SAMENESS AND DIFFERENCE IN THERAPY

By

Dueretta Angela Richards

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Department of Psychology
The City University
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SECTION A:

Introduction to the Portfolio

"The objective was not to coerce but to correct, not to break wills, but to move hearts" Martin Luther King Jnr

SECTION A: Introduction to the Portfolio

1. Overview

There has been much research on the effectiveness of psychotherapy and counselling (Basco, 2001; Blackburn & Moorhead 2001; Mooney & Padesky 2000; Persons, & Bertagnolli, 1999; Persons & Valus, 2001; Tarrier et al, 2000; Young, 1990). However, these findings have been based on research using nearly all, if not all, White European and North American samples. When ethnic minority individuals are included in such samples, their numbers are either not large enough for any meaningful conclusions to be drawn from their data, or no distinction is made between their data and the data from White people's samples (Wilson and Francis, 1997). Consequently, the majority of therapeutic models, and their refinements, have been based on meeting the psychological needs of those of the majority culture (Fernando, 1995). In recognition of this gap, this portfolio aims to understand common problems of one of the largest ethnic minority groups in Western societies, Black people of African descent, with the aim to provide some insight into how their emotional and psychological needs can be met in Western societies, especially Britain.

All three sections of this portfolio contain material on both the background of the individual, or group, and a consideration of the role, or application, of therapy in their lives. For instance, in the research section, the relevance of counselling, as practiced in Western societies, to the Black community, is investigated. Particular attention is given to issues around how to engage and retain them in the therapeutic process. Such factors as ethnic matching between counsellor and client and Black people's racial identity attitudes have been indicated as relevant to the therapeutic outcome, and these are considered. This is an issue in counselling psychology that has received much empirical attention in American, but very little in Britain, which is curious considering Black people's significant presence in Britain. In the client study, consideration of therapeutic techniques and the outcome of therapy is detailed with work on a White male client (pseudonym *'Alf'*) who, understandably, became depressed following having his job taken away from him. I consider his engagement with the therapeutic process and issues around working cross-culturally that arise in the therapeutic work that we did together. In the literature review, an exposition of what seems to be the fastest growing population – that of 'mixed race' individuals – is presented. Although the majority of mixed-race individuals of African and

- European parentage have a healthy psychological development similar to individuals from other ethnic groups, there is a small, but noteworthy, proportion that has emotional problems. It is this section that the literature review will mostly focus on.

An underlying theme that connects these three sections is that of 'sameness' and 'difference'. In the research section, the focus is on cross-cultural counselling (racial difference between White counsellor and Black client), and ethnic matching (racial similarity between Black counsellor and Black client). Since the typical form of cross-racial counselling in Western societies involves a White counsellor and a Black client, this is the cross-racial therapeutic dyad that will be considered in this portfolio, apart from in the client study. In the client study component, I present my clinical work with a *Alf,* who is different to me in terms 'race'. Whilst it is also recognised that there are other differences (e.g. gender, socio-economic and employment status), in line with the theme of this thesis, the focus will be on 'race', though where relevant other differences will be discussed. This case study is of particular interest because, unlike the usual client studies presented in therapeutic literature which report on the White counsellor-Black client scenario, this case study presents the reverse therapeutic dyad: Black counsellor-White client. Hence it contributes to the shortage of research in this area. In both section B and section C, the research samples and client had a 'monoracial' identity in that they were descendents of one 'race': Black or White. Referring to therapeutic pairs in terms of 'cross-racial' or 'same-race' dyads ('ethnic matching'), made more sense when both client and counsellor had different 'monoracial' identities, as it is usually less unclear who the 'other' is: The client who has a different 'race' to the counsellor and vice versa. However, concepts of sameness and difference in therapy become more complex when the client does not belong to one single 'race'.

The work on mixed 'race' individuals reveals the fuller picture of the underlying theme of sameness and difference. It highlights that counsellors, whether Black or White, have to be aware that whilst there may be seemingly obvious racial differences or similarities, to focus on these racial characteristics per se is not sufficient. In a therapeutic relationship, the importance of difference and sameness are negotiated between client and counsellor. Of utmost relevance is how they position themselves in terms of racial 'sameness' and 'difference', and the meaning *they* attach to these racial contrasts and resemblances. This is also reinforced very obviously by the research conducted in Section B and in my client work in Section C.

Personal Statement

This portfolio indicates my academic and professional background as a Chartered Counselling Psychologist. In a book on multicultural research, Thornton's work reminds me that *'the professional is the personal'* and that there is a connection between *'personal identity and research agendas'* (Thornton, 1999:131). My motivation for researching the above areas comes from my paradoxical experience of lack empirical British material available on cross-cultural counselling, yet (both Black and White) colleagues' abundant interest in it, and their encouragement for me to research this area. In addition, my client work in a diverse range of settings raised my curiosity as to the impact of 'race' on therapeutic outcome. I have practiced in settings as varied as residential, specialist Black counselling agencies, large psychology departments in large NHS Trusts, psychiatric wards, general medical settings (including genetic disorders centres, primary care), community mental health teams, family therapy, charity and voluntary organisations, and my own private practice.

Before entering the counselling psychology profession, I conducted research in the area of comparative psychology and was interested in how animals processed and retrieved new information (e.g. Reed & Richards, 1996). Whilst conducting psychological research with animals, I was an avid reader of *anything* that *seemed* to be remotely related to comparative psychology. Paradoxically, it was my keen interest in animal psychology research that contributed to my decision to embark on a career that devoted my energies to working with humans in the area of counselling psychology.

A very ancient, tattered and generally, neglected looking book had been left lying around at one of the colleges of the University of London where I studied. It was entitled *'Even the rat was White: A Historical View of Psychology'* (Guthrie, 1976). Since it *appeared* to be about animals, I decided to have a brief survey of it to assess its usefulness for my research on animals. Once I started 'glancing' through it, before I fully realised it, I had embarked on a journey that detailed the insults that psychology had committed against the Black 'race', especially in terms of its deficit models of Black development and the Black experience. I recall feeling professionally disenchanted with a discipline (psychology) that I so admired and personally dissatisfied with myself; surely as a *Black* woman interested, and heavily involved, in psychology, I should have had a fuller awareness of its role in the advancement and also the arrested development of Black people. Ironically, my deep immersion in a discipline that cultivates active and curious minds and my yearning to be a part of this field had suspended my

critical reflection of psychology. Since becoming more involved with cross-cultural practice, I have come across many British works that have also highlighted the manner in which Western psychology has disenfranchised Black people (e.g. Banks, 1999; Fernando, 1984, 1989, 1991; Howitt & Owusu-Bempah, 1994; Littlewood & Lipsedge, 1989, 1992; Owusu-Bempah & Howitt, 1995; Thomas, 1992, 1995).

Although Robert Guthrie's book did not contribute to my research on animals, it did have an enormous influence on my career redirection. Similarly, although I did not follow all of Guthrie's arguments, the ones that made sense to me were compelling enough for me to want to make a contribution to counselling psychology. More specifically, a contribution that had the potential to simultaneously make a difference in the lives of individuals from the Black and mixed 'race' community, and also to educate my colleagues. This includes both Black and White practitioners; especially those who are prepared to enhance the lives of individuals from ethnic minority groups, but are not sure where to start.

In the process of my counselling psychology training and continued professional development, whilst grappling with complex personal development issues (Richards, 1999a) and their interaction with professional issues (Richards, 2002); whilst researching cross-cultural counselling issues (Richards, 2000a) ; whilst providing multi-cultural competencies courses (e.g. Richards, 1999b), workshops (e.g. Richards, 1999c; Richards, 2001; Richards & Dallos, 1997), and in my general observation of progressive therapeutic work been done in counselling and psychology with different client groups (e.g. that is reported at conferences; Richards, 2000b), I have received much encouragement from both open minded and curious White and Black psychologists and counsellors. This support has demonstrated to me that there is a small, but core, united movement emerging within psychology to engage with difference and diversity. Hence, it would be inappropriate, if not naïve, to think of psychology as a discipline in terms of a domain exclusively for non-ethnic minority issues or as the 'bad guy'. If this were the case, it would not have been possible for me to embark on this thesis.

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SECTION B: RESEARCH

Premature termination, length of treatment, racial identity attitude, and ethnic matching in counselling psychology

"For, while the tale of how we suffer, and how we are delighted, and how we may triumph is never new, it always must be heard. There isn't any other tale to tell, it's the only light we've got in all this darkness".

(James Baldwin, 1965)

Abstract

There has been much anecdotal and theoretical material concerning the impact of 'race' on therapy in Britain, especially with regards to therapeutic outcomes. The three studies presented in this thesis empirically investigated the notion that premature termination in counselling, and apparently shorter duration of therapeutic treatment, amongst British Black clients is a function of lack of ethnic matching with a Black counsellor; and that racial identity attitudes may help provide some light on this attendance pattern of Black people. Results from SG1 indicated that Black people had an appropriate appreciation of the uses and benefits of counselling; that over two-thirds of Black individuals would consider receiving counselling for their problems; and, when asked directly, a statistically significant amount of Black respondents stated that if they were to see a counsellor, they would prefer to see a racially similar counsellor. However, when 'race' was not mentioned, this preference was not significant. Analysis of archival material of former clients ('SG2'), did not find a significant difference between Black and White samples in terms of premature termination of counselling or with regards to length of treatment. Similarly, no significant difference was found in terms of dropout rates between those Black clients who were ethnically matched with a Black counsellor and those who were not. The RIAS revealed low item-item reliability for the British sample in SG3. It was concluded that counsellors should take account of the heterogeneous nature of 'Black' people as a group and not automatically presume that a Black client will prefer a Black counsellor, but to explore this with each Black client. Other implications for therapists are considered and recommendations for further research are made.

Keywords: Premature termination, length of treatment, attrition rates in counselling, ethnic matching, race, and therapy

Part I: Context and Critical literature

The Privilege of The Fairskinned

Down here
Privilege relates to
How light skin gets you this
light skin gets you that

No doubt that's true
But that's down here

Up there
If you're the only black
in the neighbourhood
it makes no difference

Nigger Darkie Paki
all means the same to them

Privilege,
being relative,
isn't a constructive
measure of oppression.

Maud Sulter (in As a Blackwoman, 1985)

Chapter 1: Introduction and Overview

1. Introduction

1.1. The wider context

Britain is a multi-cultural society, which has seen the rise, and continuous increase, of its Black community. Hence, nearly, if not, all counselling psychologists will at some point of their career provide therapy for Black clients. The government has been keen to emphasise its awareness of, and commitment to, those dealing with mental health issues:

> "Despite its prevalence and importance, mental illness hasn't had the attention it deserves. That's why the Government is determined to give it much higher priority...the same priority as coronary heart disease...Mental health services, and the professionals who provide them, will get the attention and resources they deserve" (Dobson, 1999: 1-2).

The current climate in British counselling psychology is one of striving towards statutory registration and membership of the Health Professions Council. When this is coupled with the government's emphasis on an inclusive health service (Thornicroft, 1999), it is clear that increasingly counselling psychologists' success and livelihood will be linked to evaluations of their ability to meet the mental health needs of an ethnically diverse British population. Similarly, professional bodies such as the British Psychological Society ('BPS') and the British Association for Counselling and Psychotherapy [('BACP'; formerly known as the British Association for Counselling ('BAC')], aware that counsellors play a pivotal role in health agencies, strive to promote the standards of their members in fulfilling these needs. The BPS have developed its own engines committed to promoting equal opportunities ('SCPEO'; Warner, 2002), which has been passed down to its separate divisions. For instance:

> "Counselling psychology competencies are grounded in values that aim to empower those who use the services, and places high priority on anti-discriminatory practice, social and cultural context and ethical decision-making" (BPS, 2001:1) and does this in a manner which is "appropriate to the pluralistic nature of society today" (BPS, 1998:3). (Underline added).

The above quotation implies a moral code of counselling psychology that involves respecting diversity. From this emits conscientious counselling psychologists who not only acknowledge, but also actively engage with, diversity. This is clearly illustrated in the BPS guidelines for professional practice of counselling psychologists:

> "Practitioners' responsibilities and obligations to self and society [include] consider[ing] the contexts that affect clients' experiences and incorporate these into assessment, formulation and interventions" ...[They are also expected to] "make themselves knowledgeable about the diverse life experiences of the range of clients they work with... [Furthermore] practitioners will challenge views of people which pathologise on the basis of such aspects as sexual orientation, disability, class origin or racial identity" (BPS, 1998:8). (Underline added).

Similarly, the BACP is aware of the need for counsellors to suspend their cultural viewpoint when working with culturally different clients, and it states that:

> "...In a multi-cultural and multi-value society [it is important] for counsellors to respect the client's right to make value choices as he [or she] wants, although she may well feel responsible for ensuring that he has fully explored the consequence of his[her] choices. Counsellors' prior membership of a particular group may cause them to misconstrue a task/problem in a particular way. It is therefore important that in giving attention and respect to the client in order to allow him[her] to make his[her] own choices, s/he is able to avoid imposing her moral / cultural values on him[her] and should offer him[her] the choice of counselling elsewhere" (BAC 1985; in Banks, 1999:13).

Hence, it appears that the process of counselling, in which a practitioner facilitates the relief of a client's psychological and emotional distress, is inclusive, rather than exclusive, of universal benefit, and accessible to people irrespective of 'race' or culture (Department of Health, 2001). The above quotations from the BPS and BACP also give the impression that therapists should make every effort to familiarise themselves with the milieu within which their clients' world currently exists. This is done in order to understand the client's experiences (e.g. with the use of empathy) and respond therapeutically appropriately. It is therefore very clear that counselling and psychological organisations *'realise that a competent therapist or counsellor must be cross-culturally competent'* (Sue, 2000:3).

1.2. Statement of the problem

Psychological services are failing to attract and retain ethnic minority groups (Sue, 1977). This is despite the well documented research evidence and concern that some ethnic minority groups in Britain, especially people of African and Caribbean descent, are over-represented in compulsory judicial and psychiatric agencies, yet under-referred for therapeutic help (Browne, 1997; Burnett, Mallett, Bhugra, Hutchinson, & Leff, 1999; Callan, 1996; Christie, 1995; Cochrane, & Sashidharan, 1996; Davies, Thornicroft, Lesse, Higginbotham & Phelan, 1996; Fernando, 1991; Littlewood and Lipsedge, 1989; Lloyd and Moodley, 1992; Mental Health Foundation, 1997; Reid-Galloway, 1998; Dept of Health, HO, 1992; Robertson et al, 2000; Thomas, 2000). Similarly, studies in America have found that even when Black people did actually access counselling they had a higher drop out rate than their White counterparts (e.g. Sue, 1977). Lowenstein (1987) found that in his study, whereas 30% of White clients did not return for counselling after the first session, there was an alarming occurrence of 50% attrition rate for Black clients after the first session.

When pooled together, the above studies and statistics seem to indicate that somehow, a needy and vulnerable section of society are facing obstacles to engaging with a service that claims to be available to all communities of its society. This creates a big problem for counsellors since it implies that they are not meeting the needs of an ethnically diverse British population, and even that they may have (inadvertently) erected barriers that prevent Black clients from accessing their services. However, British research indicates that White counsellors are open to working with Black clients (Banks, 1999; Buabeng, 2000), and that

there are White British counsellors who are not bias to either White or ethnic minority counselling participants (Pearce, 1997).

If there is evidence for disproportional premature termination amongst ethnic minorities in Britain, then it challenges counsellors' anti-discriminatory claims and their efforts towards cultural sensitivity. One of the major problems with verifying and understanding the apparent under-representation of Black British people receiving counselling is that the empirical evidence available is mostly American and the material available in Britain is mostly theoretical and some is anecdotal. There are indeed some similarities between Britain and America. This makes it possible for some extrapolations based on American samples on issues about Black people's attendance of counselling to tentatively be made about British samples.

American theories indicate that one of the main reasons for such issues is the cultural inappropriateness of the treatment on offer by Western and White services and that the majority of Black people have a preference for a counsellor of the same 'race' as them (termed 'ethnic matching'). This is based on the premise that for most Black people their racial identity is pivotal to their self-identity. They feel that a counsellor of the same ethnicity will be able to have genuine empathy and will respond culturally appropriately to their psychological needs (Alladin, 1999). Hence, they are less inclined to have confidence in services that do not have Black counsellors. However, due to the shortage of Black counsellors, many Black people will inevitably receive counselling from White counsellors. Most White therapists are anxious over issues of 'race' in the therapeutic process (Leary, 1995). Very few White counsellors feel confident that their training has prepared them to adequately meet the psychological needs of Black people (Banks, 1999; Buabeng, 2000), and this seems to be reinforced by Black clients' high attrition rates very early on in therapy. These findings can be encapsulated in the broad theme of similarities and differences between counsellor and client. Put rather simply, it would support the psychological research that humans in general are more attracted to individuals who are similar to them on certain fundamental characteristics (Tarjfel, 1978, 1987), e.g. culture, 'race' or ethnicity (Thomas, 2002). This is also complemented by British research, which indicated that many White counsellors believed that Black clients should be given the option of ethnic matching in therapy (Banks, 1999; Buabeng, 2000). Since the common therapeutic experience for the Black client is with a White counsellor, research on the therapeutic outcome of this therapeutic dyad has wide application for the therapeutic community.

Whilst there are similarities, there are also differences between the American and British context (Yee et al, 1993). As a caveat to transporting theoretical perspectives across countries, the American psychotherapist Adams (1997) highlights that what he was presenting was what Geertz (1983) refers to as "local knowledge", and recognised that it carried with it accompanying limitations and advantages. British counselling psychologists are only too aware of the need for their own endeavours in cross-cultural counselling. Rawson, Whitehead, and Luthra, (1999) write

> "It is worth noting that much of the research in the area of trans-cultural counselling is of *North American origin* which inevitably influences both theory and practice. How this translates into the context of British culture is a meta cross-cultural theme. In addition to assimilating American experience, it *is important that British counsellors contribute their own wisdom* in the development of a trans-cultural approach" (p17). Italics added).

Some British researchers have gone even further and warned of the dangers of over-reliance on American findings and applying them to British populations (Bulmer, 1998; Jowell 1998).

Frequent use of American studies reflects the fact that the history of British transcultural / intercultural/ cross-cultural counselling psychology is short, emerging in the late 1980s and early 1990s (e.g. Lago and Thompson, 1989; Kareem and Littlewood, 1992). Theories in this field are developing, though cross-cultural counselling still has to establish itself in the empirical research domain of counselling psychology. There have been no British studies that have specifically investigated concerns over Black people's attendance patterns in therapy. Rather than look at specific attendance patterns of Black people and the extent to which these are determined by their racial identity in cross-cultural counselling, British studies have attempted to deal with the issue of Black people's use of therapeutic services with different research questions. These focus on areas such as Black clients' general experiences of mental health services without specific reference to ethnic matching (Wilson and Francis, 1997); general cultural needs of vulnerable Black psychiatric clients (Robertson et al, 2000; Sathyamoorthy et al, 2000); White counsellors' cross-cultural counselling competencies and attitude to working with Black clients (Banks, 1999); White counsellor's attitudes on ethnic matching for Black Clients (Buabeng, 2000).

Other cross-cultural counselling researchers (e.g. Fernando, 1989; Jackson, 1995; Wilson and Francis, 1997) have pointed to the inadequacy of studies that do look at the issue of premature termination, as they only include a few, sometimes no, Black respondents in their samples and

then (inaccurately) generalise their findings on attrition and retention rates in therapy to ethnic minority groups. The under-representation of ethnic minority client samples in studies on the effectiveness of therapy clearly highlights the difficulty that researchers have in accessing members of the ethnic minority community (Robertson et al, 2000). Paradoxically, though Britain (Elefthriadou, 1994), and Europe in general (Chiu, 1996), has witnessed an increase in multicultural populations there are few studies on cross-cultural issues in counselling. The current climate appears to be one where diversity is acknowledged on paper, yet practice issues such as cross-cultural counselling have received very little attention in comparison to general counselling psychology.

This creates a dilemma for British counsellors. On the one hand they are exposed to discourses about the inaccessibility of counselling to a section of society that would benefit from counselling. On the other hand, whilst it is commendable that such discussions have raised their awareness, there is little they can do until they have more material on the extent of this problem. This is compounded by the fact that one of the major arguments for the problem is lack of opportunity for ethnic matching which is currently impractical due to the dearth of Black counsellors available. So it seems that both client and counsellor are losing out because of limited resources e.g. appropriate counsellors for Black clients and unanswered questions to service provision problems for counsellors. This creates an impending sense of urgency for the therapeutic industry, since, to be effective, counsellors need to understand the factors that promote service use, compliance and retention of clients.

Chapter 2: The psychological needs of Black people, psychological functioning and within-group differences

My blackness is a beautiful cloak

Of selfhood that permeates my soul

(Maud Sulter in 'As a Blackwoman' 1985: 53.)

2.1. Introduction

> **"Black as a physical fact has little significance. Colour, as a cultural, social, and political fact, is the most significant fact of our era. Black is important because it gives us ground from which to fight – a way to feel and think about ourselves and our own reality – a way to define" (O'Neal, 1971).**

In order to clearly delineate the psychological needs of Black people, this chapter has taken account of the historical, social and political context in which Black people dwell, and considered how these impact on their psychological well-being. This has implications for the their personhood, the manner in which Black individuals present themselves for counselling and, ultimately, the therapeutic relationship with either a Black or White counsellor. 'Black' is used do denote people of African or (Afro-) Caribbean descent who, as a whole, have a shared experiences of racism, discrimination and oppression (Mama, 1992), which is also indicated in O'Neal's quotation. This group identity is likely to be reinforced by the sharing of similar racial characteristics, so that group members do not feel too alien when they meet. This in-group worldview (Tarjfel, 1978, 1987), or group identity, will vary depending on the location of group members. Hence, people have a multiplicity of identities (Rowan & Cooper, 1999), and their 'weness' (group identity) needs to be distinguished from their personal identity. Whilst in many places reference is made to *'Black people'*, this thesis is very much aware of within-group racial and cultural differences amongst the Black community, *"but what sets them apart from White people is their appearance, not their culture. It is because racial categories continue to have both political and psychological importance that we prefer the term 'race' "* (Tizard and Phoenix, 1993:4). However, within group differences must be acknowledged. Hence, throughout this thesis substantial consideration is given to the variations of Black individuals' identity, their psychological functioning and their psychological needs and limits itself to Black people of African and Caribbean descent who live and operate within Western socio-economic structures.

2.2. The Historical and Demographic Context of Black People in Britain

Although Black people are recorded as having settled in Britain since 1500s (Largo and Thompson, 1996), their presence as a noticeable and sizeable group in Britain was established in the late 1940s and early 1950s with their arrival in their thousands from the Commonwealth, on the invitation of the 'Mother' of the Commonwealth: the British Queen (e.g. 'WINDRUSH', Phillip & Phillip, 1999). The continual increase in size and regional variation of location of Black communities has been documented (Commission for Racial Equality, 'CRE', 1997; Haskey, 1991; Modood & Berthoud, 1997; Owen, 1992, 1995; Skellington, 1996). Currently, 2% of the total British population of 58,789,194 belong to Black communities (Black Caribbean, 1%; Black Africans, 0.9%; and Black Other, 0.1%) (Office for National Statistics, 'ONS', 2002), which is an increase of 0.4% from the 1991 British Census, and maintains the position of the African-Caribbean community as the second largest ethnic minority group in the UK. Black people make up 27.1% of the entire ethnic minority population in the UK, which is currently recorded as 4.5 million (or 7.6% of the total United Kingdom population; ONS, 2002) These figures indicate Black people's existence as a recognisable and sizeable group in Britain (with *'staying power'* – Fryer, 1991), who have contributed to *'the irresistible rise of multi-racial Britain'* (Phillip & Phillip, 1999). There is considerable regional variation, which reflects the fact that 48% of Britain's ethnic minority groups live in London (ONS, 2002). About 60% of 'Black Caribbeans', and nearly half of 'Other' Black people live in London. Apart from Birmingham, the London boroughs of Lambeth, Wandsworth, Lewisham, Hackney and Haringey have the highest levels of Caribbean and African populations (Haskey, 1991). Hence, any analysis of the therapeutic needs of British Black people would benefit from finding its samples from one of these London areas.

2.3 Social and economic impact of living in Britain

Typically, communities of Black people are located mostly in inner cities, where they have settled since immigration and these areas have great social and economic disadvantages. These areas have been categorised as having very low 'Jarman' indices[1], which means they have abject deprivation. Indeed, the Labour Research Survey stated: *"Discrimination and racial harassment are unfortunately all too often part of the experience of working life for Black people"* (1989:14). They tend to experience disproportionately higher levels of social, occupational and economic stress than other ethnic groups (Leong, Wagner, Tata, 1995), due to racially motivated attacks, unfairness within the workplace and from other colleagues,

[1] 'Jarman' indices are a scale of deprivation (Gilam, Jarman, White, & Law, 1989).

discrimination in unemployment and housing (Banks, 1992). Their status as one of the ethnic groups with the least power in British society (Cochrane, 1979) indicates that they are also most vulnerable to mental health problems (Bell, 1989). *"This is not a result of cultural inadequacy but the experience of prejudice and discrimination from the indigenous White community"* (Banks, 1999: 22). Such incidences are a major course of psychological distress for many Black people in Britain (Burke 1984; Fernando, 1984; Ferrell, 1995: Littlewood and Lipsedge, 1989; Littlewood and Lipsedge 1992; Wilson and Francis, 1997).

