants expressed seeking services that centered the person needs by first acknowledging challenges clients face. For example, participants described that organizations that were free from microaggressions could adopt agreements on hate crime or speech to protect vulnerable minority groups such as LGBTQ, people of color, and immigrants.

Power sharing with clients was also identified as an important factor in a HSO free of microaggressions. HSOs committed to creating environments without microaggressions would also share power with the community by being transparent about, and possibly co-develop, organizational policies and procedures with community members.

Other participants described an inherit power dynamic between providers and clients and HSO providers should make efforts to develop a reciprocal relationship with clients. Imani discussed how HSOs physical structures created interpersonal barriers between the provider and the client. She shared:

I think one of the things for me is being buzzed in. It bothers me, like you're just locking the organization away from the community. Like, you have to gain access [to services]. And if [the HSO provider] is looking at a camera, and [they are] not liking what [they] see, [the HSO] can deny you access. It's the gatekeeper!.. If this is supposed to be a social service organization anyone can come into for aid, why do I have to be buzzed in?.. I feel like, 'is this jail?' It's a huge judgment of the type of people that frequent this organization; you're not good enough for human contact.

Caroline explained that equitable client-provider relationship helps the provider better understand clients' needs:

If you really sit there and ask them 'What do you really need?' Tell them what can be provided, and they tell you what they need; it's more of a back and forth. It's more of a conversation rather than just 'here are some resources. Tell us what you need, and we'll get back to you', stuff like that …they won't tell you those things right then and there. But you'll get to know them, and then you'll know what they need throughout the conversation.

5. Discussion

The current exploratory qualitative study examined what participants envisioned providers and organizations would need to know, practice, and believe to develop an organization that would be welcoming, inclusive, and free of microaggressions. Overall, participants agreed that an organization free of microaggressions would actively value, understand, and engage in practices to increase freedom and equity in HSOs. To foster an organization consistent with these qualities, participants believed that providers must become increasing conscious of personal bias and how they perpetrate, consciously or unconsciously, systemic oppression. Emerging research supports the need for increased personal consciousness to reduce oppression. For example, interventions improving provider's empathic expressions, and perspective-taking during racially charged interracial interactions decreased microaggressions (Kanter et al., 2020). This aligns with participants in this study who stressed the importance of providers demonstrating authentic kindness to mitigate to microaggressions in their organizations.

At the organizational level, participants wanted staff to represent the local community. This included incorporating community members within the organizational structure, policies, and practices and enabling power sharing among clients and staff. Research highlights the value of shared experiences between the provider and community (Mosavel, Ahmed, Daniels, & Simon, 2011; Simon & Mosavel, 2010) including improved programmatic relevance and community support (Ti, Tzemis, & Buxton, 2012). Notably, participant also warned, and previous studies also found, that community members' participation without decision making power would be inadequate and ineffective resulting in tokenism (Bess, Prilleltensky, Perkins, & Collins, 2009).

Initially, study participants described that a HSO free of microaggressions was an impossible ideal. However, when probed further, participants described that a microaggression-free HSOs would exemplify a range of qualities and characteristics at the provider and organizational levels including: actively unlearning existing biases, being open to change when concerns regarding microaggressions emerge, and allowing individuals to be their authentic selves. These qualities were deemed necessary to reduce or prevent microaggressions in HSOs.

Importantly, these organizational characteristics would require actively cooperating with external processes and interventions to strengthen management practices. For example, socially conscious providers would need to develop a level of proactive awareness about evolving social identities and the ways social context influences experiences of oppression. However, this level of engagement requires organizational support and policies. This approach is different than existing "one and done" diversity and inclusion efforts, where organizations provide one-day trainings and workshops for their staff. While the empirical research on diversity and inclusion trainings are limited, the existing research suggests that these individual trainings have a weaker impact on affective changes, compared to more comprehensive approaches (Kalinoski et al., 2013). Furthermore, initial affective changes do not appear to be long-lasting. Consistent with participants perspectives, lasting effects occur when diversity training was a single component of a larger equitable strategy within the organization and conducted over a longer period (Bezrukova, Spell, Perry, & Jehn, 2016).

The current study findings point to the need for organizations to engage in a process of transformative change, rather than ameliorative change, to reduce microaggressions within HSO's (Evans, Hanlin, & Prilleltensky, 2007). Microaggressions, both in and out of HSO's, are integrally tied to social power structures. As such, a prevention strategy that does not include transformative change in the existing power structures at all ecological levels, falls short. Instead, HSOs can use participatory evaluation processes to focus on increasing pathways to social power for clients as well as documenting these processes (Nnawulezi et al., 2020). Participants in the current study illuminate this point by naming the ways in which providers and organizations can change their practices and policies to have a more equitable distribution of power.

5.1. Implications for practice and research

There are several notable implications for provider practices and HSO policies. At the organizational level, practices and processes that support the recruitment and hiring of staff who represent the HSO clientele is important to communicating to clients that they are the experts on their own experience (Mosavel et al., 2011; Simon & Mosavel, 2010). Second, organizations can more strongly involve both clients and staff in decision making processes and policy creation (Bess et al., 2009). Third, organizational mechanisms should be created so that providers and organizations can adequately respond to client experiences of microaggressions.

Given the exploratory nature of the study, further systematic research on sub-populations of HSO clients are needed. Further, the aims of the current study were about the ways providers and organizations can reduce microaggressions towards clients, specifically because of the power dynamic that exists between clients and providers. Although it was beyond the scope of the study, it is acknowledged that providers within organizations may also experience microaggressions *from* clients, and more research is needed on the ways to address these experiences.

5.2. Limitations

The current exploratory study moved beyond existing research to empirically examine the vision of equitable human service organizations from the perspective of HSO clients who experience them. However, interpretation of study results should be examined considering the limitations. First, it is possible that our chosen qualitative methods (focus groups, interviews) introduced some responses that were influenced by groupthink (members of a group think similarly) or social desirability bias (the tendency of respondents to respond in a way that is socially acceptable). This may have led participants to withhold information or only share their experiences in a way that aligns with the larger group narrative. It is also possible that disclosure could have been limited in the group setting compared to participation in an in-depth interview. This could not be assessed empirically given that focus group participants differed from those who participated in an interview. However, triangulating study results via interviews and focus group data provided an opportunity to explore in-depth issues across multiple perspectives. Second, based on our outreach to community-based organizations, many of our participants named community mental health centers as their primary conceptualization of human services which means that the findings may be particularly aligned with experiences from these types of organizations. Future research could focus on broadly on the types of organizations that participants frequented for services.

These study results add to microaggression research by identifying the specific knowledge, behaviors, and beliefs HSO providers and organizations would need to have in order to reduce or eradicate microaggressions within these contexts. In other words, an organization free of microaggressions does not solely involve an organization and providers not perpetrating microaggressions; it requires an active involvement in fostering an HSO that can envision, understand, and practice freedom. In contrast to previous studies on microaggressions, the focus of the current study was to identify the characteristics HSO's could strive towards to reduce microaggressions by centering the voices of HSO recipients. The results highlight that there are specific, actionable changes HSO providers and organizations can take to create a more equitable environment. Importantly, these changes are needed for HSO's to meet their social service missions.

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