As members of the British Empire, Black people were subjected to colonialism. Fanon (1967) observed *"the psychological effects of colonialism as one of the enduring legacies bequeathed to 'natives' by their colonial masters"*. He believed that 'the Black experience' could not be separated from Black people's histories as recipients of Black colonisation. Following on from this, Pelle wrote that the colonial relationship between Britain and the Caribbean has shaped the current beliefs and the behaviours of people of African-Caribbean descent and contributed to feelings of inferiority, which is difficult to *"throw off"* (Pelle, 1996). It is possible for Black people in Britain to have feelings of inferiority, either due to their direct experiences of coming from a colonised land (e.g. Empire Windrush on June 1948), or the transmission of a legacy from Black people who have had direct experience of colonialism to those who have not. Hence, the historical context still has an impact on the current lives of Black individuals, and can affect their emotional well-being.

2. 4. The qualitative experience of being Black in Britain

2.4.1 Black people have different experiences to White people

Similar to Black people in other Western socio-economic structures (Jones, 1993; Owen, 1993, 1994), British Black people's experience is qualitatively different from White people's experiences (Banks 1990; Ferrell, 1995). For instance Banks (1999:45) writes, *"...The intrapsychic world of Black people differs from that of White people due to negative socialisation forces...that affect the developmental experiences of Black people in White societies"*. Whilst Black people are disadvantaged, White people have privileges, which they take for granted (Thomas, 1997), such as the assumption that other 'races' enjoy as much autonomy as they do, when in reality this is not the case. Governmental policies and their implementation by authority agencies exemplify the ways in which Black people's freedom is restricted. For instance, the police's overuse of the Stop and Search Law, so that Black people

are six times more likely to be stopped and searched by police than White people (Steele, 2000). This illustrates the extent to which Black people's experiences can be qualitatively different to that of White people. For this reason, Black individuals may prefer a Black counsellor who they feel will share at least some of their experiences, and therefore be able to respond more appropriately to their distress (Alladin, 1999).

There is the continual highlight of Black people's ethnicity in negative media stories, yet the failure to mention White's people's ethnicity or to acknowledge that that do have an ethnicity (Gorell-Barnes, 2002). Also, in psychology, socially constructed problems are racialised when they occur among Black people (Phoenix, 1993, 1996) so that issues such as the alleged 'Black inferiority complex' or 'chip on the shoulder' are continually highlighted (Owusu-Bempah & Howitt, 1999; Phoenix, 1999). This can give the erroneous impression that a person's racial inheritance is the cause of his/her negative behaviour or attitude when s/he is Black, but not when s/he is White. This racist discourse can be very seductive. Indeed, such notions, which are usually embedded in the belief of superiority of White people, enhance the psychological well-being of White individuals, whereas for those Black people who have also internalised these perceptions, typically negative intra-psychic and interpersonal consequences ensue.

White people, especially the English in Britain, where they have a powerful majority, have tended to associate ethnic and ethnicity with exotic and far away people or goods (e.g. 'ethnic foods' or 'ethnic jewellery'; Banton, 1988 in Banks, 1999:35). Yet, even though their racial identity attitudes have the potential to indicate their reaction to Black persons (Carter, 1990), many White people have failed to realise that like every other 'race', they also have an ethnicity (Thomas, 2002).

Individuals commonly get a sense of their identity by comparing themselves to other people. For those Black people who do feel inferior, it may be because, in comparison to themselves, they notice that White people do have greater access to resources (Gorell-Barnes, 2002), and this type of racial discrimination can negatively impact on their self-perception (Owusu-Bempah & Howitt, 2000), e.g. they may wonder what they are lacking that results in them been denied such resources, or the same quality of resources.

2.4.2. Racism and discrimination experienced by Black people

Black people are subjected to both the very blatant forms of racism and also subtle types of racial discrimination. This is especially the case for Black men. Byrson (1998), with the aid of his *'Attitude Toward Black Male Scale'*, found that White people were susceptible to negative stereotypes about Black men. He concluded: *"The results demonstrate that race is a significant factor in determining how Black men are perceived"*(p290). Racially motivated attacks on Black people in Britain have increased (Macpherson, 1999; Skellington and Morris, 1992), e.g. in 1988, 1989, 1990 there were 4,383, 5,044 and 6,359 attacks respectively (Banks, 1999). It is acknowledged that the increase could be the result of differences in the way in which reporting is done, but nonetheless the figures are alarming. Similarly to other psychologists and researchers in the field of multi-cultural psychology, a fundamental assumption of the present thesis is that the experience of racism, racial prejudice and racial discrimination, as experienced by Black people in Britain (Banks, 1999; James 1993; Jones, 1993), may impact negatively on what a Black person may think and feel about being Black. This in turn may affect their self-esteem, which affects their psychological well-being, as outlined by Ferrell (1995:11):

> **"Traumatic life events especially those which have long term implications (e.g. racism), can produce significant disturbances in psychological functioning. Their capacity to disrupt, destroy or threaten the social or interpersonal life and attachments of individuals means that these experiences have the potential to induce symptoms of depression and low self-esteem... since there is a link between low self-esteem and depression".**

It is now recognised that racism can occur at three levels (Jones, 1972) – at the individual, the institutional [e.g. MacPherson Report (1999) on the Stephen Lawrence case] and cultural. Therefore, it becomes obvious that, as a mechanism, it can have negative psychological, social and financial consequences for individuals. These consequences are rooted in the past when racism justified the 'race' slave trade and functioned to retain power in the hands of the 'majority' (Gaines & Reed, 1995). *"Racism begins with the exploitation of a people*...[and as such is]...*a very real historical process of social economic and physical exploitation"* (Tinsley-Jones, 1997:99).

It seems that lip service is paid to equal opportunities with the aim of political correctness (Owusu-Bempah, 2003) so that racism continues to persist despite legislation against it and it occurs in key areas: In housing, education, employment, the health care system and in law including the criminal justice system (Brown, 1984; NAHA, 1988; Owusu-Bempah, 1999b). Indeed, legislation against racist acts has resulted in more subtle racist strategies, when they

occur, such as institutional racism (Howitt & Owusu-Bempah, 1990, 1994; Macpherson, 1999).

Those in power, especially institutions as they have social status and economic control, can restrict and even arrest the progress of individuals from certain racial groups and even whole racial groups. Similarly, they also have the authority (though it may not be justified) to promote the advancement of some racial groups over other racial groups. Typical, in the society that both White counsellor and Black client inhabit, socio-political forces convert racial difference into unfair inequality for ethnic minority communities (Maynard, 1994; Zack, 1995) that denies them access to facilities and opportunities readily available to White people.

2.4.3 Culture shock

Culture shock (Oberg, 1960) is another common way in which responses to the (White) host culture's traumatic treatment can manifest itself in psychological distress experienced by Black people. It is a person's emotional reaction to difficulties associated with dwelling in a different or new culture / environment (Boch, 1970). This includes feelings of loss, of rejection by the host culture, anxiety, disappointment, feelings of inadequacy or failure as a result of not being able to cope with the new environment, and feelings of confusion over role expectations and self-identity (Furnham, 1988; Furnham and Bocher, 1988). This is an indication of the types of psychological distress for which a Black client may need counselling: To help him/her cope with issues brought on by culture shock. One of the major components of culture shock is the feeling of not fitting in because of one's difference. Black people, admittedly are different in some ways from White people; but in drawing from feminist writings, Banks, (1999:13), emphasised that to focus solely on this difference would be inappropriate when working with Black people.

2.4.4 Implications for counselling

Black people's experience of been dismissed as worthwhile citizens has implications for counselling, as noted by Egan:

> "Many professionals have pointed out that both the differences among and the needs of minority groups, together with the contributions that such groups make to society, have been systematically ignored or misunderstood...' [Egan then goes on to emphasise that] '...This is a social problem that has implications for groups of clients, individual clients within those groups, the helping professions, and individual helpers...[Therefore] It is

> essential that helpers understand clients and their problem situations contextually" (1998:47).

Counsellors must be aware that Black people, as a group, suffer severe racism (Macpherson, 1999), and the devastating impact this can have on their lives, their families lives and on their well-being. Racism is an everyday experience for the majority of Black people (Pierce, 1969; Mama, 1995) and can lead to emotional problems (Pierce, 1969; Ferrell, 1995). Therefore, it may be relevant for the White counsellor to explore with the Black client the ways in which the client's world is both differently organised and experienced from White people's world; and that concerns about difference should acknowledge issues of hierarchy and power (Mackinnon, 1987). Maynard (1994:19) cites Rothenberg, (1990) as arguing that *"the force of racism is on the assigning of value to difference, which is then used to justify denigration and aggression and not in difference per se"*. Hence, the counsellor may also need to take account of how certain forms of differences are arbitrarily selected in society so that certain people are disadvantaged because of their difference, which *"... can lead to marginalisation of issues e.g. racism, racial domination and white supremacy"* (Maynard, 1994:10). Counsellors must also be vigilant not to fall into such a trap, where they in turn arbitrarily decide which client differences to focus on and the manner in which they are evaluated.

Beliefs about the 'ethnic-free' identity of White people, especially amongst many White people, are strongly entrenched, as they have been imbued since childhood (Gorell-Barnes, 2002; Thomas, 2002). Such a socialisation process may make it difficult for some White therapists to appreciate the relevance of their own ethnicity to the Black client and the therapeutic process. The White counsellor who is oblivious to his/her Whiteness and naïve about the implications of racial-group differences [who is likely to be in what Helms refers to as the *'contact'* stage of White racial identity (Helms, 1990)] may unwittingly communicate offensive automatic assumptions about Black people to his/her clients. If the White counsellor is not aware of his/her racial identity, then s/he will not have managed to resolve her/his own issues of racial identity that could negatively affect his/her interaction with Black clients. This type of White counsellor will not be able to get in touch with her/his own feelings about belonging to his/her ethnic group and hence have cut off another avenue through which the White counsellor can communicate empathy to his/her ethnically different client. The counsellor may also struggle with fully comprehending the relevance of a Black client's ethnicity in terms of the client's self-perception and how others respond to his/her ethnicity. Lack of understanding reduces the counsellor's level of empathy (Rogers, 1951).

Consequently, such a White counsellor may have difficulty helping a Black client explore and deal with racial issues that are at the core of the client's psychological distress.

Bearing in mind that the White counsellor, whether voluntarily or not, is part of the 'white supremacy unit', the therapeutic relationship is likely to benefit if the counsellor has some understanding of the dynamics between the race that s/he represents and the client's race (Davis, 1984). Although racism and its discourse have the capacity to compel its victims to modify their self-concept in a negative way (Wetherell and Potter, 1992), it must be emphasised that counsellors should not perceive Black clients' lives to be totally pessimistic. Experiences of racism, and oppression are feature of daily life for Black people, yet this does not mean that they are not capable of achieving healthy psychological functioning - they are (Cross, 1991) - and it is the counsellor's role to help them achieve this (BACP, 2001). In fact, experiences of racism can make the recipient more resilient to setbacks. Black clients can learn to overcome the hurt that racism causes and develop stronger ego-strength (Cross, 1991) and more effective coping strategies (Owusu-Bempah & Howitt, 2000).

2.4.5. Provision of Mental Health Treatment of Black people in the mental health system

There is a concern that Black psychiatric users are noticeably, less likely than all other ethnic groups (Fernando, 1995), especially White people (Bean et al, 1991), to be offered the opportunity of more expensive non-medical options (Christie, 1995) known for their preventative or supportive mechanisms, such as counselling (Littlewood and Lipsedge, 1997). Instead, Black people are more likely to be treated with remarkably less expensive coercive (Lloyd and Moodley, 1992) and physical treatments (Mental Health Foundation, 1997; Reid-Galloway, 1998), such as higher dosages of potent psychiatric medication (Cochrane, & Sashidharan, 1996) or ECT in a misinformed attempt to keep them '*Out of Harm's Way*' (Bean et al, 1991).

Black people are over-represented amongst people from other ethnic groups admitted to psychiatric wards on compulsory orders of the Mental Health Act (Browne, 1997; Davies, Thornicroft, Lesse, Higginbotham & Phelan, 1996; Dept of Health, HO, 1992; Littlewood and Lipsedge, 1989; Robertson et al, 2000). Epidemiological studies investigating the incidence of schizophrenia among different ethnic communities have found that higher rates are reported for individuals of African and Caribbean descent (Burnett, Mallett, Bhugra, Hutchinson, & Leff, 1999; Callan, 1996). In some cases they were 10 times more likely to be given a

diagnosis of schizophrenia than other 'races' (Harrison, 1975). Similarly, others have reported that on average Black people were four times (though this was slightly higher for Black men) more likely than White people to have 'first time admissions' for the diagnosis of schizophrenia (Dunn & Fatty, 1990; Cochrane, & Bal, 1989). Long-term outcomes for this group are likely to be poor (Mind, 1997). One paper (Mind Mental Health Statistics Factsheet, 1997) reported the disturbing statistics that the Black population had a rate of admission to medium-secure care seven-fold that of the White population (28/100,000 for 16-64 years olds in contrast to 4/100,000 respectively), whereas the figures were under double for other ethnic minority groups.

Statistically, Black people 'over utilise' psychiatric services than any other ethnic group, typically by enforced detention (Cochrane, & Sashidharan, 1996). The overrepresentation of Black clients in the mental health services points to their intensified need for psychological help (Christie, 1995), and their higher rate of psychiatric and psychological problems than other ethnic groups (Burnett, Mallett, Bhugra, Hutchinson, & Leff, 1999; Flaskerud & Hu, 1992). On the other hand, it could that they are a group that are subjected to erroneous diagnoses and over diagnosing of problems because of biases in the mental health system (Christie, 1995; Cochrane, & Sashidharan, 1996; Fernando, 1991, 1995 Thomas, 2000).

2.4.6 Inaccessibility of therapeutic facilities for Black people

There have been some explanations put forward for the prejudicial treatment that Black people are subjected to in the mental health system. The erroneous scepticism towards Black people's ability to benefit from counselling was made explicit by Jung (1930) who was emphatic that *"[The] Negro...would give anything to change his colour"* (p196). The reverberations of this can still be seen in contemporary Britain amongst many mental health professionals who remain resistant to considering Black people appropriate for certain types of treatment (i.e. therapy) and extremely willing to overuse physical treatment (Christie, 1995; Cochrane & Sashidharan, 1996; Fernando, 1995). Historically, and politically, the wrong portrayal of Black people as intellectually and psychologically immature has contributed to some of the current perceptions of them as deficient and inferior to White people (Lind, 1914). For instance, whilst the natural and rational behaviour of trying to escape one's cruel capturers is understandable, it was seen as abnormal and a sign of madness (evidence of 'personality deficit') when embarked upon by Black slaves who tried to escape from their White slave masters. In 1851 Dr Samuel Cartwright, a prominent physician who epitomised the then prevalent attitude towards Black

people and supported the slave trade, attempted to give this 'mental alienation' theory scientific authority by coining the 'diagnosis' 'drapetomania': A 'psychiatric illness' that was peculiar to Black people which caused them to runaway from their 'masters' (Hope Franklin & Schweninger, 2000; Szasz, 1963 & 2002; Thomas & Sillen, 1972). Genetic arguments were also put forward; such as, the inferior intelligence of Black people compared to White people (e.g. Hernstein and Charles, 1994; Rushton, 1995). Eysenck, 1967 claimed that Black people's IQ were 15 points below that of White people, though the 15 points vary from a sample norm of White participants in (Southern) American culture which has an infamous history of negative attitudes and punishing treatment (e.g. lynching) towards Black people. Differences may be due to a variation in contexts, different levels of access to resources, information processing processes and cultures rather than 'intelligence', which was defined by White psychologists and educationalists, many of whom held notions of Black people similar to those held in Southern America.

Theories of the inferiority of Black people, reportedly 'scientifically' grounded in statistics, were reinforced by therapists' theories and speculation. Whether consciously or unconsciously, there are White therapists who strongly believe Black clients have emotions, feelings and processing mechanisms that are inferior to those of supposedly premium emotional experiences of White clients (Sager et al, 1972). Jung (1930) wrongly argued that Black people's minds were not developed enough to use the sophisticated process of psychotherapy (Adams, 1997). Other early psychotherapists' limited contact with Black people 'supported' their inability to treat Black people effectively has left psychotherapy with a legacy of the incorrect assumption that Black people in general would not benefit from psychotherapy (Griffith, 1977). These types of 'principles', established and propagated by eminent and respected White psychologists, may explain why the talking therapies, which require articulate clients, were not automatically considered for Black people as they were perceived as ineloquent or unsophisticated. There have been endless reports of a noticeable sample of White counsellors who treat Black clients unfairly (Bamgose, Edwards and Johnson, 1980; Block, Weitz and Abramowitz, 1980; Comas-Diaz and Jacobsen, 1991; Fernando, 1991; Merluzzi and Merluzzi 1978; Owusu-Bempah & Howitt, 2000; Ponterotto and Pederson, 1993; Rack, 1982; Schneider, Schneider, Hardesty, and Burdock, 1978; Stevens, 1981; Watkins, Cowan and Davis, 1975). Their discrimination is shown by either treating Black clients less favourably compared to their White counterparts (Atkinson, 1987; Atkinson and Schein, 1986; Casas, 1984; Kareem and Littlewood, 1992; Locke, 1992), or by having fewer expectations for Black clients (Rosenthal

& Berven, 1999). This racial bias of a notable proportion of White counsellors (Cole and Pilisuk, 1976; Mayo, 1974; Yamamoto et al, 1968) indicates that in many cases well-meaning White counsellors may be unintentionally influenced by the dominant society's racial stereotypes (Roach, 1999). Unwitting acceptance of such racial stereotypes can have harmful effects on both the culturally different client and the therapeutic process (Harrison, 1975; Kelly et al, 1977: Sandler et al 1978).

2.5 Implications for counselling

As a process, wrongful labelling of behaviour as psychologically disturbing or psychotic can in itself cause psychological distress. Whilst, not every Black person will have this type of experience, as a group, Black people are reported as having high levels of psychological disturbance (either brought on by their own internal psychological processes or by external forces), which indicates that they are a highly psychologically vulnerable group. It is expected that in order to get relief from this distress, like other ethnic groups, Black people could benefit from psychological and therapeutic services. If they are reported as having high levels of psychological distress, then it is expected that they would have a corresponding high need for, and also likelihood of using, psychological services (Sue, Zane & Young, 1994). Their increase in numbers and identified emotional needs lead to an anticipated high uptake of psychological services. However, when Black people do use such services many White counsellors may expect them not to progress, which is reflected in the White counsellors' communications and reduced investment in the therapeutic relationship. Hence, if the outcome is not positive, therapists may tend to conclude that therapy was not successful because of *something inherent in the Black client*, rather than because of the therapist's interventions or the therapeutic process for which *both* client and (even more so the) therapist are responsible.

Black people's presence as a noteworthy and increasing client group makes them an ideal group to research in order to provide further insight into their psychological needs. This is very relevant for those working in the field of mental health using psychological and therapeutic models that are outdated by their inherent legacies of the emotional inferiority of Black people or their lack of relevance to the psychological needs of the Black community (Banks, 1999).

Acceptance of such 'foregone conclusions' of the inferiority of Black people by many White people and 'scientifically established' by distinguished White professionals, based on what are

now referred to by Jones (1990), and other psychologists as the "deficit hypothesis" (Jackson, 1980; Maultsby, 1982) are very powerful. The authority of these ideas silenced many opposing voices (Hope Franklin & Schweninger, 2000) and, rendered almost redundant any (so called pointless or futile) investigations that attempted to refute, or even evaluate, such 'respected' and 'accepted' claims. However, in many instances professionals may not even be aware that they are committing racist acts. Owusu-Bempah and Howitt (2000) refer to this as 'patronizing or benevolent racism' and comment that these professionals *"often act in the arrogant or false belief that they know what is in the best interests of Black people without even consulting them*...[and that this]...*patronization may take place even in an environment of genuine and profound anti-racist beliefs"* (Owusu-Bempah and Howitt, 2000:11). Hence, as Egan points out, institutions need to "*provide opportunities for practitioners to be trained in the working knowledge and skills associated with diversity-sensitive counselling and create an environment that supports professional tolerance"* (Egan, 1998, 49-50).

2.6 Developmental effects of experiences in Britain

2.6.1 Black family structure

Black families have been inappropriately judged by many mental health professionals as having patterns of relating to family members that unwittingly cultivate mental illness (Fernando, 1995; Littlewood &, Lipsedge, 1989). The Black family model is based on the extended family network, where emotions are openly expressed and family members rely on other (extended) family members for support and consult with them before decisions are made or actions taken. (Boyd-Franklin, 1989; Owusu-Bempah & Howitt, 2000). This 'collectivist' framework (Markus & Kitayama, 1991; Triandis, 1995) is in contrast to the standard 'individualist' guiding principle typical of the White British family, where the nuclear family is commonplace, autonomy of the self and independence are encouraged (Owusu-Bempah, 2002) and emotions are either repressed or seen as a sign of loss of control when expressed. This has given the British a reputation for being 'reserved' and upholders of 'the stiff upper lip'. Since many White therapists are likely to have been socialised in such backgrounds, it seems understandable that behaviours, other than those they are accustomed to, would be viewed with scepticism. This ignorance may lead them to view unfamiliar practices and behaviours as abnormal. Hence, it may come as no surprise that within the field of mental health (psychiatry

and therapy), relating very closely to family members in a pattern similar to that observed in Black families has been 'officially' labelled as 'high' in 'expressed emotions' ('EE'). EE has been cited as a contributory factor to schizophrenia.

Instruments that measure EE claim to be culturally neutral, though harmful levels of this recently devised 'mediator' variable are 'detected' mostly in Black families. Yet, this portrayal of the Black family as in crisis and producing dysfunction members leads to the perception of what Owusu-Bempah and Howitt (1999) refer to as the 'tangle of pathology'. As indicated above, a diagnosis of schizophrenia invariably results in a psychiatric admission and psychotic medication. In addition, schizophrenia is a label that once applied is difficult for an individual to 'shake it off', and once revealed to others usually conjures up images of out of control and unpredictable dangerous behaviour that others assume are the trademark of the schizophrenic individual. This of course influences how others (cautiously) approach, respond, (negatively) interpret, and even avoid interactions with individuals diagnosed as suffering from schizophrenia.

2.6.2 Professionals' perception of the Black family:

Pathologising the Black family structure is usually based on myths and stereotypes, e.g. damaging childrearing practices, 'deserted' fathers (e.g. Coleman, 1994; Russell, 1994, Schoenfeld, 1988), dysfunctional matriarchal family structures and ways of relating within Black families. Professionals who undervalue Black families are actually pathologising Black culture, since *"the family is 'the keystone' of any culture"* (Owusu-Bempah and Howitt, 2002: 41). If Black families are blamed for their so called shortcomings, then this can set up a perception amongst onlookers (e.g. some White therapists) that Black families are a hindrance to some of their Black clients. By blaming the Black family for all its 'problems', the implication is that it needs strong external interventions, so therapists invest their energies in 'fixing' members of the family using an individualistic framework. Hence, by dismissing, or simply overlooking, the focal role that the family plays in the Black client's life, White therapists may use interventions [probably based on the model of the (White) nuclear family structure] that they think are 'helping' the client to distinguish or even extricate him/herself from his/her family. However, in effect many misguided, but well-meaning White therapists run the risk of alienating the Black client from the powerful and pertinent support network that s/he relies on to imbue him with adaptive coping skills that enable him to deal with the injustices of society and to survive adversity (Hill, 1972).

2.7 Implications for counselling

In the counselling situation the White counsellor would need to be aware that his/her way of relating in his/her family might be radically different from the Black client's family patterns. In addition, since there is a higher rate of diagnosis of schizophrenia amongst the Black community than amongst other ethnic groups, the counsellor needs to be prepared that of the group of Black clients seen in therapy there is a possibility that some may either have this diagnosis, or have relatives or close friends with this diagnosis. Apart from taking into account the political and social controversy surrounding (over) diagnosis of schizophrenia amongst Black people, counsellors need to evaluate their own competence in dealing with individuals who have this diagnosis and reflect on their own feelings about Black clients who have this diagnosis.

2.9 Attribution of causality

2.9.1 Religion and spirituality

People's decision to seek psychological help for their problems, or to support others in doing so, is partly determined by their perception of the aetiology of the problem. This will also influence the extent to which they believe resources for 'recovery' reside within them or are in the hands of forces outside of them. Sue & Sue (1990) referred to this as the "locus of responsibility". Black people are more likely to attribute personal problems to external causes whereas White people are more likely to make internal attributions (Cheatham, Shelton, & Ray, 1987). This has been seen as an indication of the pivotal role of religion and spirituality in the lives of Black people. The historically important function of the Church in Black culture and the spirituality associated with it could well be *"a factor in how Afro-Americans [Black people] perceive mental health, and the aetiology of mental illness and its treatment"* (Miller et al, 1994:6).

An external locus of responsibility for problems is in contrast to the model of psychological distress typically found in the counselling room. Whereas many Black people belong to a religious or spiritual community, many White therapists belong to mainstream society that mostly has a secular culture and is dismissive of the significance of religious forces (Giglio, 1993). This makes it highly possible that White people (including White therapists) may reject religion in their own lives (as is illustrated by the White British psychologist Richard Dawkins' adherence to 'humanism'), and find it difficult to appreciate unconditional commitment to a

religious faith (Lincoln & Mamyia, 1990). This can clash with the typical deference and worship that Black people have for the Church, religion and their own spirituality. Members of a secular community, such as White therapists, are much more likely to make internal attributions for the causes of problems which is consistent with the Western therapeutic models in which they practice. Many Black people attribute significantly more importance to spirituality in causing and treating mental illness than White people (Miller et al, 1994).

2.10. Attitudes toward problem solving

Miller et al's findings are reinforced by research on Black people's approach to problem solving. Religious attitudes or spirituality was the first of four buffers that Black people used to help them cope with stress. The second source of resistance for dealing with stress was religious participation, which provided Black people with much community social support via a sense of belonging, attachment, and social involvement (Leong, Wagner, Tata, 1995: 422). Dressler (1991:215) recognised the contribution of the Church in helping Black religious believers cope with stress:

> "It was very clear that the institution of the Church was essential in supporting the everyday coping of [Black] individuals...The level of commitment to those beliefs was found to be very high indeed in the community...A strong belief in God was seen as a foundation for dealing actively with day-to day problems of the world".

Black people's perception of their own problems are not limited to the narrow psychiatric and medical labels they are given (Waltham Forest User Project, 1995). Black people are capable of conceptualising their problems beyond a purely medical framework. Hence, they are likely to be open to alternative appropriate ways of resolving their issues, such as psychological treatment.

2.11. Implications for counselling

Western counselling typically relies on the therapist convincing his/her clients of the value of the therapeutic model been used in order to help the client deal with his/her problems (Masson, 1989). Therefore the counsellor will probably need to esteem the worldview (way of understanding the client's problem) of his/her therapeutic orientation over that of his/her clients'. This privileging is more distinctive when worldviews are different as is likely to be the case between Black client and White counsellor. Overall, White people and Black people have different original ancestry (European and African respectively) which have different

communication styles (Sue & Sue, 1990) and cultural value preferences. For instance, original European values include individualism, nuclear family structure, notion of time as fixed and future-oriented (Ho, 1987; Katz, 1985; Ibrahim, 1985, Pedersen, 1988; Sue and Sue, 1987), whereas original African values include collectivism, extended family structure, the notion of time as fluid and connection /communication with dead ancestors (Holdstock, 2000; Mbiti, 1970; Nobles, 1972, White, 1984). (See also appendix 1 for Table I on Comparative worldview schematic by Nobles, 1976).

Since the focus of therapy is on the individual, then any attempts to help a client see the benefit of the counsellors' perspective, by implication, is communicating the inadequacy and possibly the pathology of a client's worldview. The experience, or the perception, of having one's views dismissed or marginalised by another person can be demoralising or even painful, especially since worldviews are integral to the person's identity. These feelings can be reduced by withdrawing from situations (e.g. demoralising counselling situations) in which such encounters occur, or avoiding anticipated situations that have the potential for undervaluing one's worldviews. This explains why individuals prefer to interact with people who share their similar core qualities and outlooks (Atkinson et al 1986), and why Black clients may prefer a counsellor ethnically similar to them (Millet, Sullivan, Schwebel & James-Myers, 1994). Although this choice does not totally guarantee that the client's worldview will be respected; as a heuristic, it does reduce the likelihood that the client will feel inferior or snubbed and increases the likelihood that his/her values will be appreciated. Black clients may feel that someone similar to them on key characteristics is more likely to understand their issues from their cultural worldview and, therefore, can formulate their problems in a way that is meaningful to both them and their counsellor (Thomas, 2002). One crude indicator of affinity to similar worldviews is membership of the same ethnic or racial group. For the Black client, a seemingly logical choice would be preference for a counsellor with whom they share the same ethnicity or 'race'.

Although Black people are mostly a spiritual people, they would consider counselling as a viable form of treatment for their problems (Wilson & Francis, 1997). So it is reasonable to reflect on the way in which their spirituality contributes to the therapeutic dynamics, especially in cross-cultural counselling. In the counselling room there can be opposing views to the cause of, and treatment for, emotional distress. A substantial proportion of Black clients are likely to come from a tradition that places the locus of control firmly within the remit of God to give

them the ability to endure emotional distress that is usually undergone against the background of the daily problems of oppression, discrimination and social injustice. The therapist is likely to have been trained in at least one of the three main schools of Western psychotherapy which all share the basic assumption of the autonomy of the individual, internal locus of control, the importance of insight and, though to varying degrees, childhood influences on adulthood (McCleod, 1998). Hence, typical themes in counselling such as intrapsychic problems of guilt and anxiety, defence mechanisms on which, for instance, psychodynamic approach attempts to offer insight, may not be as relevant for Black people as they are for White people (Grier & Cobbs, 1968; Halleck, 1971; Thomas & Sillen, 1972). Like all client, Black individuals would also need to be considered within their wider social context (Owusu-Bempah and Howitt, 2000).

In a counselling situation, where White counsellor and Black client have contrasting conceptualisations of the aetiology and resolutions of emotional distress, there is the potential for both counsellor and client to get frustrated and distrustful. The White counsellor, working within the framework of autonomy and individualism, may believe that the Black client needs to accept more responsibility for his /her problems (Alladin, 1999). The counsellor may directly or indirectly communicate his/her scepticism of the client's motivation to take responsibility to relieve his/her psychological distress. The Black client may feel that the counsellor is neither capable of appreciating what is going on for him/her in his/her world, or even able to grasp the type of restraining circumstances that restrict the Black people's (and hence the client's) autonomy in a society that both the Black client and the White counsellor share. The therapeutic relationship may break down, and result in termination, though this does not necessarily have to be the outcome.

Therapists must be able to effectively marry their (western) therapeutic models, where relevant, with the spiritual perspective of the Black client. For therapy to work in this type of cross-cultural therapeutic dyad, the Black client must trust the White therapist and the problem solving models offered in therapy. Similarly, the therapist must respect the clients' cultural approach to problem solving, and not to ignore spiritual and religious influences on the client's progress. Black therapists, like other Black people in Western societies, straddle at least two cultures: That of the Western culture and that of the culture of their racial ancestors which is steeped in a history of a nation that struggled under the oppressive rule of Western societies. Similarly, during their therapeutic training, Black therapists had been confronted with

theoretical models that ranged from undermining their 'race', challenging their cultural beliefs, to simply ignoring any reference to the Black community or 'the Black experience' (Tinsley-Jones, 1997). Nonetheless, whilst training based on Western values and assumptions about 'normality' may *"offset any gains from ethnic matching"* (Owusu-Bempah, 2002:27), Tinsley-Jones (1997) found that Black therapists had managed to successfully unite Western therapeutic underpinnings with the foundations of their own cultural teachings for the benefit of their Black clients (Christie, 1995; Thomas, 2002). This way of working with Black clients has ingredients that are acceptable and manageable to the Black client, and also ingredients that are recognisable to the therapeutic community.

The counsellor also needs to be aware that there are individual and cultural norms regarding self-disclosure (Wellenkamp, 1995) and the concept of confidentiality (Owusu-Bempah, 2002). For instance, what Western counsellors regard as necessary disclosure from clients, some Black clients might *"believe that self-disclosure is being extorted from them...[and]...resist"* getting involve in the therapeutic process perceiving that *"their cultural beliefs, values and norms...are being violated by the helper"* (Egan, 1998: 138). Similarly, 'confidentiality' to a Western therapist may mean the therapist adhering to professional ethics of privacy of the client's issues from everyone else apart from relevant professionals. Though, such non-divulgence may be interpreted by Black clients as secrecy and exclusion of significant (extended and nuclear) family members who are inseparable from the clients' concept of 'self'.

2.12. Help seeking behaviour amongst Black people

Help-seeking behaviour is a function of two processes: The person appraising certain behaviours or emotions that s/he displays as problematic, and that person actually approaching another person(s) to aid in relief / reduction of such problems (Helms and Richardson, 1997). The concept of a problem and its aetiology varies from culture to culture as illustrated by indigenous psychologies approach (Kim & Berry, 1993). Hence, there will be a discrepancy between the amount of people that need help with psychological problems and the amount of people that actually seek professional psychological help (Leong, Wagner, Tata, 1995). On this premise, it could be expected that such variations would manifest themselves in differences in seeking help amongst different ethnic groups.

Most individuals usually make use of both their informal network of helpers and professional helpers for their personal problems (Brown, 1978). Many Black people who seek professional psychological help see it as additional to their spiritual guidance, not instead of it, so counsellors need to be mindful of this when working with such clients. Whilst many Black people may not share all of the dominant culture's concepts of mental illness, some of them do have similar positive attitudes as the dominant culture toward seeking psychological help (Hall and Tucker, 1985). However, they present themselves for professional help comparatively late after onset of distress. This delay in seeking help has been explained as being due to Black people's suspicion of statutory helping agencies in Britain (Lloyd & Moodley, 1992; Waltham Forest User Project, 1995).

The sad paradox is that many Black people's fear and suspicion of statutory services, including psychological services, acts as a barrier (Sussman, Robins & Earls, 1987) to the very help of which they are in serious need. Contributory factors include Black people's own negative experiences of mental health services, and observations, of the way other Black people have been treated by professionals in the mental health field (Wilson and Francis, 1997), examples of which were illustrated above (sections 2.4.5 & 2.4.6). Snowden & Cheung (1990) identify abuse of Black people in psychiatric services as a realistic fear experienced by the Black community. After all, there is a discrepancy between the higher rates amongst Black people than those amongst White people in terms of psychiatric hospitalisation, and diagnoses for certain mental illnesses (especially schizophrenia). Since a diagnosis of schizophrenia invariably acts as an 'automatic pathway' to hospitalisation (Burnett et al, 1999), and there are higher rates of 'death by misadventure' for Black people in psychiatric institutions (especially Black men), understandably, Black people are extremely cautious about seeking help from such institutions.

2.13. Within group differences amongst the Black community

Whilst studies have presented the profile of 'the Black experience' as if Black people were a homogenous group, it is recognised that this is done within the context of the research samples employed and the (limited) extent to which their results can be used to generalise to certain groups of the Black community. There are many variations within the Black community e.g. perceptions of what constitutes a problem, type of, and access to, support, attitudes towards seeking psychological help (Boyd-Franklin, 1989; Leong, Wagner,& Tata, 1995). In addition,

there are within group differences in degrees of cultural mistrust (Terrell & Terrell, 1981, 1984); variations in self-disclosure in counselling (Ridley, 1989); preference for an ethnically similar counsellor (Helms, 1990); and differences in racial identity attitudes (Cross, 1971, 1991). Merta, Ponterotto & Brown, (1992) stress, *"Researchers in cross-cultural counselling need to place greater emphasis on within group differences among the culturally different".*

As with every racial community, there are many different aspects of personhood amongst the Black community, which vary culturally (Owusu-Bempah and Howitt, 1999:126). Although all Black people are of African descent, they do not necessarily all have the same group identity. For a start, their immediate relatives may not all come from African or even the same Caribbean island. Indeed, many Black people in Britain come from South America and even within that part there are different Black identities (e.g. 'Dutch Guyanese', 'British Guyanese'). Many theories and models about Black people are made too global. Cross's notion of 'Shades of Black' recognises that not only are there variations between Black people in terms of the hue of their skin tone, but also in terms of their self-concept. In this case, it is problematic to use the concept of 'Black identity' as if reference is being made to a single group identity that encompasses all Black people. There is no *one* theory that can describe *all* Black people. Hence, it makes more sense to appreciate different types of Black identity on a spectrum. The different experiences that each Black person has had will also add to the various identities to be found amongst Black people resulting in them having different relations with other Black and White people.

2.13.1 Differences in acculturation and individualistic tendencies amongst the Black community

Just like in other ethnic minority groups, there are various levels of acculturation within the Black community, which contributes to its individual members' personal identity. Therefore, despite the variations in the concepts of personhood amongst Black people that have been established by their culture of origin (i.e. of African and Caribbean descent), the Black person's identity must also be understood within the context of a Black person interacting and surviving in a Western society. Black people will assimilate some of the values of the dominant culture and some Black individuals will assimilate more than others. For instance, many Black people still have tight bonds with their country of origin, visit it regularly, and many intend to re-settle there (Banks, 1999). Daily activities expose Black people to the values of the majority

society. Since individualism underpins British society, even if Black people do not assimilate any other values, it is very difficult for them to exist in British society and resist cultivating some components of this pervasive Western value. If nothing else, because of its dominance, they will need it to survive in Western society. This will have implications for the Black person's selfhood, especially for those Black people who have immigrated to Britain. Their original self-identity may be modified as it comes into contact with Western concepts of the self, so that their notion of the self shifts closer to the Western notion of personhood.

For many of the Black individuals who were born in Britain, whilst their self-identity has some remnants from their African ancestry, a large part, if not all, of it will be framed within an individualistic perspective. Since many Black people born in Britain identify themselves as British (Tizard and Phoenix, 1993), it is only natural that they have individualistic tendencies, unless they have been nurtured and educated in an environment that has successfully transmitted core African (or non-Western) values. Counselling practice is based on models that rely on Western principles, especially individualism. It is *because* of shifts in some Black people's identity, and *because* there are Black people whose current self-concept overlaps with individualistic principles, that there is the potential to meaningfully apply Western counselling methods (i.e. based on individualism), that incorporate these individuals' concept of personhood. That is, whilst there are Black individuals in Britain for whom the ideology of the self is very different (and even contradictory) to the portrayal of self that is based on Western principles, there are also Black individuals whose notion of personhood can accommodate these Western principles. This has implications for counselling, since the degree of acculturation could be a function of whether an ethnic minority person approaches a White counsellor. Ethnic minority individuals who are highly acculturated are more likely to seek out a Western style (typically White) counsellor, than those who are less acculturated e.g. have a collectivist worldview (Korsgaard, 1990). It is these former individuals who would probably gain the most benefit from a therapeutic method based on individualism, and it is these individuals for whom this thesis is most germane.

2.14 Differences in racial identity attitudes

> *"We, Black people, express a wide range of opinions on what it means, existentially speaking, to be Black"* (Cross, 2001: 35).

2.14.1 General overview of Black Racial Identity Theories

The psychological concept of identity is essential to human psychosocial development and functioning (Bem, 1974; Erickson, 1971). One aspect of identity is racial identity. It is the intensity and quality of a person's commitment to his/her socially ascribed racial group (Helms, 1986). This dimension of identity has different degrees of importance for, and within, the various ethnic and racial groups. These attitudes determine Black individuals' levels of trust towards either an ethnically similar or ethnically dissimilar counsellor as well as their degree of disclosure in counselling. On the whole, because of their identity as culturally different and salient communities in industrialized societies such as Europe and America, ethnic minorities' (different) racial identity is emphasised (Brown, 2000; Gorell-Barnes, 2002; Owusu-Bempah & Howitt, 1999; Owusu-Bempah & Howitt, 2000; Phoenix, 1993; Root, 1992). Earlier research set out to demonstrate the psychological effects of segregation, oppression and racism on Black identity (Clark and Clark, 1939; Fanon, 1967). The contribution of identity theorists such as Erikson's classical work stems from his acknowledgement of the evolution of other racial identities apart from a White identity as a necessary developmental task for members from other ethnic groups (Erikson, 1965). Indeed, process models devised by Black psychologists that presented a Black development perspective were addressed as early as 1968 (e.g. Pinderhughes, 1968).

Extensions of Erikson's conceptual framework of stages is exemplified in generic models of ethnic minority racial identity (Atkinson, Morten and Sue, 1983; Phinney, 1989); White racial identity (Helms, 1990); and Black racial identity (Cross, (1971; Helms, 1990; Jackson, 1975; Thomas, 1971). Similarly to Erikson's theory, usually in the theories of Nigrescence (Cross, 1971) there is at least one major task or experience in each stage that the individual has to resolve or reconcile with his/her current self-perception. This is illustrated by Cross (1995:980), who writes: *"Nigrescence is a model of a resocialising* experience *that explains how assimilated as well as deracinated, deculturalised, or miseducated adolescents or Black adults are transformed by a series of circumstances and events, into persons who are more Black or Afrocentrically aligned"*. A 'deracinated' person is someone *"who views being Black as an obstacle: A problem that is associated with social stigma and social discrimination. It is*

seldom a symbol of culture, tradition or struggle" (Cross, Parham & Helms 1990: 322), and never pride.

Following the originator, Cross (1971), Nigrescence models *"describe the different ways (conceptualized as stages) in which Black people resolve the identity issues caused by their need to function in a racist society"* (Helms, 1986:62), by gauging a Black person's collective awareness around issues of culture and 'race'. Whilst there are a variety of models on Black racial identity within the field of counselling psychology [e.g. Jackson's (1975), four stage model; Thomas's (1971) six stage '*negrommachy*' model)], Cross's *'Nigrescence'* models have been most developed and applied to deal with issues facing counselling psychologists. Cross stated that his model extends beyond *"race consciousness"*, to *"one of race and culture consciousness because...'race' was only part of the issue. More important was a Black person's consciousness of Black culture"* (Cross, 2001: 35). Nigrescence models that aim to delineate core aspects of psychological experience by appreciating that *"race [is] as much an existential as a physical reality"* (Cross 2001: 35) share the same aim as therapists. They set out to understand the contribution that different values attributed to 'race' by Black people in Western societies have towards their' perception of themselves, of others, and how they will interact with other individuals who either share their 'race' (e.g. Black counsellors) or are racially dissimilar to them (e.g. White counsellors). Cross's models are also attractive to therapists because they argue that racial identity attitudes can be predictive of psychological functioning. Similarly, reviews of Nigrescence research (Cross, 1991; Cross, Parham & Helms, 1995; Helms, 1990) that tested Cross's (1971; 1978) model found empirical support for his prediction about the relationship between racial identity and psychological functioning (Carter, 1991; Parham & Helms, 1985). It has been possible to empirically test Cross's model mostly because of racial identity attitudes instruments created by Helms (especially the 'RIAS', which will be described and evaluated in chapter 5).

2.14.2. Description of the Black racial Identity stages

The essence of Nigrescence Process models *"is not the change process per se but an analysis of the identity to be changed"* (Cross, Parham & Helms 1990: 322). Cross described a psychological process whereby the Black person moves from not much love of his/her 'race' to a love and a pride in it, and then an appreciation of difference in all 'races'. According to Cross (1971) there are 5 racial identity attitude stages that a Black person can potentially experience (Pre-encounter; Encounter, Immersion-Emersion, Internalization, Internalization-

Commitment, though only the first 4 are normally referred to). Black people can be clustered into different racial identity stages according to their common underlying attitudes on 'race', though there are also within stage divergence (Cross, 1991).

2.14.2.1 *Pre-encounter stage:* Black individuals in this stage are united by the lack of significance they give to the Black 'race' as part of their core identity. There are Pre-Encounter individuals who do not attribute much importance to racial identity and are able to find other outlets apart from 'race' to enhance a psychologically healthy identity and achieve self-actualisation. There are also other Pre-Encounter individuals who have an anti-Black attitude, which can accompany dysfunctional psychological elements such as self-loathing and low self-esteem.

2.14.2.2 *Encounter stage* has the effect of raising Black individuals' self-awareness (especially those with an anti-Black attitude in the Pre-encounter stage) about their 'Blackness', though the experiences by which this is achieved vary amongst individuals. For some Black people the 'encounter(s)' that makes a difference to their racial identity attitudes may be a negative experience such as being the recipient of a significant racial act on top of daily cumulative racism by White people, whereas for others it may be a positive experience. This could include an important or momentous cultural experience, such as visiting Africa, or a spiritual or awe-inspiring process gained by attendance at a rally related to racial issues [e.g. as was the case for Malcolm X and Martin Luther King Jnr (Reicher, 1999)]. Though these experiences are varied, due to their personal significance to the Black individual, they all have the effect of raising the Black person's racial consciousness and of making him/her want to be more affiliated to their racial group.

2.14.2.3 Immersion-Emersion More so for the anti-Black Pre-encounter individual than the 'race'-neutral attitude Pre-encounter individual; as a consequence of the 'encounter(s)', there is the realisation of the unfairness of a society that s/he has idealised and this provides a rude awakening for the Black individual. S/He reacts to this disillusionment by taking on an extreme perspective, which is almost a reversal of the attitude s/he had in the Pre-encounter stage and is reflected in his/her ostentatious behaviour (i.e. what s/he perceives to be 'Black' behaviour). Hence, attitudes in this stage are polarised in terms of pro-Black and anti-White (Fischer, Tokar & Serna, 1998), especially in the first part of this stage, the Immersion phase. Towards the end of the Immersion phase, the Black individual realises that every experience cannot be

understood exclusively in terms of 'Black and White'. This marks the end of the Immersion era and prepares the way for the Emersion phase of this stage, during which the individual begins to become aware that there are more subtle aspects to being Black.

2.14.2.4 Internalization.

Racially, Black people's attitudes in this stage have what Erikson would refer to as '*Achieved identity'* (Erickson, 1971). Their new identity that was beginning to form in the Emersion part of the Immersion-Emersion stage is becoming established and effectively integrated into their overall self-concept and worldview. The Black person is not so preoccupied exclusively with Black values, but shifts towards a 'multi-cultural perspective', so that her/his racial identity is integrated with other identities (e.g. religion, gender, career, class and role orientation) (Cross, 1991).

In the Internalization stage, the Black individual is now at ease with his/her Black identity (Cross, Parham, & Helms, 1990). It is a stage where there *is "resolution of the conflicts between the 'old' and 'new' worldview"* (Cross, Parham, & Helms, 1990:326). This results in a self-confident Black identity perspective from which the Black individual feels secure enough to take an interest in, and even have some preferences for, non-Black cultures (Fischer, Tokar & Serna, 1998). *"While still using Black people and culture as a primary reference, the person moves towards a pluralistic and non-racist perspective, although relationships are negotiated from a position of strength rather than weakness"* (Cross, Parham, & Helms, 1990:326). During this process in the Internalization stage, the Black person is now able to recognise that good and bad can exists in both racial groups, is able to again engage with, or renegotiate, friendships with White associates.

There is an appreciation of his/her 'bi-cultural identity structure' (Cross, 1971; Jackson, 1976) in which the Black person recognises that s/he lives in "*two material and cultural realities; realities which at times are quite distinctive and at other moments are so interwoven as to give the appearance of a common fabric...the ubiquitous twoness found in all Black psyches"* (where Black people live in a Western host culture) (Jackson, 1976: 42, in Cross, Parham, & Helms, 1990:327). Whilst Black British individuals in this stage are very much aware of their own Blackness, they are also able to identify with aspects of the British culture that they find acceptable (e.g. material possessions, financial security, independence), and oppose aspects that are venomous (intolerance of diversity and oppression e.g. racism, sexism, colonialism).

The person is Black oriented but can comfortably engage with non-Black cultures and systems beyond Blackness. Due to their deep exploration of themselves and those around them, *"they are likely to understand people as reflections of systems and personal experiences, and less so as clusters of every distinct racial groups"* (Cross, Parham, & Helms, 1990:330). By the time they have arrived at the Internalization stage, Black individuals would have undergone their identity change, so at this stage the most change "*occurs within the person's worldview, value system, ideology or reference group and not the general personality or personal identity component of the self concept"* (Cross & Fhagen-Smith, 1995:112). Though there is likely to be much ideological diversity amongst individuals in this stage.

Although the stages can form a continuous linear progression, which is indicated by the overtones of one stage to the next, each stage can also be appreciated as a worldview in its own right (Cross et al, 1990). They are more than just ephemeral ancillary stages, or *'diaphanous and evanescent'* personalities (Cross et al, 1990) whose main function is to provide one of the stepping-stones for the end product: Internalization racial identity attitudes. If the attitudes an individual holds in a particular racial identity stage are not causing him/her any psychological tension (e.g. the 'race'-neutral attitudes Pre-encounter Black individual), then s/he is unlikely to search for another racial identity worldview. It is only if a Black individual's attitudes towards her/his 'race' trouble her/him to the extent that s/he feels 'something' (though s/he may not be able to articulate it) is making him/her uncomfortable with her/his perception about her/his 'race', will that person become open-minded to starting a journey of racial discovery. Even though many Black individuals may 'pass' through the different stages at various paces and achieve 'ultimate' Black racial identity, they may revisit stages at different points in their lifespan development ('recycling' of stages; Parham, 1989). Each time individuals revisit a stage, they do so with the hindsight of additional experiences, which gives them a different perspective of that stage. Therefore, revisiting can result in individuals adjusting their racial identity attitudes to fit in with their current life cycle issues. Depending on the issues, this can result in considerable, or little, modification to the individual's core racial identity.

2.15 Racial identity attitudes and the therapeutic process

Counsellors would need to be sensitive, if not cautious, as to how they broach connections between the Black client's racial identity attitudes and their psychological problems, especially if racial identity is genuinely not an issue for the Back client. It would also be useful for

counsellors to bear in mind that although some links have been made between racial identity attitudes and psychological well-being, a persons racial identity attitudes does not exclusively establish her/his level of psychological functioning. It is the *ideology* that distinguishes the stages. This is why the stages can be considered as worldviews in their own right. However, with regards to Black racial identity, the stages can also be considered as indicating various degrees of 'enlightenment' or advancement in racial consciousness, since the Nigrescence model is a conversion model. *"It describes the ways in which a person may come to hold a different worldview from the one they hold, and the condition under which the new perspective may be maintained over time"* (Owusu-Bempah and Howitt, 2000:137). Nevertheless, this does not mean that advancement in Black racial identity is to be seen as a direct function of increased mental health. It is possible for an individual in the least advanced stage of Black racial identity (Pre-encounter) to have a higher level of psychological well being than an individual in the most advanced stage of Black racial identity (Internalization), or vice versa. Similarly, it is also possible for them to have the same level of psychological functioning. *"The key factors that separate Pre-Encounter Blacks from those who are Afrocentric are not mental illness, but value orientation, historical perspective and worldview"* (Cross & Fhagen-Smith, 1996:104; underline added). Hence, counsellors need to be careful about assuming that for Black clients who do not give a lot of attention to the significance of 'race' as their core identity, that part of their emotional distress was caused by their denial, or lack, of interest in their racial group.

2.16 Adapting Nigrescence as a therapeutic intervention

Although there are limitations with the concept of Nigrescence as a model of psychological development (Owusu-Bempah and Howitt, 2000), it can be used effectively as an intervention if the emphasis is kept on its function as a model of politicised Blackness, in which the Black individual appraises his/her negative racist experiences, and responds in light of those appraisals. Due to its leanings to a more individualistic notion of selfhood, than a collectivist framework, its approach is in keeping with the individualistic perspective of most of Western counselling that takes place in Britain. Hence, it would be relevant for those Black people who have an individualistic outlook. In addition, the Nigrescence model does not present racism as a process that totally annihilates the Black person's self-esteem or his/her personhood. In fact, the appraisal process with which the Black individual engages, in relation to the racism s/he experiences, has the potential to strengthen his/her resilience to such experiences. This has

parallels with the concept of individual *hardiness* which was originally developed by existential psychologists (e.g. Kobasa & Maddi, 1977) to explain why stressful life events did not appear to correlate with greater incidence of illness or debilitation for some individuals, whereas others appeared to suffer ill effects (Berk 1991).

Racism is a stressful life event (Ferrell, 1995), though the majority of individuals who are victims of it do manage to survive in the face of this adversity (Owusu-Bempah and Howitt, 1999). However, this does not always happen and it may be that the role of the counsellor is to cultivate more adaptive coping strategies in Black people to help them deal with racism. This would fit in with the general counselling models such as cognitive therapy, which aims to help the client deal with situations by developing adaptive problem solving strategies. The way in which the individual is stated to appraise and re-appraise the racist experiences s/he encounters in the Nigrescence model is not that dissimilar to the notion of cognitive evaluation or interpretation in cognitive behavioural counselling (Trower, Casey and Dryden, 1988).

Nigrescence theory has indicated that Black individuals appraise and re-appraise their racist surroundings, and also that the different racial identity stage in which the person can be located will determine how s/her reacts to racism. According to Nigrescence theory, the later stages indicate that the Black person has become more 'politically Black'. Similarly, the Black person could be seen to have developed more effective and adaptive coping mechanisms as they progress through the stages. Having some knowledge of the stage that the client was in may give the counsellor some indication as to the type of skills the Black person has developed in response to racism. For instance, a person in the immersion part of the immersion-emersion stage may deal with experiences of racism by completely aligning him/herself with Black groups and with the aim of avoiding contact with White people. This may not be a realistic strategy since, in a society dominated by White people, it would be more or less impossible to avoid interaction with them.

The counsellor may start with helping the client recognise triggers (such as his/her internal processes) that indicate what cognitive therapists refer to as 'all-or-nothing' thinking. Further therapeutic work could involve helping the client to evaluate the incident of racism, and then looking at adaptive coping strategies to deal with future incidences. Whilst this would be obviously helpful for individuals who have a repertoire of maladaptive coping strategies, it would also be of benefit to individuals who need to consolidate their useful coping skills. It

must be emphasised that this in is *no way* condoning racism or the client's acceptance of racism, but a way of empowering him/her so that s/he can deal with the experience of racism in a more adaptive way. In addition, the counsellor would be expected to acknowledge that the client is living in a racist society and, as suggested by Owusu-Bempah and Howitt (2000) should *"focus simultaneously on both the client and the social structure*...[so that the counsellor] *works ultimately towards social change"* (p24). This focus on both the 'abused' (victim of racism) and the abuser (the system in society that perpetrates racism) is similar to the strategies suggested by other psychologists (e.g. Reicher, 1999).

2.17 British Studies on Black Racial Identity

Whilst Cross's racial identity theory has been frequently quoted in British psychological literature (e.g. Alladin, 1993; Banks, 1999; Owusu-Bempah & Howitt, 2000; Patel et al, 2000), there has been a paucity of studies that have actually conducted empirical research using his model. A study by Ferrell that looked at racial identity attitudes and their relationship to psychological well-being reported a partial relationship between these two variables. Ferrell's study is relevant here because it used a Black-British non-clinical general sample and also because it made use of an instrument ('RIAS') that is based on Cross's model. The RIAS attempts to understand Black racial identity issues from the perspective of within group differences amongst Black people. Ferrell's research was designed on the assumption that the psychometric properties of this American devised racial identity instrument was maintained with a British sample. Ferrell clearly acknowledged reported limitations of the instrument by American studies, though focused on her aim to investigate the status of Black people's psychological well-being, and any relationship this had with their racial identity attitudes.

Although she commented on the psychometric properties of the two scales of psychological well-being (the GHQ and a life events measure) used in her study and their reported norms for a 'British' (White) population, Ferrell missed an opportunity to produce a much needed British evaluation of the psychometric properties of the RIAS's reliability. This is particularly pertinent, since her research is one of a few, if not the only, available British studies that used a psychometric measure of racial identity, albeit an American measure, and this instrument has not been standardised using a British sample. Ferrell acknowledged that the *" number of correlations that were carried out in this [her] study increased the possibility that some of the significant results may have occurred by chance".* If it is the case that some of the results

could have been due to Type 1 error, then again this would indicate the relevance of some type of consideration of the application of an American instrument to a British sample, as meriting investigation in its own right. Though, it must be recognised that Ferrell goes on to say *"However, the relationships that were found to exist, generally supported racial identity development theory"* (Ferrell, 1995).

2.18 Implications for current study

The main implication for the relationship between ethnic matching and premature termination in counselling is the claim that the stage of a Black client's racial identity attitudes could give some indication as to whether s/he had a preference for a racially similar counsellor (Cross, 1991; Helms, 1990). In addition, by responding to this preference when it was revealed, therapists and service providers could noticeably reduce attrition rates of Black clients in therapy compared to when Black clients with a preference for a racially similar counsellor were not ethnically matched. If there were early indications in therapy that a client may prefer a racially similar counsellor, then this could be discussed with the client and an appropriate referral made. Research has shown that there are Black people who have stated that they are receptive to a White counsellor who is able to demonstrate cultural sensitivity. It may be that by the counsellor simply addressing the topic of 'race' when it appears to be an issue in counselling, this could reassure the Black client that the (White) counsellor is able to be sensitive and hence receptive to the client's 'race'-related issues.

2.19 Relevance to counselling

The White counsellor needs to be prepared that, whilst many of their Black clients have experienced racism, and this is likely to affect their approach to entering into a therapeutic relationship with a White counsellor, there will also be individual differences that influence how clients engage with the therapeutic process. Hence, the counsellor must not assume that all clients are the same, or that their problems are rooted in similar causes. There is a need for the counsellor to wait for the client to bring up any experiences of racism that they feel have contributed to their emotional distress, to reduce the possibility of collusion with the client and letting issues of racism get in the way of discussing the clients real intrapsychic issues (Alladin, 1994; Kareem, 1992). The relevance of the Nigrescence model to counselling has already been discussed

2.20. Appreciating 'race' along the diversity continuum: Similarity of 'the Black experience' with other marginalized groups in society

Although this thesis focuses on the role of 'race' in counselling, it can also be placed along a continuum with other discourses that consider the impact of diversity on the therapeutic process, where both therapist and client have to negotiate their differences. Pedersen states that multiculturalism should also recognise that each person is unique from the next, and probably all therapists would to various degrees agree with this (Pedersen, 1995). However, some groups do have common experiences because they have some characteristics which are core to their identity, which has led to them being discriminated against in society. Black people share experiences of marginalization with such groups because their features in some way depart from the characteristics of the archetypal '*average* middle-class White male'. These groups include gay and lesbians (Milton, 2000); women (Gilbert and Scher, 1999; Mama, 1995; Maynard, 1994); refugees (Veer, 1998).

Whilst, not all the material in this thesis will apply to issues of difference such as sexual orientation, gender, age, body size, disability, refugee status, religion and class, there are overlaps and parallels can be found between some of the material on, for example, racial identity and other core identities, or ethnic matching and other types of matching. Nevertheless, although the focus is on racial identity, this does not mean that a Black person's identity could not incorporate any, or even all, of the other areas of difference. 'Race' is just one of the features of a person's identity. For instance, the Black person also has a gender identity, is of a particular age and may be disabled. It is a matter of which identity is of importance to the person's notion of self, so even though a person is Black, of more importance may be his sexual orientation as was demonstrated in Johnson's (1981), research on Gay Black men. Similarly to Black people, the role of power in therapy (Masson, 1989) for oppressed groups is likely to be a key feature (even though it may never be acknowledged by either party) in the therapeutic process. Similar to the experience of being Black, the therapeutic relevance of the experiences of other marginalized groups lends itself to a wider debate e.g. the extent to which counsellors should share the experiences of their clients before they can be said to be able to empathise with their clients e.g. rape victims, victims of torture, discrimination because of one's sexual orientation, gender or racial group.

2.21. Similarities between Black and White people

Like other ethnic groups, Black people struggle with problems apart from those on a racial level. There is the typical 'battle of the sexes' (Hall, 1992; Mama, 1995) that are also found in other ethnic groups. To focus Black people's issues exclusively around 'us and them' (White versus Black) dichotomy would be to oversimplify the oppression that Black women experience with both the White society and Black men (Mama, 1995), which is comparable to the discrimination that White women experience in White society (Gilbert and Scher, 1999). Other within group differences amongst White individuals, such as class differences, can also be found in the Black community (Boyd-Franklin, 1989), just like differences in the perception of the importance of one's 'race' for both Black people (Cross, 2000) and White people (e.g. Gambo, Tosi & Riccio, 1976; Helms, 1990; Proctor and Rosen). Generational issues and boundaries as faced in the White community, are also experienced in the Black community, as are issues of childrearing and discipline. There are similar individual problems that both Black and White clients wish to sort out intrapsychically (e.g. bereavement, work and career issues, growth and development); Black people also want help with relationship concerns as a couple (e.g. relationship therapy; marriage or couple therapy), or with other family members (family or systemic therapy, Boyd-Franklin, 1989). Similar to other ethnic groups, including White people, Black people need counselling for vocational, educational problems (Webster & Fretz, 1978), and advice for practical problems (e.g. administration, legal problems, social services agencies and schools, Woods & Sherrets, 1984).

Whilst there are indeed differences in help-seeking behaviour between Black people and White people, it must not be assumed that this is always the case. Cheatham, Shelton & Ray (1987) did not find a significant relationship between causal attribution and help-seeking behaviour amongst either Black or White students. Whilst aware that many Black people may attribute different causes to psychological problems, psychologists must also realise that similarly to White people, Black people's help-seeking behaviour may at times not be related to their perception of their problems. This would mean that the typical therapeutic intervention of exploration, in order to help clients gain insight into their problems and processes that maintain them, can be equally as relevant and effective for Black clients as it is for White clients.

2.22. Black people can benefit from counselling

Black people's psychological problems include those dealt with on a daily basis in mainstream counselling e.g. depression, anxiety, low self-esteem, though Black people may be affected by a more severe form of such emotional disorders. Black British women's scores on the GHQ revealed that they had disproportionately high levels of clinical depression. Ferrell states,

> "The wider implications of this for Black women and the Black community are potentially worrying. For example, studies have shown that children being cared for by depressed mothers may experience low self-esteem (Goodman et al, 1994), behavioural problems (Alpern & Lyons, 1993) and anxiety (Politano et al, 1992)" (Ferrell, 1995: 18).

However, such differences in severity is under-reported, which may be due to the fact that Black people are more likely than their White counterparts to present depressive like states via somatic complaints (Burke, 1984; Sham et al, 1996). The Black community prides itself on being the nation that has survived adversity and continual oppression (Boyd-Franklin, 1989). Hence, whilst physical complaints are acceptable, disclosure of melancholy is usually trivialised and seen as succumbing to the weakness of having too much time on the sufferer's hands. A typical stereotype is 'the strong Black woman' (Mama, 1995). The danger is that such presentations may lead clinicians to underestimate Black people's psychological needs but perceive them to be related to the physical complaints and hence assume that they will resolve once the physical needs have been met. On this basis, many Black people's emotional distress may be seen by medical practitioners as not needing specific attention or may even be ignored. This may also explain why there is a lower diagnostic rate of depression for Black people than White people.

The problem becomes more complex if a Black person's psychological dis-ease is configured by a practitioner as mainly a symptom of her/his presenting *physical* discomfort. By conceptualising mental distress in this way, there is little opportunity to explore the negative psychological impact that unmet social and cultural needs have had on the Black person's emotional suffering. When individuals' needs are ignored or dismissed, this can leave them feeling rejected and not been heard. Such feelings can contribute to emotional distress. By extension, the likelihood of mental distress for Black people can be increased by others' dismissal of the importance of their social and cultural needs. In addition, political, economic and social inequalities experienced by Black people such as racism, poverty, unemployment and substandard housing exacerbate, if not cause, mental illness (Fernando, 1995). Counselling benefits individuals with psychological and emotional issues that have arisen from intra-

personal experiences of rejection and disempowerment. This adds further support to the argument that many Black people with mental distress would also benefit from appropriate counselling.

Whilst Black people may experience some disturbing incidents that are different from those experienced by White people, they also experience similar problems (e.g. psychosis, Ridley, 1989). Black people's responses to their experiences more or less manifest themselves in the types of mental distress similar to those displayed by other ethnic groups (e.g. depression, low self-esteem, schizophrenia), which have been found to be responsive to therapy and counselling (Basco, 2001; Blackburn & Moorhead 2001; Mooney & Padesky 2000; Persons, & Bertagnolli, 1999; Persons & Valus, 2001; Tarrier et al, 2000; Young, 1990). Hence, Black people's emotional distress is of the type that would benefit from psychological interventions. Yet, unlike the host culture, Black people do not seem to be able to readily access treatment, such as psychotherapy / counselling, that have been found to be effective for relieving mental health problems. Christie expresses this view:

> "It is clear that different types of treatment can be helpful at different times and to different people, but the experience of African-Caribbean patients seems to indicate a bias towards the use of drugs rather than other treatments" (Christie, 1995:17).

It could be argued that with such racism and discrimination in Britain, may be what Black people 'really' need is to live in a non-racist society, rather than receive counselling. Apart from the idealist nature of this utopia, if not pure fantasy, such an argument ignores the fact that racism is by no means the only cause of psychological distress for Black people. Mental illness is a universal human condition. It affects every 'race'. Racism is an additional variable in that complex equation for Black people surviving in Western societies. Besides, Black people somehow manage to cope with this daily occurrence. This thesis is not arguing that racism is the only negative psychological experience that Black people have, or that the experience of racism is the aetiology of all Black people's problems, though under certain conditions it can have psychologically devastating effects for certain Black people. Racism can affect Black people, just as for example, sexism affects women, 'ableism' affects disabled people and ageism affects elderly people and other types of discrimination or exclusion affects people. The common thread amongst all these groups is that they have visible differences to those powerful sections of society, which in many situations, though not exclusively, can be the foundation on which other individuals in power build their opinions, are judgemental, and also prejudicial to the disadvantage of such groups.

I am arguing emphatically in this thesis that Black people ***do*** have the similar basic emotional and psychological needs as White people. However, as the above material has shown, throughout history Black people have always been treated badly by those in power because of their colour (Williams, 1949).

Ridley (1989) outlines the bleak picture for Black people in mental health system in Western societies compared to White people:

> "Consider the following adverse outcomes in counselling and other mental health services: compared to White clients, ethnic minority clients are more likely to receive inaccurate diagnosis; be assigned to junior professionals, paraprofessionals or non-professionals rather than senior professionals; receive low-cost, less preferred treatment consisting of minimal contact, medication, or custodial care rather than individual psychotherapy, be disproportionately represented in mental health facilities, show a much higher rate of premature termination; and have more unfavourable impressions regarding treatment" (p55).

Browne (1997) has also reported similar findings. It is this treatment that renders Black people more likely to be faced with more frustrations, defeats and conflicts on a daily basis in Western societies than White people (Owusu-Bempah & Howitt, 1994; 1999; 2000). Even at the very practical level, junior staff may not be in a position (either in terms of status, professional experience, required knowledge or training) to generally refer clients to counselling.

2.23 Conclusion

The above material on the experiences of Black people in Britain clearly indicates that one of the major contributors to their current difficulties is racial discrimination perpetrated especially by those people powerful in socio-economic structures, but, unfortunately, also those in the discipline of psychology (Owusu-Bempah and Howitt, 1999; 2000, Phoenix, 1999; Reicher, 1999), and the delivery of its services such as counselling and therapy (Banks, 1999). For instance, the nature in which the majority of Western counselling is practiced, i.e. at the intra-psychic level, means that the resources for psychological recovery are seen to reside within the individual. By implication, if the solution lies with the individual, then the aetiology of part (if not all) of the problem is located within the Black client. This can be damaging to the personhood of the client since the communication is that 'the problem is your fault' and does not recognise the major part played by society's economic and social structures. Owusu-Bempah & Howitt (1999, 2000) argue that this type of victim blaming functions to absolve the counsellor from dealing with the problem at the macro level (racism), yet seems to chip away at the Black person's self-identity or personhood.

Whilst this chapter has highlighted some of the stark differences between Black people and White people, it has acknowledged that there are also similarities between the two groups, for instance in terms of gender issues and the similarities in basic psychological needs, and that is why Black people would benefit from counselling. Ridley (1989) indicated that many White helping professionals are ignorant of the cultural aspects and individual differences in help seeking behaviour amongst Black people who need psychological help. Therefore, it is important that, whilst counsellors bear in mind that although 'Black clients' may be united by some similar experiences, they are not a homogenous group. For instance, there are within group differences with regards to cultural trust, self-disclosure and racial identity attitudes. Until recently, there has been hardly any empirical attention paid to whether there is a genuine difference between the outcome of counselling for Black clients and White clients. Similarly, little consideration has been given to whether Black people have specific therapeutic needs that are different to those required by White people, such as the need for an ethnically similar counsellor.

Lack of material, including evidence-based practice, has made it difficult to dismiss claims about the inappropriateness of therapy for Black people as mythical or anecdotal. The large presence of Black people in Britain (Census, 2002), and their experiences that render many of them potentially vulnerable to psychological distress (caused, for example, by social issues, Fernando, 1995) makes it almost inevitable that at some point in their career counselling psychologists will come across Black people. Many White counsellors are keen to work with Black clients, but are, rightfully, cautious about practicing beyond their competencies. Therefore, counsellors must be adequately trained to work with Black clients, and it is essential to conduct research that provides more insight into the psychological needs of Black individuals (Sue, 2000).

PART II

EMPIRICAL STUDIES

"Today everybody and their mother are talking about 'Afrocentricity'. But Hamsberry [first Black female playwright to have a work staged on Broadway])was writing about it long before it became fashionable ('Hell no, don't call me no African! I'm a Negro, I'm colored etc, etc.' We all heard that numerous times). For me, the brilliance of 'Raisin' [in the Sun' – the play] is the examination of the [Black family]. And we all have to ask ourselves, have things gotten any better than when the play was written [1950s]? I have to say I think they've gotten worse".

(Spike Lee, 2001)

Chapter 3: Study Group 1 ('SG1') Ethnic matching and counsellor preference

3.1 Introduction

Box 3.1. SG1 Research Link

This is the first of 3 studies that attempts to provide an insight into components that contribute to the complex question of the impact of 'race' on the outcome of counselling. One major piece of the jigsaw is whether the 'race' of the counsellor is a significant determining variable in Black British clients' decision to engage with the counselling process. This study (SG1) approaches this research question by asking former and 'potential' Black clients about their preference for a counsellor of the same racial or ethnic background as themselves.

3.1.1 Difference between counsellor and client as an issue in counselling

Therapists who are significantly different from their clients have the most difficulty with effective constructive exploration with those clients (Carkhuff & Pierce, 1967). Since each therapeutic encounter is ultimately unique, 'difference' per se between client and counsellor is not necessarily an insurmountable factor – it is how that difference is perceived. This perception impacts significantly on the therapeutic process. Counsellor and client characteristics may be viewed by either or both parties as too divergent, and the differences between them may act as a distraction that prevents effective therapy taking place, or even result in a harmful process. For another therapeutic dyad, diversity between therapist and client is highlighted, yet these features facilitate therapeutic effectiveness. Similarly, in the typical Black client and Whit counsellor cross-racial dyad, it is how diversity is approached and worked with that determines the effectiveness of counselling (Alladin, 1994; Draguns, 1981; Lago and Thompson, 1989; Richards, 2000; Sue and Sue, 1999).

3.1.2 Studies that have not found significant preferences for ethnic matching amongst Black people

Simply being a Black person does not mean that one will have an automatic preference for an ethnically similar counsellor (Griffith, 1977; Parloff, Waskow & Wolfe, 1978). Gambosa, Tosi & Ricco (1976) did not find a preference for a Black counsellor amongst either 40 Black delinquent girls. Many Black clients attached higher importance to the counselling style (Peoples and Dell, 1975), or whether or not the counsellor could do the job. Sattler (1977), in his review noted:

> **"...Other things being equal, many Black subjects prefer Black therapists to White therapists. However, a competent White professional is preferred to a less competent Black professional and the therapist's style and technique are more important factors in affecting Black clients' choices than the therapist's race" (p267).**

Ponterotto, Anderson, & Grieger (1986) found that the Black racial identity of participants was not significantly related to preferences for a Black counsellor. It could be that the main effect of preference for an ethnically similar counsellor was actually shorthand for other assumed counsellor characteristics rather than just 'race' per se. In fact, in one study it was found that *both* Black and White participants preferred a Black (female) counsellor regardless of type of problem presented (Bernstein et al, 1987).

This could suggest that the client's and counsellor's ethnicity do not necessarily influence the therapeutic processes (Gordon and Grantham, 1979; Ponterotto, Anderson, & Grieger, 1986; Reed, 1988). Indeed, it could be that Black client-White counsellor cross-racial dyad can be of benefit to the Black client, as suggested by Schachter and Butt: *"Racial differences may have a catalytic effect upon the analytic process, and lead to a more rapid unfolding of core problems"* (1998:792). Similarly, Grier (1967) wrote that the therapist is provided *"...with an unique opportunity to trace complex, intensely experienced conflicts by means of the brightly coloured thread of race".*

3.1.2.1. Cautions against presenting Black professionals as the only solution.

Not all researchers are convinced that ethnic matching is *the* solution to improving the situation for all Black clients (e.g. Asante, 1987; Fernando 1989; Hall, 1997; O'Brian, 1990, Owusu-Bempah, 1989b, 1990, 1994a), or that having a Black therapist will be successful in dealing with the Black clients emotion issues (O'Brian, 1990; Sue, 1988). Some have gone so far as to point out that not all perpetrators of cultural errors or racism in therapy are White and may even be committed by Black therapists (Hall, 1997; Owusu-Bempah &Howitt, 2000). The

point is that it is not enough for the therapist to simply be Black, or to be able to empathise with the client, but they must be able to formulate and articulate the client's problems in a way that is consistent with his/her needs, anxieties and frustrations (Owusu-Bempah and Howitt, 2000: 23). A Black counsellor who is able to do this is likely to think of the context of the Black client's problems and not just about the Black client as an individual. The Black therapist, due to his/her own experiences, may not simply have an individualistic conceptualisation of the client's problem, but also acknowledge that society contributes to some of Black people's problems that require psychological interventions (Owusu-Bempah and Howitt, 2000; Tinsley-Jones, 1997). Hence, the Black worker would simultaneously focus on both the client and his/her social structure. In this case, the Black worker has a social change outlook rather than only a problem solving outlook at the individual level. This is different from the conventional therapy of the Western approaches that trainee counsellors and therapists are taught on standard counselling programmes (Buabeng, 2000).

3.1.3 Studies that have found significant preferences for ethnic matching amongst Black people

However, many Black individuals do not feel comfortable with a White therapist. They felt discouraged from entering into therapy when the therapist was White, or therapeutic progress was inhibited for some Black clients in such a relationship. Tien and Johnson (1994) found that 60% of their Black sample preferred to see a Black therapist. In a very convincing analysis and thorough review of numerous studies, Sue concluded that *"there is evidence that [ethnic] match[ing] is related to treatment outcome and clients' perceptions of the sessions"* (S.Sue, 2000:10). The problems caused by ethnic 'mismatch' between client and counsellor is a recurrent theme in cross-cultural counselling psychology (Aponte, Rivers & Wohl, 1995; Comas-Diaz & Griffith, 1988; Le Vine & Padilla, 1980; Pope-Davis & Coleman, 1997; D.Sue, Ivey, & Pedersen, 1996; Trimble & La Fromboise, 1985). Indeed, "...*cultural differences can affect the validity of assessment as well as the development of therapist-client rapport, therapeutic alliance, and treatment effectiveness"* (S.Sue, 2000:4).

For many Black British people, it is believed that mainstream therapeutic and mental health services are run by White people, and, hence, are set up to benefit White people and either exclude, or offer a second rate service to, Black people (Christie, 1995). This belief has the potential for Black people to perceive such therapeutic facilities as irrelevant to their own psychological needs. Since British ethnic minority communities appear to be suspicious and critical of counselling and mental health services for such reasons (Parkman et al, 1997;

Sashidharan, 1999), the absence of Black professionals (e.g. therapists) is likely to reinforce this perception.

3.1.3.1 Studies that used simple choice (paired comparison) methodology

A simple choice design involves presenting participants with two options from which to make their selection. In the case of ethnic matching in counselling participants are asked whether they would prefer to receive therapy from a racially similar counsellor. Therefore the two options are 'to be ethnically matched with a racially similarly counsellor' or 'not to be ethnically matched'. Studies using such a design found ethnic minority clients preferred an ethnically similar counsellor (e.g. Atkinson 1983 & 1985; Greene, 1982; Harrison, 1975; Sattler, 1977). This is supported by later research using the same technique with clients from a range of other ethnic minority backgrounds [e.g. American Indians (Bennett & Bigfoot-Sipes, 1991); Asian Americans (Atkinson, Poston, Furlong & Mercado, 1989); Mexican Americans (Atkinson, Poston, Furlong & Mercado, 1989)]. White clients also preferred a counsellor of similar ethnicity to them (Atkinson, Poston, Furlong & Mercado, 1989).

The above findings led Atkinson and Lowe to conclude in their review that this *"provides strong evidence that, in general, ethnically similar dyads are associated with more positive counselling process and outcome than ethnically dissimilar counselling dyads"* (Atkinson and Lowe, 1995: 405). Their conclusion that the 'race' of the counsellor has an affect on the therapeutic outcome reinforced earlier findings. For instance, Ponterotto, Alexander & Hinkston (1988) stated: *"...Results of empirical studies focusing specifically on Afro-Americans... have supported the conclusion that Afro-Americans generally prefer counsellors of the same race"* (p175). Similarly, whereas ethnic diversity in the counselling dyad arrested the progress of the therapeutic process (Pinchot, Ricco & Peters, 1975; Ricco & Barnes, 1973; Strangers & Ricco, 1970), ethnic matching contributed to effective outcomes (Berman, 1979; Flaskerud, 1986; Terrell & Terrell, 1984; Wade & Bernstein, 1991). In addition, according to Atkinson (1983:82):

> **"...The consistency with which Black subjects preferred racially similar counsellors implies that for many Blacks, utilisation of counselling services may be a function of the availability of Black counsellors".**

3.1.3.2 Studies that used a ranking system design

Among the studies which have specifically investigated Black clients' counsellor preference, those by Atkinson, Furlong & Poston, (1986) and Ponterotto, Alexander & Hinkston, (1988), are particularly relevant to the current debate. Not least, because in American they have attempted to address a concern that has now become a growing issue in British therapy. Similarly, to many of the other studies these two have been conducted by counselling psychologists. Their methodological design that utilised a ranking system has produced interesting results. With regards to the investigation on ethnic matching, ranking systems involve presenting participants with a list of counselling characteristics, and the participants then organise the list in order of their preference for counsellor features. Ponterotto et al's (1988) study, which is both a replication and an extension of Atkinson et al's (1986) study, found that when respondents had to choose specifically between either an ethnically similar counsellor or an ethnically dissimilar counsellor, they expressed a preference for the former 90.1% of the time, compared with 69.5% in the Atkinson et al study.

3.1.4 Reasons why Black clients may prefer an ethnically similar counsellor

3.1.4.1 Similarity and Empathy

Individuals are attracted to others who are similar to them [e.g. Tajfel's (1978) social identity theory on social categories]. This is illustrated by Thomas, who writes:

> **"The obvious benefit of same-same therapy for those in minority groups is that to some extent the therapist will have some experiences (if not all) that mirror those of the patient. [This therapist] could help clients who have cultural ways of dealing with an issue that might seem not only alien to majority [culture] therapists but pathological or dysfunctional." (Thomas, 2002:52).**

The issue regarding empathic capacity is very relevant since the importance of the therapeutic role of empathy is now firmly accepted within the counselling field (Banks, 1999: Rogers, 1951). So Black clients who have a preference for a Black counsellor perceive them as more likely to be able to understand them, and appropriately help them reduce their emotional distress than an ethnically dissimilar counsellor (Alladin, 1999).

3.1.4.2 Counsellor credibility

It has been argued that ethnic matching contributes towards a positive outcome in therapy because the client is more likely to perceive a counsellor from his/her ethnicity as more credible than a counsellor who is of a dissimilar ethnicity. This is based on research which

suggested that the more credible a source, the more influence it has (Strong, 1968). Hence, it would be expected that if ethnic minority clients found their ethnically similar counsellor to be a highly credible source, then the counsellor could influence how they perceive, approach and resolve their problems. Since, the process of counselling involves the counsellor influencing the client, the counsellor's credibility plays a critical role in the counselling process.

3.1.4.2.1 Expertness, Trustworthiness and Attractiveness

Credibility has usually been operationalised as a construct constituting variables such as *'expertness'*, *trustworthiness'* and *'attractiveness'*. Studies would then look at the correlations between strength of credibility and participants' willingness to receive counselling from the counsellor. Compared to research on ethnic matching, the results in this area are less conclusive, though most did not find a strong relationship. Whereas Atkusu, Lin & Zane (1990) found that counsellor credibility was a strong predictor of utilisation intention among both Chinese and Caucasian students, other researchers have not found this to be the case with other ethnic minority groups [e.g. Lopez et al's (1991) work on Mexicans], or with Black participants. For instance, reviews by Atkinson et al (1983 & 1985) did not find a significant effect of ethnicity on counsellor credibility. In fact, only two out of the eleven studies they reviewed (Atkinson et al, 1983) found a significant effect for counsellor-client credibility.

A logical argument for ethnic matching is that a counsellor who shares the client's ethnic background will be able to respond to the client within the context of what is pertinent to the client's culture with an appropriate level of expertness. There is likely to be qualitatively different interventions from the Black therapist compared to the White therapist working with a Black client. An example of this is Thomas's work in the 1990s (e.g. Thomas, 1992), and his later work, where he states that for Black therapists the use of the self is more overt in the sessions to help Black clients understand their situations than it is for White therapists (Thomas, 2002).

With regards to the particular ethnic minority group that this thesis will focus on, results for Black people are conflicting. Whereas Shipp (1986) found that Black people did rate an ethnically similar counsellor as more expert, trustworthy and attractive than a White counsellor, four years later Goldberg & Tidwell (1990) did not find this effect with their Black participants who found White and Black counsellors equally attractive. *'Attractiveness'* was part of the construct of *'credibility'* and defined as '*friendliness*', '*sociability*', '*warmth*' and

'trustworthiness'. In contrast, the work of Terrell and colleagues (e.g. Watkins and Terrell, 1988; Watkins, Terrell, Miller & Terrell, 1989) found a strong link between high levels of cultural mistrust of White people amongst Black people, and expectations that ethnically dissimilar (i.e. White) counsellors would be less credible when dealing with problems such as anxiety, shyness, feelings of inferiority and dating difficulties.

Some explanation for the above conflicting results can be found in the sampling procedure. Atkinson and Lowe (1995) noted that within-group differences, such as different stages of Black racial identity development (Helms and Carter, 1990), or different degrees of cultural mistrust (Terrell and Terrell, 1981) can act as moderators in the link between ethnicity and counsellor credibility. For instance, Goldberg & Tidwell's (1990) sample consisted of Black school pupils who probably were mostly in a different stage of racial identity development (e.g. *'Pre-encounter'*) compared to the majority of adults (e.g. *'Encounter'* or *'Immersion'* stage) used in Shipp's study. That is, conflicting results may be due to different racial developmental stages of the samples in different studies.

3.1.4.3 *Perceived helpfulness of counsellor*

There is some evidence to suggest that ethnically similar (in this case Black) counsellors are seen by Black people as more helpful e.g. by Black college students (Berg & Wright-Buckley, 1988; Greene, Cunningham, & Yanico, 1986), and in some cases White students (Berg & Wright-Buckley, 1988). In fact, there is a lower drop out rate amongst ethnic minority clients in services where ethnically similar counsellors are practising than those where there are few or no ethnically similar (i.e. White) counsellors (S.Sue, 2000).

3.1.5 Methodological critique of previous studies

The methods adopted either ask respondents whether they had a preference for a Black counsellor (same 'race') over a non-Black counsellor (*'simple choice methodology'*), or give them a list of counsellor characteristics and ask them to choose between them [by using both the pair-comparison technique (Dunn-Rankin, 1983) and also ranking methods]. There has been some discussion over which is the more efficient way to test the hypothesis that Black clients favour same 'race' counsellors. (e.g. Ponterotto et al 1988).

From a scientific and research perspective, the features of the design used by studies such as Atkinson et al's and Ponterotto et al's have various attractions, though many practitioners may be curious as to the level of ecological validity that such studies can claim. Like other studies cited above, they would have benefited by increasing their ecological validity. This is likely to include providing more realistic stimuli and including a participant sample of former clients or those that were particularly psychologically vulnerable making them likely to need counselling. Whilst student samples can provide useful material and some students do experience psychological distress to the extent of being psychological vulnerable, the problem with student samples is that results they yield are limited in their ability to generalise to the general population as a whole. Though some students will have experience of campus counselling, the majority of them may be naïve about the operation of therapeutic and psychological agencies in the *community* (i.e. outside of 'studentville'). Responses made by students to questionnaires on counsellor preference may be from an idealistic position, based on knowledge limited to appropriate (on-campus) therapeutic services tailored to their needs (or based on an extrinsic goal, such as those most wanted additional course credits), rather than a wider view.

3.1.6 Summary of previous research findings

Whilst acknowledging some of the methodological challenges presented to counselling psychology research that utilises student samples, when the design is well executed, the results can provide some guidance as to what can be expected. They indicate that when either a 'simple choice' or 'paired comparison' methodology is used; on the whole, Black participants had a strong preference for a similar 'race' counsellor. The results are less clear for counselling process variables such as attractiveness, perceived credibility, trustworthiness, and their relationship with ethnic matching. Conflicting results have been presented as to whether a Black participant is likely to perceive, or rate, a counsellor of similar ethnicity as a more credible source than a White counsellor. Such a contrast in findings could be due to a sampling effect, in that participants in the different studies had varying levels of trust and racial identity. This reflects within group differences and highlights the heterogeneity of what is commonly referred to collectively as 'Black people' or 'the Black group'. With regards to other process variables such as helpfulness, again it does appear that Black clients do have a preference for ethnically similar counsellors, perceiving them to be more helpful than a White counsellor. Though the evidence is not as conflicting as that found for counsellor credibility, mixed findings were also presented. In addition, the fact that whether an ethnically similar counsellor

was available had an effect on attending counselling and *"reinforces the need to take within-group diversity into account when examining the effects of counsellor-client ethnic similarity"* (Atkinson & Lowe, 1995:396).

3.1.7. Rationale for present study

3.1.7.1 The wealth of American research and the dearth of British research

The above studies were more or less all conducted in the USA, so it would seem logical to see if these findings applied to Black people in Britain. The main interest would be whether or not Black clients in Britain have a preference for an ethnically similar counsellor. Previous writings suggested that they would. American research that investigated this presented clients with a choice of reasons, rather than allow clients to generate their own reasons as to why they would prefer a Black counsellor over a White counsellor. It may be that, whilst the reasons identified *for* participants are relevant, there are other reasons that are just as, if not more, important to them. There may be a difference between researcher generated reasons and participants' reasons.

3.1.7.2 Indication that Black British people prefer a culturally sensitive practitioner

Wilson and Francis's (1997) study revealed that Black *British* mental health sufferers would prefer a professional who had knowledge of their culture; but no distinction was made in the questionnaire between Black and White professionals. Furthermore, respondents were not asked if they preferred to be treated by a Black mental health professional or whether they felt that White mental health workers would have been able to respond to their psychological needs equally as well as Black professionals. Hence, the issue of ethnic matching was, although indirectly hinted at, not directly empirically investigated. Although the issue of the importance of cultural awareness was addressed in Wilson and Francis's (1997) study, most of the items in the questionnaire focused on getting an overview of how Black mental health sufferers felt about the treatment they received in all areas of the mental health system, not solely psychological services. Robertson et al (2000) found that Black participants preferred an ethnically similar mental health worker. Similar to the work of Wilson and Francis, (1997), this is an important finding in the field of general mental health, and provides a logical basis for counselling research, though this study did not look specifically at therapists. This makes it difficult to comment on whether the ethnicity of counsellors in particular is of relevance to the therapeutic process and outcome.

3.1.7.3. The need for a fuller understanding of Black British people's psychological needs

Chapter 2 indicated that Black people have a variety of support mechanisms that they utilise to help them deal with emotional distress. Consequently, any study that attempted to find out whether Black clients preferred a counsellor of the same ethnicity as them, would also benefit from ascertaining the importance they place on counselling per se. It may be that some Black people are unlikely to present themselves for professional psychological or therapeutic help provided by mainstream services. As well as individuals who will attend counselling, a tentative profile of, or any material on, Black individuals who would not consider therapy for their psychological needs would aid service providers and therapists in delivering an effective package for Black people. Therapeutic facilities could be better tailored to meet the needs of a target population: Black individuals who would be likely to make use of such services (*'potential clients'*). At the very least, this would reduce the pitfall of dispersing limited resources and energies on a heterogeneous population that included those who would not consider counselling. Such material may also provide additional information that practitioners can use in order to improve their services and make them attractive to Black individuals who may not have originally regarded Western style counselling as a process they could benefit from.

Some individuals may not consider counselling because of their naïveté about it. If, as has been argued by some therapists, that Black people are unsophisticated in their use of counselling, then therapists and psychologists need to be aware of this. This indicates a requirement for counsellors to get insight into the actual level of the psychological mind-set of, and the degree of education needed by, Black clients about the counselling process ('pre-therapy') for them to fully benefit from counselling. Many counsellors intuitively use the notion *'psychologically-minded'* to help them assess their clients' potential progress in therapy. For instance, Pedersen et al (1989:5) stated some ethnic minority individuals are *'unmotivated, resistant, and lacking in psychological-mindedness'*. In spite of the probability that, as a construct, 'psychologically mindedness' has little scientific meaning, it would be useful to find out if Black individuals had an appropriate understanding of what counselling can be used for, its process, and the potential benefits it offers Black clients.

3.1.7.4. The need for representative samples

The above criticisms of analogue studies that they do not reflect the actual counselling situation point to the need for more representative studies. Involving Black clients currently in therapy is attractive when the area of focus is about some aspect of an ongoing therapeutic relationship or process. Nevertheless, for the current study conducted below, the research question is about a discrete aspect of the Black person's decision-making process: Would the 'race' of the counsellor be a predictor variable for entering a therapeutic relationship? Apart from the ethical complications in asking Black clients in therapy if they would prefer an ethnically similar counsellor, the research question would be served better by using former clients and those that counsellors could engage in counselling. In addition, another group that would seem relevant for this research are members of the Black community, who, because of their life experiences, are likely to be in need of counselling. That is, 'potential clients' who would benefit from counselling. Former clients who could benefit from additional counselling are also technically *'potential clients'*.

Black users of psychiatric services are an appropriate group, since their psychiatric diagnosis (e.g. schizophrenia, bipolar depression) is usually entangled with emotional difficulties: Ones that are often seen by therapists, e.g. psychological distress, and treated successfully (Basco, 2001; Blackburn & Moorhead 2001; Mooney & Padesky 2000; Persons, & Bertagnolli, 1999; Persons & Valus, 2001; Tarrier et al, 2000; Young, 1990). Considering speculation as to the suitability of therapy for Black people with mental health problems, it would be pertinent to ascertain whether or not psychiatric Black patients would be receptive to therapy (e.g. Carter, 1995; Helms, 1990) in the first place. Similarly, of relevance would be the role that they attribute to such services as part of their resources for effectively reducing psychological distress. Since perceptions of what constitutes a psychological benefit varies, as does the attitude to seeking help, it may be important to also understand Black potential clients' perceptions of how a counsellor can help them. This would be important to find out before any question could be asked about their counsellor preference. Any findings on the important issue of counsellor preference could then be interpreted within a fuller and, hence, more meaningful, context.

3.1.7.5 Aims of present study

Following on from the rationale, the aims of this study are to:

Aim 1: Outline support mechanisms used by potential Black clients (e.g. the Church, extended family, community), with a view to understanding how their use of counselling compares as a treatment of choice in relation to other types of informal emotional help available.

Aim 2 Provide some insight into the level of 'psychological mindedness' of potential Black clients with specific regards to whether their perception of counselling is 'appropriate', in terms of their understanding of types of issues that can be brought to therapy, and the benefits it can provide.

Aim 3: Identify the general reasons that would encourage Black individuals to visit a counsellor and those that would deter Black people from doing so.

Aim 4: Investigate whether 'potential Black clients' have a preference for an ethnically similar counsellor.

3.1.7.6 Hypotheses of present study

Following the above objectives, there are three hypotheses to be tested:

Hypothesis 1: Participants will give significantly more psychological and emotional reasons for visiting a counsellor than social / 'practical' reasons (i.e. advice for financial, housing, and social welfare problems).

Hypothesis 2: There will be a significant difference between Black participants' preference for a White counsellor and a Black counsellor. Black participants would express a preference for a Black counsellor.

Hypothesis 3: There will a significant difference in terms of reason for counsellor preference between those participants who expressed a preference for a Black counsellor and those who did not.

3.2 Method

3. 2.1 Pilot study

15 service users were approached of which 4 (3 Black males and 1 Black female) agreed to provide feedback on a proposed questionnaire to be used in the study. The difficulty in getting these participants at this early stage of the study indicated that recruitment would be challenging. The initial intention was to distribute the questionnaires to all Black users of the service for self-completion. They constituted about 95% of the user population in the targeted agency. However, the pilot revealed that participants did not readily engage with the questionnaire and, the few that did, wished to be 'guided' through the questionnaire (i.e. they wanted the items to be read out to them). This indicated that participants would need someone to aid them in their completion of the questionnaire. It was evident that the researcher best filled this role. In addition, feedback revealed that in order to engage respondents, it would be beneficial to place the photo stimulus as the first item of the questionnaire. No other amendments were made to the final questionnaire to be used in the main study. The initial estimated self-completion time of about 10 minutes had to be revised in light of the fact that the researcher would now be reading aloud the items for the respondents. This increased completion time to 15-20 minutes.

3.2.2 Main study

3. 2.2.1. Design

This was an independent design with 'race' as the independent variable and participants' responses to the questionnaire was the dependent variable.

3.2.2.2. The Participants

3.2.2.2.1 Participant sample

Of the 60 service users who agreed to complete the questionnaire, 45 actually did so, but 16 of these were discarded. Of the 16, 6 participants later changed their mind about having the material included in the study; 6 participants did not successfully complete the questionnaire (e.g. due to distraction, confusion over what was being asked of them); 3 participants during

completion began to present in a psychotic state; 1 participant was not racially Black. The eventual sample consisted of 28 Black participants of which 7 were female and 21 were male.

3.2.2.2.2 Participants' location

Participants were from a community based drop-in mental health service. This provides supportive, culturally responsive services (e.g. advocacy, meals, and recreation) for individuals of all ethnicities with a psychiatric diagnosis. It is situated in East London, which is ethnically diverse. 22% of East London's population are of African or Caribbean origin. They make up 34% of the community's increasing range of ethnic minority population in the area. If these figures are considered in the context of the national statistics, there is a higher representation of Black people than the national average. This richness in diversity makes East London an ideal location for access to people from the Black community. In contrast to its ethnic richness, East London is a severely economically deprived area rated with a Jarman score of 43 (Sathyamoorthy et al, 2000)[2]. East London Users of Mental Health Services (ELUOMHS) *"single out East London as a region in the country that is in desperate need for more mental health resources, particularly in the community, as well as more alternative treatments and support systems, for mental health needs, additional to psychiatric intervention.* ...[which indicates that there is*] ... a dire need for cultural specific mental health services"* (East London Users of Mental Health Services, 2000:2).

3.2.2.3 The Researcher

The researcher was a British born Black woman of African and Caribbean descent and a chartered counselling psychologist.

3.2.2.3 Material

3.2.2.3.1 'HWMPI'

A short semi-structured self-completion questionnaire was designed specifically for this study ('Help With My Problems Inventory', 'HWMPI'; see appendix 3), with the main aim of finding out Black participants' attitudes toward ethnic matching between themselves and a

[2] 68 is the most deprived score, while a score of -47 describes the most affluent area of the country (Gilam, Jarman, White, & Law, 1989).

counsellor, should they decide to receive individual counselling for their psychological problems. For instance, a 'photo stimulus' was presented that contained a colour picture of a pair of Black and White female 'counsellors' taken from a group of nine such pairs. The question that accompanied this 'item was: "*Both of these people are counsellors. If you were to see one of them for counselling, which one would you prefer to see about your problems?*" This was followed with *"Why do you say that"*. Another later item was *"If you were to see a counsellor, would you prefer to see a counsellor of your own race"*, with an accompanying response set of 'YES / *NO*'. This was followed with *"Why do you say that?"* Other items in the questionnaire included questions about issues that would either encourage or discourage participants from seeking psychological help, and also items that asked for demographic information, e.g. age, gender, ethnicity, and receipt of counselling or psychotherapy. The questionnaire was devised in consultation with the researcher's supervisor, with additional comments from those who worked at the agency where respondents attended.

3.2.2.3.2 Counsellor photos

The photo stimulus sheets had been compiled using racially Black and racially White female faces (see appendix 4) about the same age range as the workers at the agency (approximately between 20 and 40 years old), and were taken from magazines. A panel of 9 Black people was asked to match 15 Black with 15 White faces so as to produce pairs of racially different female 'counsellors', one Black and one White, who looked similar in age and appeared to have similar emotional expressions. The panel consisted of two female and two male workers at the agency where the study was to be conducted, four men who worked in the Black community (e.g. one was a pastor in a Black Church), and one female homemaker. After some discussion, all panel members reached agreement on the matching of 9 of the 15 pairs. The other 6 pairs of photos were discarded and not used in the study.

3.2.2.4. Procedure

3.2.2.4.1 Engagement

The aim was to first engage the target population (Black service users at the agency), which was done mostly by participant observation. The researcher partook in many of the activities that the participants were also involved in and spent the beginning of the research process by

making herself familiar to them. This engagement strategy was decided in consultation with the manager after consistent failure in recruiting participants for the study (SG1).

3.2.2.4.2 Recruitment

During service times, the researcher approached service users individually and asked them if they would be prepared to take part in the research. Those who agreed to take part in the study were then offered the option of completing the questionnaire unaided or with help from the researcher. All participants opted for the latter. It was explained to participants that the researcher would read out only those items on the questionnaire, and that this was not a counselling session. All participants had an allocated key worker, who they were advised to consult in the unlikely event that the questionnaire prompted any issues for concern. Participants were advised that the estimated completion time of the questionnaire was about 15-20 minutes, that all material they contributed would be confidential and recorded in a manner that would make their responses anonymous. It was understood that they agreed to take part on a voluntary basis, which constituted their consent, and that they could refuse to continue with the questionnaire at anytime. It was emphasised that any decisions they made, including withdrawing from the study, would in no way affect the treatment by staff and the services that they received at the agency. Every effort by the researcher was made to ensure that participants understood what was been conveyed to them including offering them the opportunity to clarify anything related to the study.

3.2.2.4.3 Completion of questionnaire and debriefing

Once a participant volunteered to participate in the study, s/he was taken to a quiet place where the questionnaire was read out to him/her on an individual basis. Each participant's responses were recorded on a questionnaire by the researcher. A debriefing session took place immediately after completion in which each participant was invited to ask the researcher any questions related to the research and to feedback any comments s/he had about the questionnaire. Where appropriate participants were referred to their key worker.

3.3 Results

3.3.1 Demographic Characteristics of Respondents

3.3.1.1 Age and gender

Table 3.1: Age and Gender Characteristics of Participants

MEAN AGE	35.32 Years (SD 6.75 Years)
AGE RANGE	22 Years To 47 Years
MODE AGE	33 Years (14.3%)
PERCENTAGE FOR AGE GROUP 20-29	10.7%
PERCENTAGE FOR AGE GROUP 30-39	64.3%
PERCENTAGE FOR AGE GROUP: 40-49	25%
MALE (n=21): MEAN AGE	35.43 Years (SD. 6.73 Years)
FEMALE (n=7) MEAN AGE	35 Years (SD. 7.70 Years)

Table 3.1 shows that the majority of the sample were in their 30s, a few participants were in their 20s. None were older than 47. Three times as many males (75%) than females (25%) agreed to participate in the study, which more or less reflected the actual Black male to Black female service user ratio at the organisation of 3.3 to 1. The males in this sample were slightly older than the females, though the standard deviations indicated that there was more variance amongst the female sample. This is probably due to the small number of females in the sample. It needs to be highlighted at this stage that the following analyses are conducted with very small numbers, and so all results must be interpreted with this in mind.

3.3.1.2. Ethnic Self-Identification of Participants

Table 3.2, below, shows although participants defined themselves as 'racially' 'Black', which included 3.6% who defined themselves as 'Black mixed race', there were variations in the

labels that these participants attached to their self-defined ethnicity. Though constituting the largest group, only 46% of participants identified themselves as either Black British or Black UK, when in fact 75% were born in this country.

Table 3.2. Ethnic Self-Identification of Participants

Self-allocated ethnic group	**Percentage**
Black British / Black UK	46%
Caribbean / West Indian	36%
African	14.4%
Black mixed race	3.6%

3.3.1.3 Psychiatric In-patient Admission

82.1% of participants had at least one psychiatric in-patient admission and 14.4% of respondents had 5 or more multiple admissions.

3.3.1.4 Diagnosis

FIG 3.1 Psychiatric Diagnosis of Respondents (given in percentages)

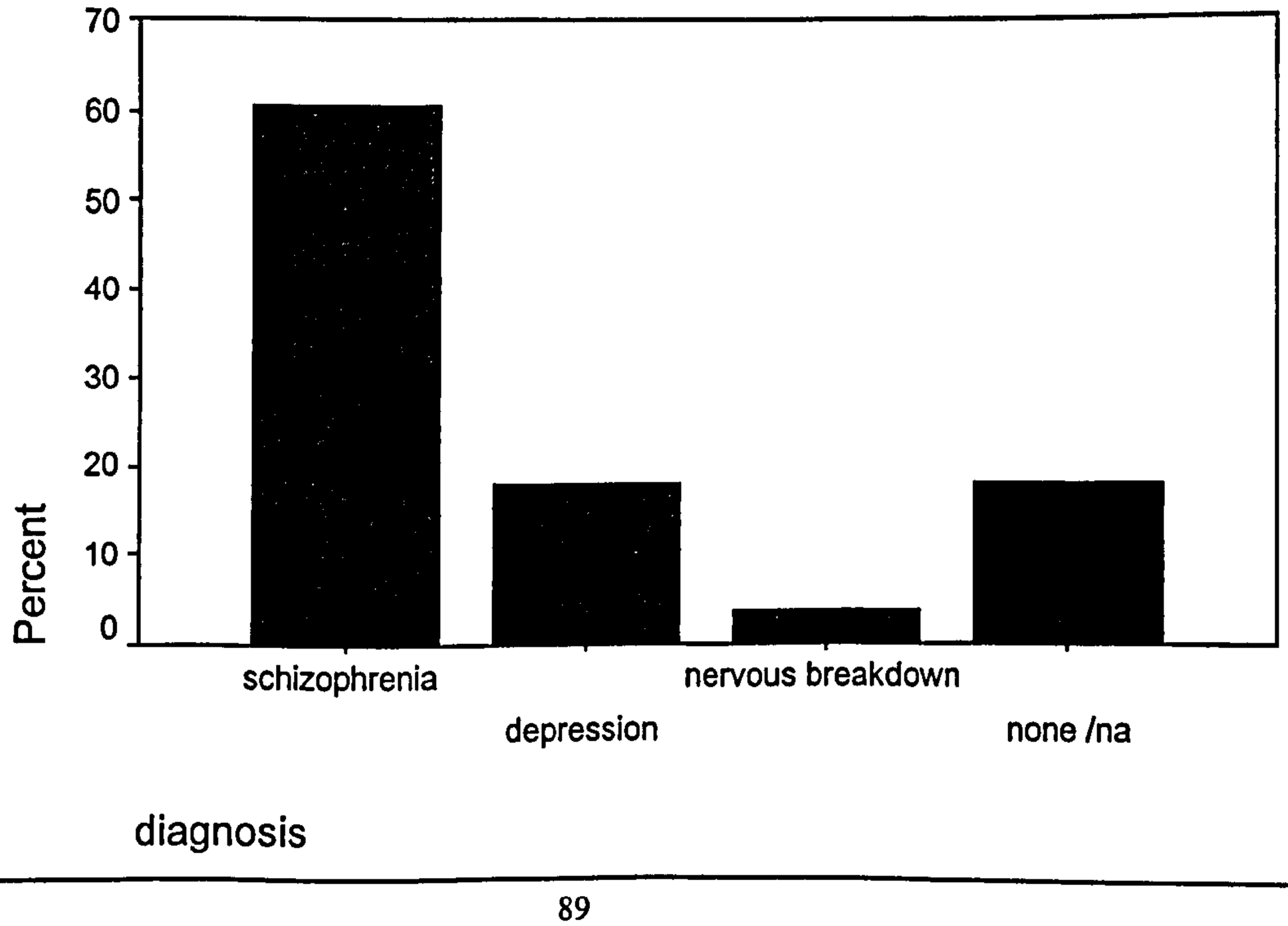


Fig 3.1 shows that an overwhelming majority of participants had a diagnosis of schizophrenia, followed a long way behind with the diagnosis of depression and one participant reported been diagnosed as suffering from a 'nervous breakdown'. There was little variation in the range of diagnosis and 18% of participants did not have a psychiatric diagnosis.

3.3.1.5 Previous counselling experience

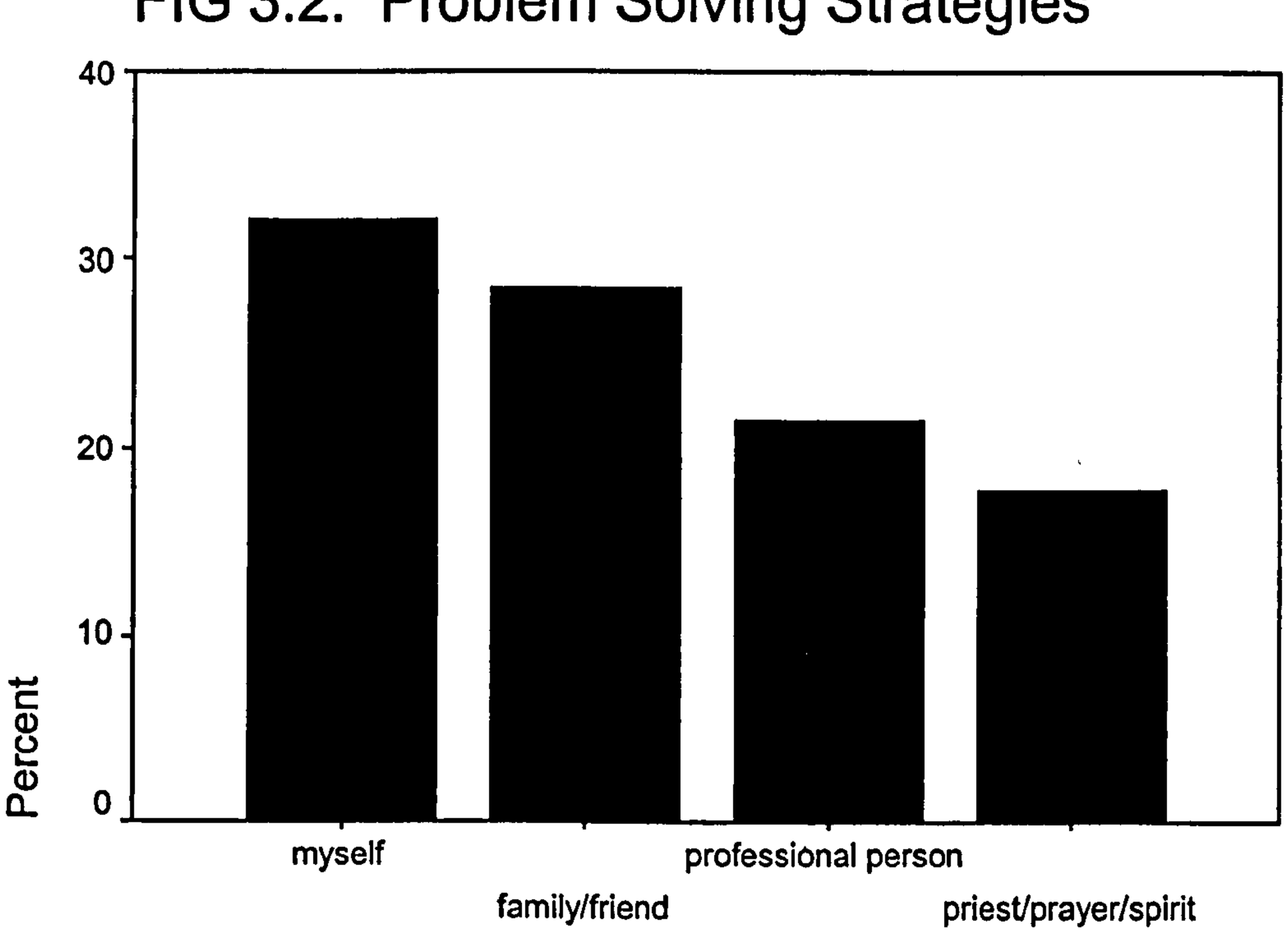
Over half (56.6%) of participants had received some type of counselling or psychotherapy in the past that varied from 3 times a week to every other week.

3.3.1.6 Currently receiving counselling

Only one respondent reported currently receiving counselling. This was weekly.

3.3.2 Help seeking behaviour and problem solving strategies

FIG 3.2: Problem Solving Strategies



how do you solve your problems

Fig 3.2 shows that this was a self-reliant group. Nearly a third of participants initially coped with their psychological problems by using their internal resources (*'myself'*). Many originally sought help from informal sources such as family and friends; and the support of the Church, which 'led' them in prayer and grounded them in spirituality to help them contextualise their problems. When combined, the use of different types of informal support networks accumulated to 46.5%. This figure is over double the amount of participants that primarily considered professional help with their emotional problems. At this stage, of particular interest to practitioners is that FIG 3.2 shows that there was not much difference between the amount of participants who had elicited the help of a spiritual leader/Church, and those who had approached a professional as their first point of call for help with emotional problems (17.9% versus 21.4% respectively). Moreover, it is relevant to highlight that the category 'professional person' also included other health and mental health professionals (i.e. GPs, psychiatrists, social workers) and did not apply exclusively to counsellors.

3.3.2.1. Consider seeing a counsellor in the future for problems.

Although participants did not identify therapy as their first strategy for dealing with their emotional distress, 67.9% stated that they would consider seeking the help of a counsellor in the future for their problems.

Results for Hypothesis 1

3.2.2Reasons for seeing a counsellor

Table 3.3 Reasons for seeing a counsellor

PROBLEM	***PERCENTAGE***
MENTAL HEALTH PROBLEMS	28.6%
'PRACTICAL' PROBLEMS (E.G. FINANCIAL, HOUSING PROBLEMS)	21.4%
PROBLEMS THAT ARISE IN CHILDHOOD OR YOUNG ADULTHOOD	10.7%
RELATIONSHIP AND FAMILY PROBLEMS	10.7%
OTHER TYPES OF NON-PSYCHOLOGICAL PROBLEMS (E.G. SOCIAL WELFARE PROBLEMS)	10.7%

When asked *"What type of things would make you more likely to see a counsellor?"* participants described the above problems in Table 3.3 that they would like to discuss with a counsellor: Table 3.3 illustrates a range of problems from aetiology problems / developmental issues (e.g. *"what happened in my childhood to make me the way I am"*) to practical / social problems (e.g. concerns over finances, housing). When 'mental health problems' were put forward as a reason for receiving counselling, participants typically referred to talking to someone when things got 'unbearable' or when there were triggers or signs that the participant was becoming potentially mentally unstable. Many respondents in this group saw the use of a counsellor to help them reduce their chances of psychiatric hospital re-admission by talking to them and supporting them during crisis periods. Relationships or family problems were one of the lowest reasons that participants would seek therapeutic help. When participants' responses are collapsed into psychological and non-psychological issues, it can be seen that 50% of respondents would consider seeing a counselling for psychological problems whereas 32.1% would see a counsellor for more social and practical reasons. The remaining 17.9% said that there was nothing that could convince them to see a counsellor.

Table 3.4 Chi-Square Test for Differences Between Practical and Psychological Reasons for Seeing a Counsellor

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.982[b]	1	.322		
Continuity Correction[a]	.224	1	.636		
Likelihood Ratio	1.054	1	.304		
Fisher's Exact Test				.611	.327
Linear-by-Linear Association	.939	1	.333		
N of Valid Cases	23				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.96.

Table 3.4 indicates that a Fisher's Exact Probability Test did not show that participants gave significantly more psychological and emotional reasons for visiting a counsellor than practical reasons (i.e. advice for financial, housing, and social welfare problems) (X^2 =.982, df=1, p=.327).

Table 3.5 Correlation coefficients for relationship between willingness to see a counsellor and psychological reasons for considering seeing a counsellor

Correlations

			Is the reason for seeing a counsellor emotional or practical	Consider Counselling if needed help
Spearman's rho	Is the reason for seeing a counsellor emotional or practical	Correlation Coefficient	1.000	-.207
		Sig. (1-tailed)	.	.172
		N	23	23
	Consider Counselling if needed help	Correlation Coefficient	-.207	1.000
		Sig. (1-tailed)	.172	.
		N	23	28

As can be seen from table 3.4, the results of the Spearman's rho correlation coefficients revealed a weak negative relationship between Black potential clients' willingness to see a counsellor and their selection of psychological reasons, as opposed to practical reasons, for seeing a counsellor (rho= -.207, N=23, p=.172). Since this result was not significant, it could not be argued that participants had given significantly more psychological and emotional reasons for visiting a counsellor than 'practical' reasons (i.e. advice for financial, housing, and social welfare problems), even though the frequency statistics (percentages) had given that initial impression.

3.3.2.3 Reasons for not seeing a counsellor

Table 3.6 Barriers to Seeking Therapy

PERSONAL BARRIERS TO SEEKING THERAPY	*PERCENTAGE*
NO BARRIERS	21.4%
DISCLOSURE OF SELF (E.G WHEN LOW IN MOOD)	17.9%
LACK OF CONFIDENTIALITY/PRIVACY	14.3%
OTHER SUPPORT NETWORKS	10.7%
PARTICIPANT INVOLVED IN ILLEGAL ACTIVITIES	10.7%
SKEPTICAL OF COUNSELLOR'S COMPETENCE OR INTEREST IN CLIENT	10.7%
OTHER	10.7%
STIGMA AND SHAME ATTACHED TO RECEIVING COUNSELLING	3.6%

Table 3.6 shows that there were a variety of factors that could deter participants from seeing a counsellor, though the highest percentage of participants responded that nothing would discourage them from seeing a counsellor if they required such treatment. In contrast to most participants' responses with specific illustrations of problems as to why they would seek counselling, when asked, *"what type of things would make you not want to see a counsellor"*, participants' answers seemed to be framed in less specific problem focused terms. Participants commented more on the context and process of counselling e.g. 'lack of confidentiality or privacy'. Whilst there were those who had someone else to talk to about their problems, an equal amount of participants said that they would not seek counselling if they were involved in some illegal activities. This implies that they were aware that, like all other professionals, counsellors would have to disclose any illegal or harmful practices that came to their knowledge. Only one participant was concerned with the stigma and shame of seeing a counsellor, to the extent that this would dissuade him/her from seeing a counsellor.

Results for Hypothesis 2

3.3.3 Ethnic matching of client and counsellor

3.3.2.1 Response to photo stimulus

Table 3.7 Chi-Square Test for Differences in preference for a Black or White counsellor when visual stimulus was used

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.333[b]	1	.068	.	
Continuity Correction [a]	1.939	1	.164		
Likelihood Ratio	3.243	1	.072		
Fisher's Exact Test				.097	.083
Linear-by-Linear Association	3.214	1	.073		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.89.

As can be seen from table 3.7, Fisher's Exact Probability did not find a significant difference between participants' choice out of a Black or a White counsellor when they were asked to choose either a Black or White counsellor from photo stimulus that contained a pair of counsellors – one White and one Black. (X^2=3.333, df=1, p=.083). That is, it cannot be argued that participants had a significant preference for a photograph of a Black 'counsellor' over or a photograph of a White 'counsellor' as the person they would choose if they were to receive counselling.

Table 3.8 Correlation Coefficients for relationship between preference for a Black or White counsellor, when visual stimulus was used, and ethnic matching

Correlations

			picture preferred by participant	preference for ethnic matching
Spearman's rho	picture preferred by participant	Correlation Coefficient	1.000	-.345
		Sig. (2-tailed)	.	.072
		N	28	28
	preference for ethnic matching	Correlation Coefficient	-.345	1.000
		Sig. (2-tailed)	.072	.
		N	28	28

As can be seen from table 3.8, the results of the Spearman's rho correlation coefficients revealed a weak negative relationship between participants' preference for a White counsellor or a Black counsellor and their desire for ethnic matching. A statistically significant relationship between choice of a Black or White counsellor and participants wanting ethnic matching was not found (rho= -.345, N=28, p=.072).

3.3.2.2 Response to direct question of counsellor preference

Table 3.9 Chi-Square Test for Differences in preference for ethnic matching when participants were asked directly if they had a preference for a Black counsellor

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	11.476[b]	1	.001		
Continuity Correction[a]	8.873	1	.003		
Likelihood Ratio	12.407	1	.000		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	11.066	1	.001		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.86.

As can be seen in table 3.9, a Fisher's Exact Probability did find a statistically significant preference amongst participants when they were asked directly if they would prefer to receive counselling by a counsellor of the same 'race' as them (X^2= 11.476, df=1, p=0.001). This was a highly significant result. Therefore, it could be argued that when asked directly whether or not they would prefer ethnic matching in counselling, participants did indeed prefer this option. Hence, hypothesis 2 is partly supported, since participants do show a preference for ethnic matching when asked directly.

Table 3.10 Correlation Coefficients for relationship between preference for ethnic matching and directly asking participants about their preference for ethnic matching

Correlations

			preference for ethnic matching	relate because of race
Spearman's rho	preference for ethnic matching	Correlation Coefficient	1.000	.640**
		Sig. (2-tailed)	.	.000
		N	28	28
	relate because of race	Correlation Coefficient	.640**	1.000
		Sig. (2-tailed)	.000	.
		N	28	28

**. Correlation is significant at the .01 level (2-tailed).

As can be seen from table 3.10, the results of the Spearman's rho correlation coefficients revealed a highly statistically significant relationship between preference for ethnic matching and directly asking participants about their preference for ethnic matching (rho =0.640, N=28, p=000). This gives further support for the hypothesis that Black individuals do have a preference for ethnic matching.

Results for Hypothesis 3

3.3.4 Reasons for counsellor preference

As can be seen in table 3.11, a Fisher's Exact test revealed a highly statistically significant difference between participants who preferred a White counsellor and those who preferred a Black counsellor with regards to their reasons for their choices (X^2 =110495, df=1, p=0.001). The main difference was that those who chose a Black counsellor explained their preference in terms of 'race' related issues such as the counsellor was from the same 'race' as them so she would be more able to understand their problems than a White counsellor. For those participants who chose a White counsellor from the photo pair, the main reasons given for this choice were not in terms of 'race' related issues, but in terms of competency e.g. the White counsellor appeared to be competent.

Table 3.11 Chi Square test for differences in reasons between those who had a preference for a White counsellor and those who had a preference for a Black counsellor when presented with photo stimulus

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Squa	11.495[b]	1	.001		
Continuity Correcti	8.908	1	.003		
Likelihood Ratio	14.974	1	.000		
Fisher's Exact Tes				.001	.001
Linear-by-Linear Association	11.084	1	.001		
N of Valid Cases	28				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expecte 4.18.

Table 3.12 Correlation coefficients for relationship between choice of either Black or White counsellor and reason given for preference

Correlations

			picture preferred by participant	was race included as reason
Spearman's rho	picture preferred by participant	Correlation Coefficient	1.000	-.641**
		Sig. (2-tailed)	.	.000
		N	28	28
	was race included as reason	Correlation Coefficient	-.641**	1.000
		Sig. (2-tailed)	.000	.
		N	28	28

**. Correlation is significant at the .01 level (2-tailed).

As can be seen in table 3.12, there was a strong negative correlation between choice of either Black or White counsellor and reason given for preference (rho= -.641, N=28, p=.000). This confirms the hypothesis that there is a relationship between the choice made for either an ethnically similar counsellor or a White counsellor and the reason given for this preference. Participants chose an ethnically similar counsellor mainly based on the anticipation that, because counsellor and potential client shared the same 'race', they would share common experiences. They believed this increased the likelihood that the counsellor had a similar outlook to them, which would make it easier for the counsellor to be empathic. In addition,

participants felt that common experiences brought about by similar racially features would make it less difficult for the Black counsellor to understand the Black person's 'burden', therefore increasing the likelihood that the counsellor's interventions were appropriate and relevant to Black clients' experiences.

3.4 Discussion

3.4.1 Summary of results

3.4.1.1 Preference for an ethnically similar counsellor

The results were partially in support of the hypothesis that participants were more likely to prefer a similar 'race' counsellor. Participants significantly expressed a preference for an ethnically similar counsellor when they were asked directly if they preferred a counsellor of the same 'race' as them than when they were simply asked to make a choice between two counsellors. When they were presented with the photo stimulus of Black and White 'counsellors', the preference was not statistically significant. When participants selected an ethnically similar counsellor, the main reason they gave was that since she shared the same 'race' as them, she would be able to understand them and appropriately help them more than the White counsellor.

3.4.1.2. Help-seeking behaviour and 'psychological- mindedness'

Although a large majority of participants would first try to sort out their psychological problems themselves or turn to their informal support network (e.g. family, friends, the Church) for help, few were deterred from seeing a counsellor as an additional option for relieving emotional distress. Numerically, the majority of participants were aware that a counsellor focuses on psychological issues. There were some concerns about self-disclosure, confidentiality, counsellor's competence, being involved in illegal activities whilst seeing a counsellor. Only one client was concerned about the stigma and shame that can be associated with seeing a counsellor.

3.4.2 Discussion of results in relation to previous studies

The findings in the current study are partly consistent with previous studies that report Black participants' preference for ethnic matching in counselling (e.g. Atkinson and Lowe, 1995; Greene, 1982; S. Sue, 2000). The results lend some support to the argument that potential Black clients may not be attracted to some counselling agencies due to their lack of recruitment of Black counsellors. It appears that diversity contextualises the experiences of many Black clients and is reflected in their counsellor preference (Thomas, 2002).

Even though they had stated that they would prefer an ethnically similar counsellor, some of these participants were included in the group of participants who previously had not selected a 'counsellor' on the basis of 'race' when they were asked simply to make a choice between two counsellors, despite the counsellors being racially different. Clearly, for some Black people, visible 'race' differences per se between themselves and a White counsellor would not deter them from entering into a cross-racial therapeutic relationship with the counsellor, and is consistent with other previous findings (Gambosa, Tosi & Ricco, 1976; Griffith, 1977; Parloff, Waskow & Wolfe, 1978). For such Black participants, racial differences in the therapeutic dyad would probably be accepted as a physical reality, rather than a distracting or interfering dynamic in the counselling relationship. If they were to terminate therapy prematurely, then disappointment with counsellor characteristics other than 'race', such as the counsellor's competence, may explain their actions. This is consistent with literature that found that counsellors' competence, credibility and expertness were important to clients (Atkusu et al, 1990).

The inconsistency in some participants' reported preferences are reminiscent of the inconsistencies to be found in the established literature in cross-cultural counselling psychology (e.g.. Goldberg & Tidwell's, 1990 and Shipp, 1986). Hence, it is feasible that discrepancies in the results reported in the current study also reflect within group racial identity differences in the sample, and would explain why they had various attitudes towards receiving counselling from a racially similar counsellor.

In line with previous research, the Church played a supportive role for many participants in this study. Since participants' use of religiosity, mysticism and spirituality feature as prominent processes in helping them deal with emotional distress, counsellors should bear this in mind when working with such individuals. Attitudes or interventions by counsellors that

communicate dismissal, or trivialising, of the role of God, or mystical forces in helping the client progress in therapy, are likely to alienate the client. In addition, they may be seen as evidence of the counsellor arrogantly and wrongly placing him/herself above a higher entity. Therapists need to be aware that an effective approach to helping many Black clients will incorporate their religious and spiritual beliefs. This does not mean that secular counsellors cannot work with Black people who are religious, though it does indicate a need for them to respect the pivotal role that spirituality plays in Black people's lives.

3.4.3 Consideration of contributory factors to results of current study (SG1)

3.4.3.1. Environmental and psychological factors

The vicinity from which the current sample belonged has a highly diverse range of ethnic groups and the area can actually boast a mental health workforce that includes a couple of Black psychiatrists and a few Black counsellors. However, like other professional Black mental health workers (apart from standard grade nurses), they are a small minority. When presented with the photo stimulus, participants may have made their choice based on these likely circumstances. Knowledge of such limited availability might have played a major role in their selection. Due to the paucity of such resources, it is more than likely that if they wanted to see a Black counsellor, the waiting duration would be much longer than for seeing a White counsellor. However, when asked directly about their preference for a counsellor of a similar 'race' to them, participants identified a Black counsellor. Possibly, with all other things being equal, and 'race' the only variance, participants would select a counsellor on the basis of her 'race', as Salter (1977) found with his participants.

3.4.3.2 Methodological factors

The study used two different methods of inquiry to find out participants' counsellor preference. The main difference between them was the presentation of visual images of two female 'counsellors' in the first condition, and that of highlighting 'race' in the second condition. Hence, both a multiple-choice design and a simple choice design (Ponterotto et al, 1988) respectively, were employed. When the first design was used, in which participants were simply presented with a picture of 2 female 'counsellors' who had many different physical features, of which one was 'race', participants' choice was not dominated by the 'race' of the counsellor. Yet, when the second deign was used and the counsellor's 'race' was mentioned,

then the majority of participants chose a counsellor who was racially similar to them. These findings correspond to the results of studies that have used the respective research designs.

Demand characteristics, such as the ethnicity of the researcher, may have contributed to the results. The presence of a *Black* research counselling psychologist asking *Black* participants about the importance of the '*race*' of the counsellor may have signalled to participants that to respond that they had a preference for an ethnically similar counsellor constituted the 'right' answer. However, it could also be argued that this design allowed for participants to be open and forthright about their preference.

Another way of trying to elicit participants' counsellor preferences without prompting them was to ask them a general question that seemingly did not specifically require a comment about 'race'. Participants were first asked what would encourage them to see a counsellor, and then what factors would put them off seeing a counsellor. Interestingly, not one respondent referred to 'race'. At least two explanations could be relevant here. The most obvious one would be that participants did not mention 'race' as a factor because it simply was not an issue for them in the counselling relationship. However, a more complex explanation may be more plausible. At this stage of the questionnaire, the concept of 'race' had not yet been introduced to participants; whereas the direct link between seeing a counsellor and presenting with psychological problems had been established. It is probable that when participants were asked about 'what type of things would make you more likely /or unlikely to see a counsellor', they were answering these questions within the constraints of 'presenting problems'.

As there was a reasonable split between those who had previous experience of counselling and those who had not, it was possible to investigate whether this experience influenced counsellor preference. This was not a predictor of counsellor preference in relation to 'race' and reinforces the findings of Atkinson et al, who also found that former clients' counsellor preference did not differ from those of 'naïve' respondents. This sample (in SG1) comprised of psychiatric consumers who were educated in psychological services. More than half had received therapy, which is similar to other studies, e.g. 60% in Rogers, Pilgrim & Lacey (1993). As a group of Black users of psychiatric services who had experienced talking therapies, respondents in the current study fared better than other Black psychiatric samples. But they did not fare as well as their psychiatric White counterparts in other studies in which 75% of White users had received therapy (Mental Health Foundation Report, 1997).

An enigma emerged in that even though over half of the sample were former clients, few cited counselling as their first strategy for helping them deal with their problems. During reading out the questionnaire this pattern became apparent. It was extremely tempting for the researcher to comment on this somewhat contradictory response, and to ask respondents to reflect on it. However, considering the role of the researcher as solely a 'talking questionnaire' rather than an interviewer, it was decided to refrain from this line of questioning and to stick precisely to the items in order to duplicate the questionnaire. This was also in keeping with what had been agreed with the respondents.

On reflection, by not asking respondents to expand and reflect on their answers, the researcher may have missed a valuable opportunity to get a deeper insight into the cognitive processes of former clients about counselling. Despite that, some speculation could be made as to possible contributory factors to the somewhat contradictory nature of former clients' responses. When former clients' responses were linked with the finding that nearly two thirds of respondents said they would consider seeing a counsellor, their responses do not appear incongruous. Most respondents had stated that counselling would not be their *first* port of call. They had not stated that they would not see a counsellor. Indeed, the majority of respondents considered themselves appropriate beneficiaries of counselling. It is probable that they would indeed seek counselling, though they would have tried other coping strategies before turning to counselling. Counselling was an option, but a last resort. This would support respondents' problem solving profile in that most of them first made use of their own internal resources and informal support networks.

3.4.4 Limitations of sample

The results can be used to provide some understanding of Black people's counsellor preferences, though there are some characteristics of the current sample that limits the extent to which the results can be generalised to other groups of Black people in the community. The majority of the participants constituted a clinical sample, and their typical diagnosis was schizophrenia. Since schizophrenia invariably leads to in-patient admission, it is not surprising that the majority of respondents had at least one, if not multiple, psychiatric hospital admissions. However, this may be due to inappropriate over diagnosis of this mental illness amongst Black people (Harrison, 1975). This prevalence of schizophrenia of 60.7% is lower

than reported for female respondents in other studies (74%), though more similar to the level reported for male respondents (55%) (Wilson and Francis, 1997).

Whilst there are many experiences that respondents have in common with other (non-clinical samples of) Black people, at the same time they also have extremely different experiences that are idiosyncratic to those groups of people with psychiatric diagnoses. Hence, their outlook as a member of the Black 'race' is flavoured by the type of treatments and interactions usually bitterly swallowed by those suffering with mental health problems. These include sectioning, forced medication, removal of human rights and privileges, denial of privacy, indelible labelling and stereotyping, psychiatric histories and files exposed to unwanted 'interested parties', alienation, stigmatisation, discrimination, loss of control, and being misunderstood, even shunned, by family, friends and one's community. Whilst some of these experiences may be familiar to Black people, for former psychiatric in-patients these debilitating experiences have a different aftertaste when force-fed to someone labelled as suffering from mental health problems. Here there is the 'double whammy' of being oppressed due to one's visible racial difference, and also due to one's mental health status.

The sample size consisted of 28 participants, which is low for studies using questionnaires. The small sample size reflects the difficulty that the researcher had in recruiting participants. This difficulty is typical for studies of this nature that are interested in the views of Black people, especially users of formal psychiatric and therapeutic services, who are approached by professional researchers (Robertson et al, 2000). One of the reasons is that Black people feel that they have been 'over researched' (Christie, 1995), yet they have not seen any 'real' application of their contributions by mental health service providers (Christie, 1995).

Of this sample, there was an overwhelming majority of male respondents. This reflects differences in gender attendance at the agency, and reinforces findings that Black men fare worse than Black women and a lot worst than their White male counterparts in terms of psychiatric diagnosis and hospital admissions (Cochrane, & Bal, 1989; Dunn, & Fatty, 1990). The results also complement research findings involving non-clinical samples of Black men that indicate they are viewed disparagingly (Byrson, 1998).

3.4.5 Conclusions and recommendations for further research

The majority of Black participants are 'psychologically-minded' and have an appropriate understanding of therapy. Therefore, they would make suitable clients for therapy, and few of them would need 'pre-therapy'. Although generalisation on a large scale cannot be claimed, this study provides some insight into racial counsellor preferences of Black former and potential clients. When asked directly about the importance of 'race' in the therapeutic encounter, Black participants overwhelmingly stated that they preferred a counsellor of the same 'race' to them, but did not mention this as frequently when the issue of 'race' was not raised. Considering the centrality of the 'race' of the counsellor in this study, it is feasible that the 'race' of the researcher was a confounded variable. Nevertheless, it could be inferred that by using a Black researcher to ask Black clients directly about their counsellor 'race' preference, this gave participants the permission to respond openly about a sensitive topic to a professional who accepted their views as valid. This may have been a rare opportunity. It is also clear that this group considered counselling as a viable option to help them deal with their problems.

However, it needs to be emphasised that respondents had 'reported' what they would, or intended to, do and their theoretical understanding of counselling. Intention does not always correlate with action. In addition, whilst participants could adequately describe the issues for which they would consider seeing a counsellor, it could be argued that this did not demonstrate that they would make appropriate use of therapy, such as attendance of sessions. Any analysis that hopes to provide insight into the impact of 'race' on the counselling process and Black people's appropriate use of therapy must take account of premature termination rates, preferably by looking at differences in drop out rates between different ethnic client groups seen by an ethnical diverse group of counsellors. Such a study would overcome the limitation of the current study, which asked participants to predict how their current feelings would influence their behaviour in the future. Like other studies that asked participants about their intentions to act in a certain way, rather than measuring their actual behaviour, it is appreciated that *"only modest correlations* [have been demonstrated] *between the two...Behaviours are affected by multiple factors including personality, motivation and situational variables"* (Ward, 1995: 62-3). Translated in terms of the current thesis, there may be a difference between participants' stated preference for a similar 'race' counsellor, as a pivotal factor in them engaging in counselling, and their actual pattern of help-seeking behaviour. Considering the controversial and probabilistic

relationship between intentions and behaviour, one way to address this is to look at the actual behaviour of Black clients.

CHAPTER 4: STUDY GROUP 2 ('SG2'): Client Premature Termination of Counselling and Length of Treatment

We don't judge a man because of the colour of his skin. We don't judge you because you're White; we don't judge you because you're Black; we don't judge you because you're brown. We judge you because of what you do and what you practice.

(Malcolm X,1989)

4.1. Introduction

Box 4.1. SG2 Research Link

Study group two (SG2) is the second of the three studies that attempts to unpack the relationship between 'race' and therapeutic outcome. SG2 is a logical progression from SG1, since it approaches the research question of the impact of 'race' on the outcome of counselling by looking at the actual behaviour of Black clients – attendance patterns in therapy in comparison to White clients, and also comparisons when their counsellor was either Black or White. Key indicators of how well therapy was acceptable and accessible to Black clients can be found in their withdrawal from counselling, and the amount of time they stayed in therapy.

Two results in particular from the previous study (SG1) indicated the need to conduct the current study (SG2): Firstly, when asked directly if they would prefer an ethnically similar counsellor, participants overwhelmingly responded affirmatively, yet most did not bring this issue up themselves; secondly, the high level of acceptability of counselling by potential Black clients as an appropriate resource for relieving emotional distress. Black individuals would consider counselling as an appropriate (additional) agency for problem solving even though they had access to other support mechanisms. These results indicated that contrary to much popularised non-empirical (e.g. anecdotal and purely theoretical) literature in psychology, there

is evidence to suggest that Black individuals are interested in (cross-racial and same-'race') therapy and would use it appropriately for helping them relieve psychological issues.

The participants in the previous study (SG1) were suitable, as the aim of the research was to explore Black people's 'psychological-mindedness' and whether they would be deterred from entering into counselling when the facility of an ethnically similar counsellor was not provided. It was designed to ascertain Black people's appropriateness for counselling and to get an insight into a decision making process *before* (re-) entering into counselling, especially whether or not the 'race' of the counsellor was a determining factor in entering counselling.

Ethnic minority participants might not explicitly express a preference for a counsellor of a similar 'race', yet they may have an actual preference for this same 'race' dyad in the counselling relationship (e.g. Turner, & Manthei, 1986), which was indicated by their non-attendance due to the absence of an ethnically similar counsellor (Akintson, Jennings & Liongson's, 1990). These studies reinforce the truism that intentions are not a convincing predictor of actions (La Piere, 1934; Shrigley, 1983; Ward, 1995). The implication is that in some situations Black clients may have a preference for same 'race' counselling dyad, but for some reason may not feel able to state this preference. This indicates the complex and multilayered relationship between preference for an ethnically similar counsellor and help seeking behaviour.

In order to get a clearer understanding of the impact of 'race' on the outcome of counselling, a logical progression would be to look at the *actual behaviour of Black clients.* A typical behavioural measure would be their actual drop-out rates (Abramovitz & Murray, 1983). There is a lack of a healthy supply of statistics on ethnic profiles of clients. This makes it very difficult, if not impossible, to investigate any type of relationship between counsellor preference of Black British clients and premature termination of therapy. This difficulty may explain inconsistent findings. Not all studies have supported a high correlation between racial counsellor preference and unplanned ending of counselling by Black clients. Reed (1988) found that there was no difference in drop-out rate between Black clients who preferred a Black counsellor but were assigned a White counsellor, and those who preferred a Black counsellor and were assigned a Black counsellor. Surprisingly, whereas some of Sue's findings have advocated the therapeutic benefit of ethnic matching for some Black clients, some of his other work has indicated the opposite. Sue, Fujino, Hu, Takeuchi (1991) reinforced Reed's

findings when they concluded that *"for all groups except the African Americans, ethnic match [ing] resulted in substantially lower odds of dropping out than for unmatched clients"* (p536).

However, Terell & Terell (1984) found that an ethnically similar counsellor had a significant effect on outcome of counselling. Black clients with high levels of 'cultural mistrust' were more likely to terminate counselling prematurely with a White counsellor than with a Black counsellor. Black clients who were assigned a White counsellor had higher drop-out rates after the first session than those who were assigned a Black counsellor (Flaskerud, 1986). Similar results were reported by Wade & Bernstein (1991) over a period of three sessions as well as for White clients (Sue, Fujino, Hu, Takeuchi & Zane, 1991).

In view of the difficulties studying cultural match, most researchers have reformulated the issue into one involving ethnic matching (which usually means visible racial features) in terms of whether ethnic similarity between therapist and client results in better treatment outcome than those achieved from ethnically dissimilar dyads (Alladin, 1994). Obviously, 'ethnic' matching is not identical to 'cultural' matching because individuals of the same ethnicity may be culturally different. Nevertheless, ethnicity and cultural knowledge are highly correlated (Sue, Fujino, Hu, Takeuchi, Zane, 1991).

Though the findings in SG1 do not apply directly to premature termination, they do imply that lack of ethnic matching between client and counsellor may be part of the reason why some Black clients may decide to withdraw early from therapy, such as after the first session. Similar to other clients, for many Black clients, the initial session provides the first opportunity for them to find out the 'race' of their counsellor. Since the counsellor's skin colour (which is invariably an obvious indication of racial group) is non-negotiable, a client who is dissatisfied with a racially dissimilar counsellor is unlikely to return. Related to this is the amount of time clients actually stay in counselling since *"...Length of treatment (is) an important indicator of outcome because it is known to be directly related to favourable treatment outcomes"* (S.Sue, 2000:7). Both White and Black clients stay in therapy longer when ethnic matching occurred (Orlinsky, Grawe & Parks, 1994).

Although most researchers cite the importance of matching, few empirical studies have been conducted – most of them have been analogue, typically with the use of students (e.g. Ponterotto et al 1988; Sue 1988). It is evident that any study that wishes to gain a clearer understanding of

the impact of 'race' on the outcome of counselling should apply itself to first investigating the status of Black clients' non-attendance after initially engaging with counselling. Such information could then provide the foundation on which to paint a wider picture of the relationship between premature termination and ethnic matching. This would have implications for the outcome of therapy. In order to increase insight into this issue, a study would need to be conducted that made meaningful comparison between different ethnic groups, with regards to attrition rates. This indicates identifying a population rich in racial and ethnic diversity, including substantial African and Caribbean communities, that is likely to have a representative sample of Black clients.

One of the challenges to conducting research on the relationship between ethnicity and counselling outcome, such as attrition rates is that clients are requested, not required, to state their ethnic identity. Some staff may feel uncomfortable to ask clients this at the assessment session. Inevitably, in most cases clients do mention their ethnicity and its importance. This may be later on in counselling, by which time counsellors may not add it to the standard demographic questionnaire, though they may include this information in the body of their session notes. In order to maintain very high standards of confidentiality, session notes are usually kept separate from standard intake material, which is anonymous and typically used for statistical and service planning purposes. With such irregularity of recording, and no obligation to do so, not many counselling services publish figures regarding the ethnic profile of their clients (Eleftheriadou, 1994: 11). Whilst respecting the policy and ethics of therapeutic service, this makes it difficult to explore patterns of premature termination of counselling by Black clients in Britain, though there is some indication that recently counselling agencies are beginning to consistently publicise such figures. Khan (1991) produced some clinical evidence to show that counselling psychology services do not reflect the racial and cultural diversity in Britain (cited in Eleftheriadou, 1994:11). However, if studies not have benefited from access to all of the relevant details on each client, this may explain concerns over retention of Black clients.

4.1.2 Rationale for present study

Many studies have tended to approach this question of ethnic matching using one of two research designs. Clients are either asked about their counsellor preference at the beginning of counselling and then their attrition rate is noted after, typically not more than a few sessions, or archival data is

analysed (Flaskerud, 1986; Sue, Fujino, Hu, Takeuchi, 1991). The attraction of archival data is that a wider range of clients over a longer period of time is available. This gives a fuller picture of patterns of counselling attendance amongst clients.

Premature termination is typically operationalised in the counselling psychology literature as the client not returning after the first session, for instance, Flaskerud (1986) who looked at the records of 300 clients in four public community mental health agencies; a review by Sue, Fujino, Hu, Takeuchi, (1991); and the work by Terrell & Terrell (1984). If a disproportionate number of Black clients drop-out prematurely from therapy with White counsellors, then it can be inferred that 'race'/ethnicity is relevant and has probably been ignored or mismanaged in counselling (Abramovitz & Murray, 1983). Similarly, if the 'race' of the counsellor is a significant variable, Black clients' decision to remain in, or withdraw from, counselling is likely to be affected once they have seen the 'race' of the counsellor (which is revealed in the first session). The counsellor's 'race' would predict whether or not Black clients return for their next counselling session. It is acknowledged that there could be other reasons why Black clients do not return, but this principle is one of the few designs to limit decision-making processes to first impressions that include physical appearance.

The underlying theme is whether Western style counselling can meet the psychological needs of Black individuals. This poses the challenge of whether to look at the therapeutic outcome for Black clients per se or whether to compare them with another ethnic group. The advantage of the first option is that comparisons can be made within this group such as whether Black clients benefit from certain therapeutic processes: In this case ethnic matching between counsellor and client. The second option is attractive, since it allows clarification as to whether Black clients' outcome in therapy is different from that of other ethnic groups. Intuitively this makes sense: If Black clients are found to be faring similarly in therapy compared to other ethnic groups, then any issues around outcome of therapy are not exclusive to the Black community. Though, of course, it is acknowledged that this does not deny the fact that Black clients' issues may be qualitatively different from other racial groups. This would go beyond research that looks simply at premature termination and would consider whether Black clients engage with the counselling process shorter or longer than other ethnic groups. Hence, whilst looking at Black clients' behaviour after the first session conveys something about their premature termination in counselling, also looking at their length of stay in therapy in comparison to other racial client groups provides a fuller insight into their overall attendance profile within a wider context.

4.1.2.1 Objective of present study

Following on from the rationale for the current study (SG2), the objective of this study is to determine if ethnic matching for Black clients is predictive of drop out status by:

1. Investigating if Black British clients drop out of counselling prematurely. This would complement the mostly American findings on this issue and add to the paucity of British research in this area;
2. Investigating whether Black clients length of stay in therapy is comparable to other ethnic groups;
3. Ascertaining if there is a relationship between Black clients' attrition rates in counselling and whether or not they are ethnically matched with their counsellor.

4.1.2.2. Hypotheses of present study

Following the above objective, four hypotheses are proposed:

1. That there will be a significant difference in premature termination of counselling between Black and White clients. The prediction is that more Black clients will withdraw from therapy after the first session than White clients;
2. That there will be a significant difference in duration of counselling attendance between Black and White clients. It is expected that Black clients will stay in therapy shorter than White clients;
3. That there will be a significance difference in premature termination between Black clients who receive counselling from a Black therapist and those who do not. The prediction is that less Black clients who receive counselling from a Black therapist will withdraw from therapy after the first session than those Black clients who do not;
4. That there will be a significance difference in length of stay in counselling between Black clients who receive counselling from a Black therapist and those who do not. The prediction is that the latter will remain in counselling significantly shorter than the former.

4.2. Method

4.2.1 Design

This was an independent design and the follow tests were used to test the 4 hypothesis

1. *A 2x2 Chi-Squared design.* One variable was Black clients and this had two levels: Black clients who returned after the first session and Black clients who did not return after the first session. This was compared with the other variable, White clients, of which there were two levels: White clients who returned after the first session and White clients who did not return after the first session.
2. *An independent t-test.* The independent variable was 'race' with two levels: Black clients and White clients. The dependent variable was duration of counselling. This was measured in discrete interval counselling units. Each session attended counted as one counselling unit.
3. *An independent t-test.* The independent variable was Black clients with two levels: Black clients who received counselling from a Black therapist and Black clients who did not receive counselling from a Black therapist. The dependent variable was duration of counselling. This was measured in discrete interval counselling units. Each session attended counted as one counselling unit.
4. *A 2x2 Chi-Squared design.* One variable was Black clients' premature termination of counselling and this had two levels: Black clients who returned after the first session and Black clients who did not return after the first session. The other variable, 'race' of therapist seen for counselling, had two levels: Black clients who were seen by a Black therapist and Black clients who were not seen by a Black therapist.

Following the established tradition of other research in the area of counselling psychology (e.g. Flaskerud, 1986; Lowenstein, 1987), in this study premature termination is operationalised as the client not returning for counselling with the same counsellor after the first session.

4.2.2 Participants

The participants had formerly received counselling at a mental health agency for local residents. Only self-referrals are accepted and this can be done by telephone, letter, or in person. The agency is located in a part of inner-city London, rich in racial and ethnic diversity with one of the largest African and Caribbean communities in England (Haskey, 1991). The individuals are mostly from low socio-economic background and have high levels of unemployment. Of the 279 records, 104 on Black and White clients were in a usable form: These contained enough details on both clients' and counsellors' ethnicity, and clients' attendance patterns.

4.2.3 Procedure

Former clients' attendance records from the agency, since its conception, over a period of 7 years, were analysed. Demographic profiles of 104 former Black and White clients, which are kept separately from session notes, were used. Details were collected on former clients' age; gender; ethnicity; counsellor characteristics preferences; whether clients returned for counselling after the first session; the amount of sessions that each client attended; the gender and ethnicity of the counsellor they saw for counselling; whether or not they had received therapy in the past. These were then recorded on a grid designed by the researcher especially for this study.

4.2.4 Analysis of Data

The data was analysed using SPSS 10.1 for Windows.

4.3 Results

4.3.1 Client characteristics

4.3.1.1 Ethnicity and Gender

Table 4.1: Ethnicity and Gender of Clients

		GENDER		Total
		MALE	***FEMALE***	
ETHNIC GROUPS	***BLACK***	6	19	25
	WHITE	29	50	79
	Total	35	69	104

Table 4.1 revealed that over three times as many White former clients compared to Black former clients attended the organisation for counselling. Similarly, over three times as many Black females attended for counselling, compared to Black men, whereas just under double the amount of White women attended compared to White men. In addition, the figures in Table 4.1 showed that overall, nearly twice as many females as males attended the agency for counsellor.

4.3.1.2 Age

Table 4.2 Age of Respondents by Ethnicity

ETHNIC GROUP	***AGE***	***N^0***
White Clients	36.26	79
Black Clients	32.55	25

Table 4.2 shows that Black former clients were younger than White former clients. The average age for the both groups was nearly 35 years (34.81 years), so the White former clients were slightly older than the average age of the two client groups.

Results for Hypothesis: 1

4.3.2.Ethnicity and premature counselling

Table 4.3 Chi-Square Test for Differences in Premature Termination Rates Amongst Black and White Clients

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.476[b]	1	.490		
Continuity Correction[a]	.172	1	.679		
Likelihood Ratio	.463	1	.496		
Fisher's Exact Test				.582	.332
Linear-by-Linear Association	.472	1	.492		
N of Valid Cases	96				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.75.

As shown in table 4.3, a Fisher's Exact Probability Test did not demonstrate that premature termination of counselling was significantly related to ethnicity ($X^2 = .476$, df = 1, p =0.332). That is, there was no difference in early withdrawal rates between Black and White clients. Hence, hypothesis 1 was not supported and it could not be argued that Black clients had a significantly higher early drop out rate than White clients.

Table 4.4 Correlation Coefficients for relationship between Premature Termination of Counselling and Ethnicity of Clients

Correlations

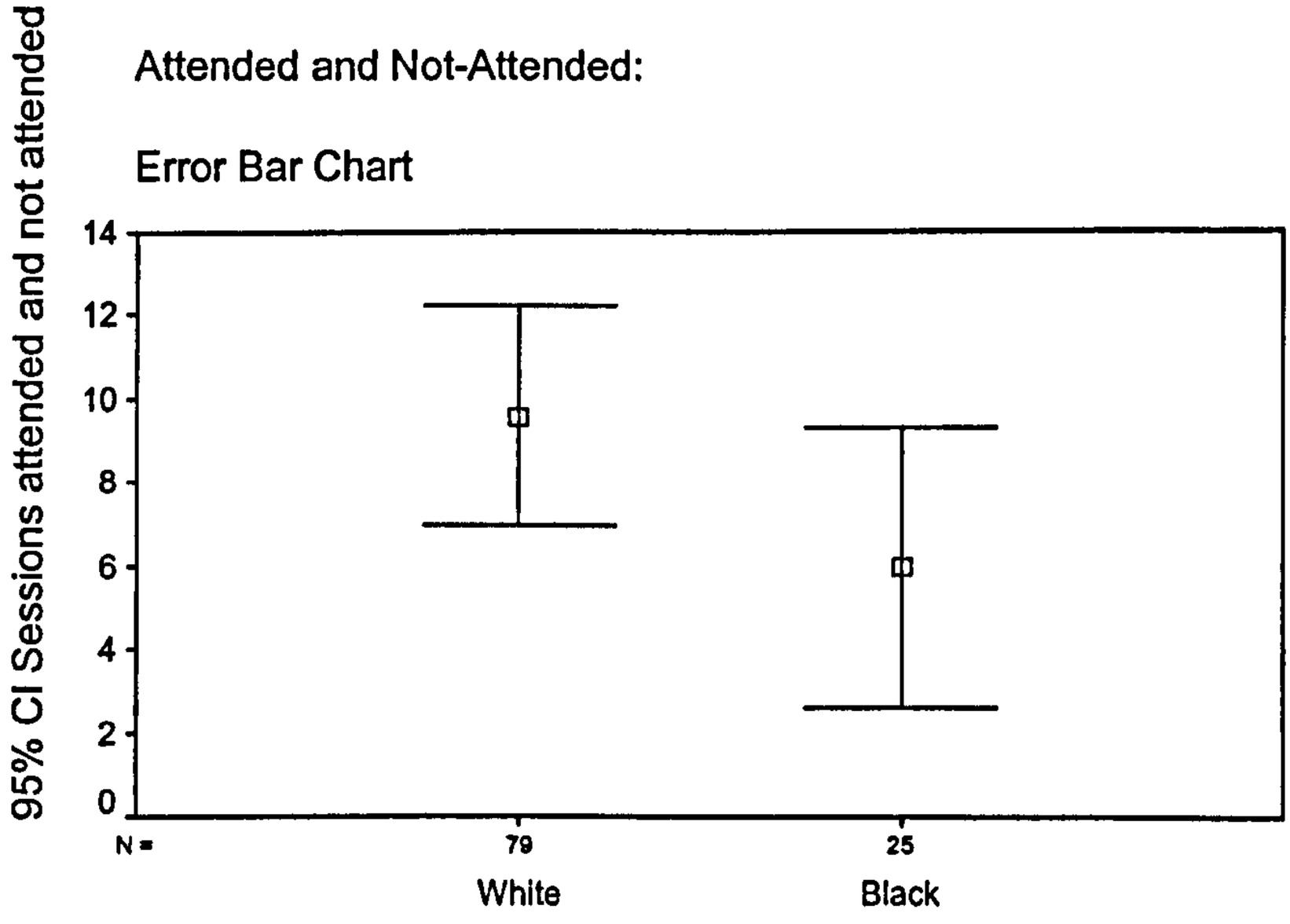
			ethnicity of clients: either Black or White	return rate of Black and White clients
Spearman's rho	ethnicity of clients: either Black or White	Correlation Coefficient	1.000	.070
		Sig. (1-tailed)	.	.248
		N	104	96
	return rate of Black and White clients	Correlation Coefficient	.070	1.000
		Sig. (1-tailed)	.248	.
		N	96	96

As can be seen from table 4.4, the results of the Spearman's rho correlation coefficients revealed a very weak positive relationship between ethnicity and premature termination of counselling. A statistically significant relationship between 'race' of client and premature termination in counselling was not found (rho=.070, N=96, p=.248).

Results for Hypothesis: 2

4.3.3.Ethnicity and length of_counselling

Fig 4.1 Confidence Intervals of Sessions Attended and Not-Attended:



Sessions attended and sessions not attended

As can be seen from Fig. 4.1, the error bar chart shows that the mean number of sessions attended (based on both those sessions that were and were not attended) for White clients was around 10 sessions (9.60), whilst the mean no of sessions attended (based on both those sessions that were and were not attended) for Black clients was 6. This seemed to suggest that, on average, White clients attended more sessions than Black clients. However, as the sample means are only point estimates of the population means for each group, consideration of the confidence would indicate where the population mean for each sample would fall. The error bar shows that the lower bound for the 95% confidence interval for the White sample was around 7 (6.96) sessions, and the upper bound was around 12 (12.22) sessions. This indicates that one can be 95% confident that the mean number of sessions for this population fell within this interval. The lower bound of the 95% confidence interval for Black sample was around 3 (2.61) sessions, and the upper bound was around 9 (9.39) sessions. This indicates that one can be 95% confident that the mean number of sessions for this population fell within this interval. If the difference between Black and White clients was due to sampling error, then there would be overlap between the two sets of confidence intervals. As can be seen (Fig. 4.1), there is considerable overlap between the two sets of confidence intervals, so any difference found is likely to be due to sampling error, rather than actual difference

Table 4.5. Independent *T*-Test for Difference in Duration of Attendance of Counselling Between Black and White clients for attendance and non-attendance.

Independent Samples Test

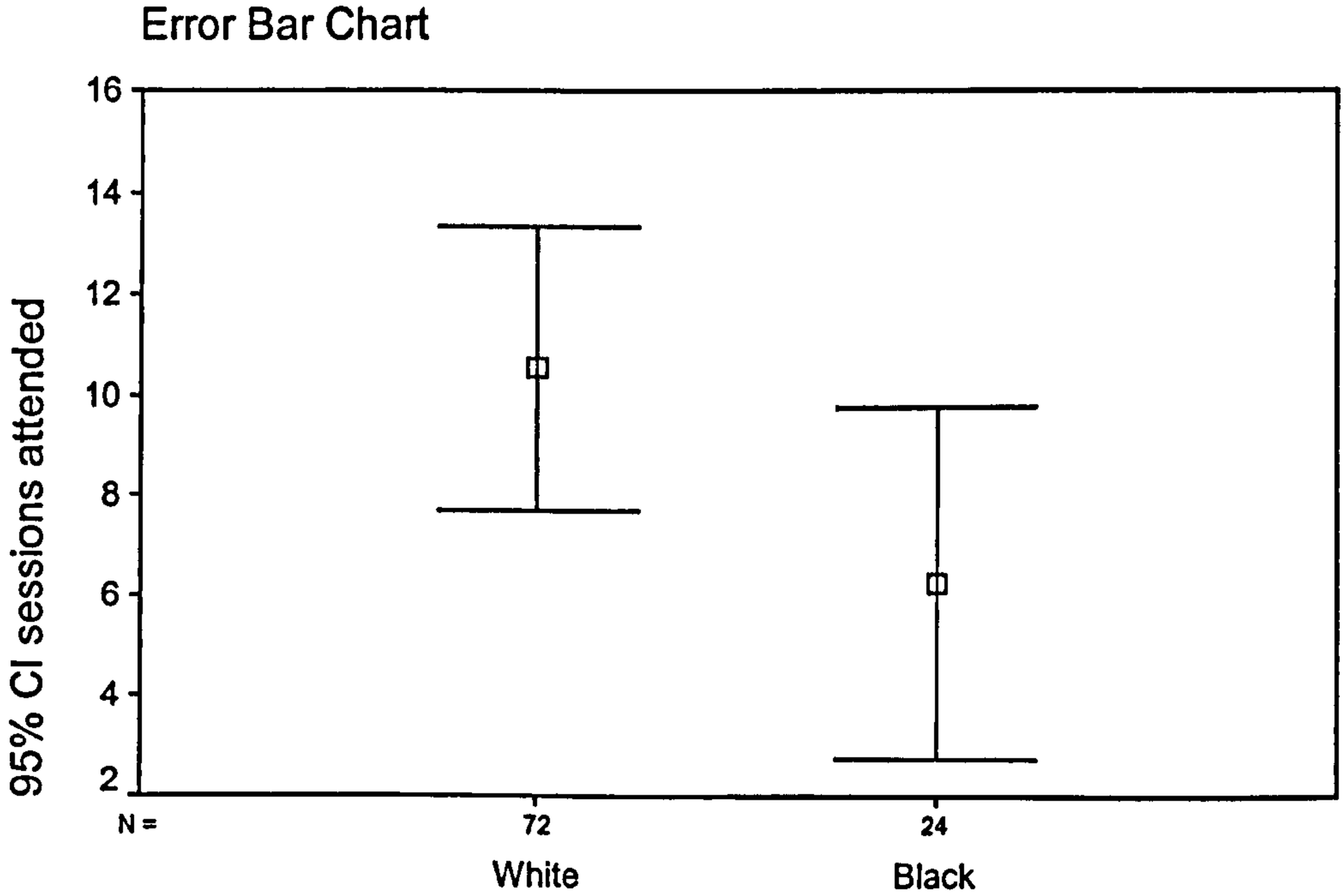
		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sessions attended and not attended	Equal variances assumed	2.264	.135	1.422	102	.158	3.5949	2.52738	-1.41812	8.60799
	Equal variances not assumed			1.706	57.7	.093	3.5949	2.10762	-.62441	7.81428

Although the descriptive statistics indicated that there was a numerical difference, which seemed to suggest that White clients stayed in counselling longer than Black clients, as shown in table 4.5, an Independent *t*-test did not show a significant difference in length of counselling for both sessions attended and not attended between Black and White clients ($t = 1.422$, df = 102, $p = 0.079$, one tailed).

Sessions attended

Fig 4.2 indicates that any difference found is likely to be due to sampling error, rather than actual difference as there was some overlap between the two sets of confidence intervals. The lower bound of the 95% confidence interval for sessions attended by White clients was 7 (7.73) sessions and the upper bound was 13 (13.32) sessions. The lower bound of the 95% confidence interval for sessions attended by Black clients was 3 (2.74) sessions and the upper bound was 10 (9.95) sessions.

Fig 4.2. Confidence intervals for sessions attended



ethnicity of clients: either Black or White

Table 4.6. Independent *T*-Test for Difference in Duration of Attendance of Counselling Between Black and White clients for attendance.

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
sessions attended	Equal variances assumed	1.965	.164	1.632	94	.106	4.2778	2.62157	-.92740	9.48296
	Equal variances not assumed			1.947	56.753	.057	4.2778	2.19745	-.12295	8.67851

Descriptive statistics indicated that there was a numerical difference, which seemed to suggest that, when only sessions attended were taken into account, White clients stayed in counselling longer than Black clients. The mean number of sessions attended for the Black client group was 6 (6.25) and the mean number of sessions attended for the White client group was 11 (10.52). Indeed, they only slightly missed statistical significant. However, as shown in table 4.6, an Independent *t*-test did not show a significant difference in length of counselling between Black and White clients ($t = 1.632$, df = 94, $p = 0.053$, one tailed). Hence, it could not be argued that White clients stay in therapy longer than Black clients.

Results for Hypothesis: 3

4.3.4.Ethnicity and counsellor preference

Table 4.7. Chi-Square Test for Differences in return rate between Black clients who were seen by a Black counsellor and those who were seen by a White counsellor

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.336[b]	1	.562		
Continuity Correction[a]	.013	1	.908		
Likelihood Ratio	.344	1	.557		
Fisher's Exact Test				.669	.461
Linear-by-Linear Association	.322	1	.570		
N of Valid Cases	24				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.63.

It was not possible to conduct a statistical analysis on Black clients' preference for an ethnically similar counsellor since not all clients were asked about their counselling preference, and, more commonly, preference stated by many clients was for a female counsellor. However, there was some sparse qualitative data that indicated that for some Black clients, especially those bringing 'race'-specific issues to counselling, a culturally sensitive counsellor was of vital importance. An analysis was made of the differences in return rate between Black clients who were seen by a Black counsellor and those who were seen by a White counsellor. Table 4.6 shows that a Fisher's Exact Probability Test did not reveal a statistically significant result (X^2 = .336, df=1, p=.461). So it could not be argued that Black clients who received therapy from a Black therapist had lower rates of premature termination than Black clients who were seen by a White therapist.

Table 4.8 Correlation Coefficients for Differences in return rate between Black clients who were seen by a Black counsellor (ethnic matching) and those who were seen by a White counsellor

Correlations

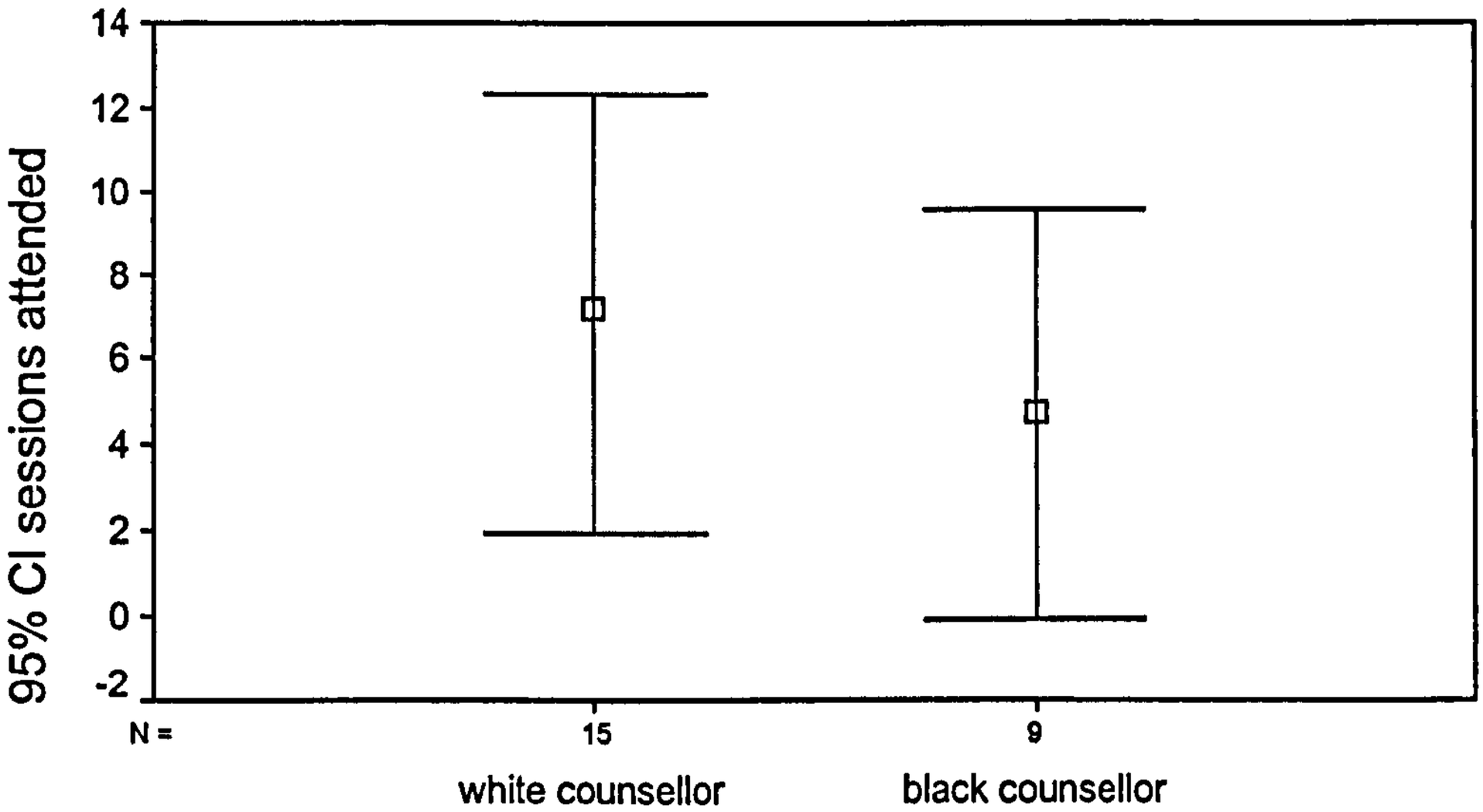
			whether a Black client was seen by a Black or White counsellor	whether or not Black client returned
Spearman's rho	whether a Black client was seen by a Black or White counsellor	Correlation Coefficient	1.000	-.118
		Sig. (1-tailed)	.	.291
		N	24	24
	whether or not Black client returned	Correlation Coefficient	-.118	1.000
		Sig. (1-tailed)	.291	.
		N	24	24

As can be seen from table 4.7, the results of the Spearman's rho correlation coefficients show that there was a very weak negative relationship between ethnicity and ethnic matching in counselling. A statistically significant relationship between 'race' of counsellor and whether the Black client withdrew prematurely from counselling was not found (rho= -.118, N=24, p=.291).

Results for Hypothesis 4

4.3.5. Ethnicity and Counsellor retention rates

Fig 4.3 Confidence interval for sessions attended by Black clients



whether a black client was seen by a black or white counsellor

Fig 4.3, indicates that any difference found is likely to be due to sampling error, rather than actual difference as there was considerable overlap between the two sets of confidence intervals. The lower bound of the 95% confidence interval for sessions attended by Black clients seen by White counsellors was 2 (1.93) sessions and the upper bound was 12 (12.33) sessions. The lower bound of the 95% confidence interval for sessions attended and not attended by Black clients who were seen by Black counsellors was 0 sessions (-.0498) and the upper bound was 10 (9.61) sessions. In fact, this is a very unusual result. At first glance it would appear that may be the result was due to some type of mistake or oversight with inputting the data. So a check was performed to locate possible data entry errors (e.g.

scrutinising a frequency grid for any noticeable irregularities). This did not provide any insight into the odd result. One of the problems with this data is that whilst there is a reasonable size data set, there is actually a relatively small sub-set of Black clients compared to White clients: A ratio of nearly 3:1. This meant that when analysis was conducted on only Black clients seen either by a Black or White counsellor, the analysis would have included all other data as missing values. In order to control for this type of calculation all other cases were filtered out. This did not have any real impact on the lower bound of the confidence interval for sessions attended and not attended by Black clients who were seen by Black counsellors It was clear that larger numbers were needed and, as it stands, if this result were extrapolated to the wider population, no difference between the sessions attended and not attended by Black clients who seen by White counsellors and those who were seen by Black counsellors would be found.

Table 4.9 Independent *t*-test for differences in length of stay in therapy between Black clients who received therapy from a Black therapist and those who received therapy from a White therapist when only sessions attended were considered.

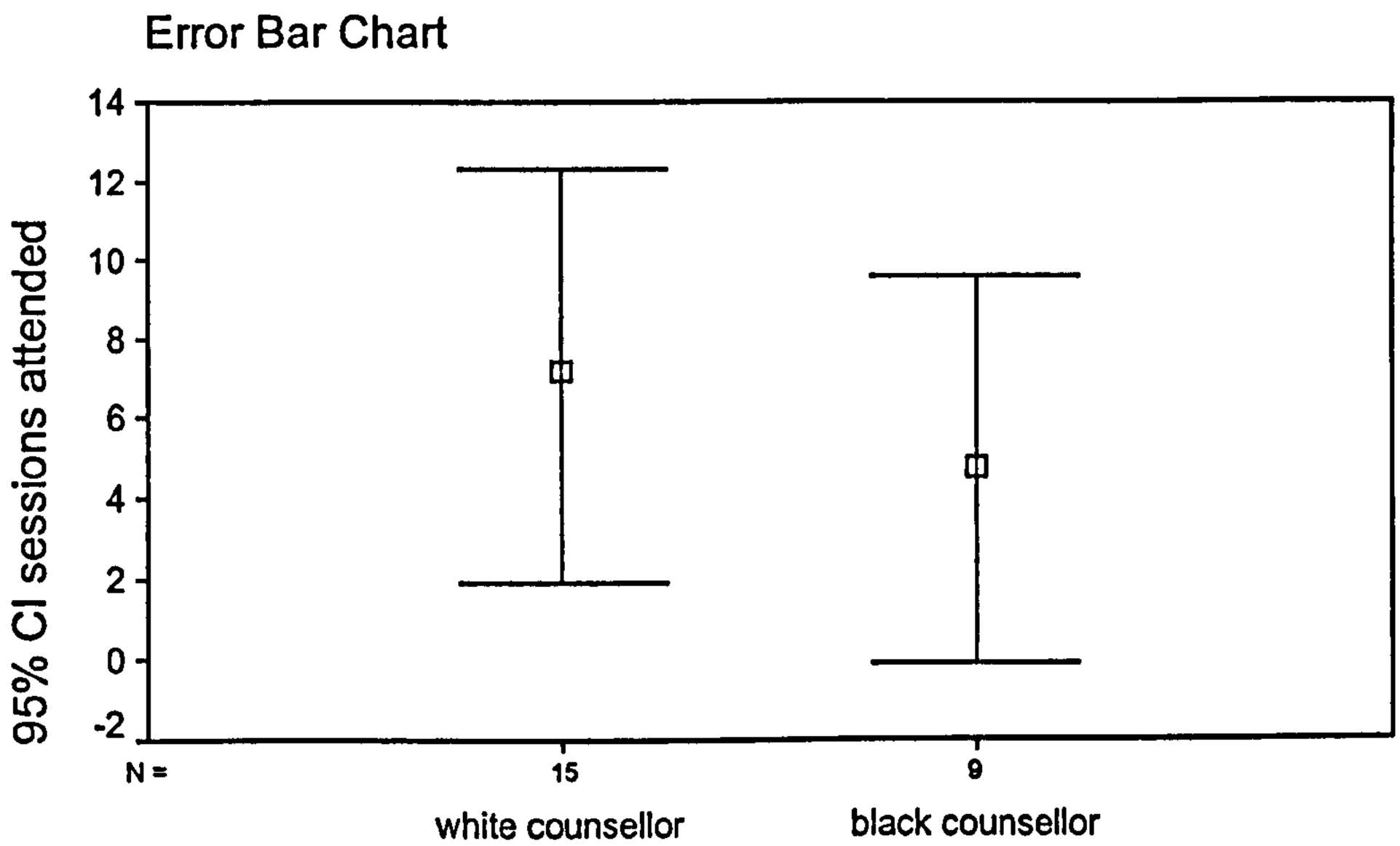
Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
sessions attended	Equal variances assumed	1.559	.225	.666	22	.513	2.3556	3.53829	-4.98241	9.69352
	Equal variances not assumed			.735	21.622	.470	2.3556	3.20275	-4.29329	9.00441

The mean number of sessions attended for the Black client group who were seem by a Black therapist was 5 (4.78), whereas, the mean number of sessions attended for the Black client group who were seen by a White therapist was 7 (7.13), which suggested that there may be a possible significant difference, though not in the direction predicted. It was expected that Black clients on average would stay in therapy longer if they received therapy from a Black therapist than if they received it from a White therapist. These means indicated the reverse to be true. However, as shown in table 4.8, an Independent *t*-test did not show a significant difference in length of counselling between Black clients who were seen by a Black therapist and Black clients who were seen by a White counsellor ($t = .666$, $df = 22$, $p = 0.256$, one tailed). Hence, it

could not be argued that Black clients remain in counselling longer when they are seen by a Black counsellor than when they are seen by a White counsellor.

Fig 4.4. Confidence interval for sessions attended and sessions not attended by Black clients whether a black client was seen by a black or white counsellor



Similarly to fig 4.3, Fig 4.4 indicates that any difference found is likely to be due to sampling error, rather than actual difference as there was considerable overlap between the two sets of confidence intervals. This is not surprising, since for one set of results sessions attended and not attended were considered, and for another only sessions attended were considered. In reality, there was only one client who did not attend any sessions. The lower bound of the 95% confidence interval for sessions attended and not attended by Black clients seen by White counsellors was 2 (1.93) sessions and the upper bound was 12 (12.33) sessions. The lower bound of the 95% confidence interval for sessions attended and not attended by Black clients who were seen by Black counsellors was 0 sessions(-.07) and the

upper bound was 9 (8.67) sessions. As indicated by fig 4.3, this is a very unusual result and would seem to suggest that if any significant difference were found, it could *only* be due to sampling error. It would be very surprising if any difference were found between the sessions attended and not attended by Black clients who were seen by White counsellors and those who were seen by Black counsellors.

Table 4.10 Independent *t*-test for differences in length of stay in therapy between Black clients who received therapy from a Black therapist and those who received therapy from a White therapist when sessions attended and not attended were considered.

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sessions attended and not attended	Equal variances assumed	1.919	.179	.840	23	.410	2.8333	3.37277	-4.14378	9.81045
	Equal variances not assumed			.914	22.999	.370	2.8333	3.09990	-3.57930	9.24597

Similarly, to when only sessions attended were considered, it appeared that Black clients stayed in therapy longer with White counsellors than with Black counsellors. There was little difference between the mean number of sessions attended when either only sessions attended were analysed or when sessions attended and sessions not attended were analysed for the Black clients who were seem by a Black therapist and those who were seen by a White therapist. This could have been because in reality, there was only 1 Black client who did not attend. The Independent *t*-test in table 4.9 did not show a significant difference in length of counselling between Black clients who were seen by a Black therapist and Black clients who were seen by a White counsellor ($t = .840$, df = 23, $p = 0.205$, one tailed), when both sessions attended and those not attended were considered together. Hence, it could not be argued that Black clients remain in counselling for a shorter period of time when they are seen by a White counsellor than when they are seen by a Black counsellor even when sessions not attended were considered.

4.4. Discussion, Conclusions and Implications

4.4.1 Summary of results

The results showed that there were no significant differences in premature termination of counselling between Black and White clients. Black clients did not have a higher early attrition rate than White clients. There was no significant difference in duration of counselling attendance between Black and White clients. On average, both Black and White groups spent about the same time in therapy. Black clients who received counselling from a Black therapist did not remain in therapy longer than those Black clients who did not.

4.4.2. The use of cultural sensitivity in engaging Black clients

To some extent these findings were not surprising since one would not necessarily expect there to be a significant difference if ethnic matching is based exclusively on visible 'race' feature. This would support the work of Patterson (1986) who is against ethnic matching and argued that what is important is that the counsellor is culturally sensitive. It is probably that one of the reasons for not finding a difference was because the counsellors themselves were culturally sensitive. This would be reflected in the fact that they elected to practice in an area rich in ethnic diversity. However, it is not a one way process, and the client must be willing to engage in order for the therapist to demonstrate cultural sensitivity or respond appropriately to the his/her needs. This is highly likely to be the case as all clients had self-referred themselves for counselling.

4.4.3. Relating interpersonally and racial identity attitudes in cross-racial dyads

Clients' willingness to simply engage, though a powerful process in counselling, seems to be too a vague a variable as the sole key to understanding the complexity of cross-cultural counselling. Of specific relevance is how Black clients see themselves in relation to their 'race'. The concept of personal identity is central to both the content and process of counselling for both the client and the counsellor. For the cross-racial dyad of Black client and White counsellor in this study, it was not so much 'race' per se, but probably how relating at the interpersonal level accommodated the client's racial identity.

4.4.4 Methodological issues: Availability of demographic details and representative sample

This study contained a small sample size of former Black clients, and this limits the extent to which the findings can be generalised to individuals in the Black community. It could be argued that whilst the geographical location from where the sample was taken is rich in ethnic diversity, the small numbers support the many claims in cross-cultural counselling literature that Black people in Britain are not accessing mainstream psychological services (Browne, 1997; Burnett, Mallett, Bhugra, Hutchinson, & Leff, 1999; Callan, 1996; Christie, 1995; Cochrane, & Sashidharan, 1996; Davies, Thornicroft, Lesse, Higginbotham & Phelan, 1996; Eleftheriadou, 1994; Fernando, 1991; Khan, 1991; Littlewood and Lipsedge, 1989; Lloyd and Moodley, 1992; Mental Health Foundation, 1997; Reid-Galloway, 1998; Dept of Health, HO, 1992; Robertson et al, 2000; Thomas, 2000). However, they do indicate that once in counselling, Black clients did not fare any worse than their White counterparts. This small sample size reflects the difficulty that researchers in this area have documented in accessing full data sets. Small sample sizes point to the need for counselling agencies to record complete demographic profiles on their clients (though many may be reluctant to do so), if these same agencies are to benefit from studies that endeavour to answer research questions around accessibility and acceptability of their therapeutic services to their ethnic minority community

4.4.5. Implications and conclusions

Since it is shown that not all Black clients wish to be paired with a racially similar counsellor, we as counsellors, therapists and psychologists need to be more sensitive to how we address the issue of cross-cultural counselling. This has implications for how we as practitioners communicate our curiosity to clients e.g. not to be over-curious, or prescriptive, about their 'need' for ethnic matching. Whilst caution should be exercised when extrapolating these findings, the results suggest that for some clients, ethnic matching is not essential. This again highlights the need for inter-cultural and multicultural counselling competencies training to be given a higher profile in counselling e.g. for trainee counselling psychologists and for continuing professional development ('CPD'). The results also demonstrate that there are White counsellors who are able to apply their skills in the therapeutic relationship to provide an appropriate therapeutic service when working cross-culturally.

Chapter 5: Study Group Three ('SG3'): Application of an American psychometric tool to a British Sample

"We [the film team of the movie' Mo Better Blues'] had a wrap ceremony [end of film production celebration], as we always do...It was very moving [amongst] the cast and crew...There was a powerful feeling among us, a sense of family. There we were, a group of young Black people who had forged ahead and made a difference in the vicious world of Hollywood...We have so much love and respect for each other as Black people who continue to grow in our respective fields. This bond between us may have made some White crew members feel like outsiders, but on wrap day everyone's happy, everyone feels part of the team". (underline added). Spike Lee, 'The Wrap: December 1, 1989' (In Lee & Jones, '*Mo' Better Blues*', 1990 p101),

5.1 Introduction

Box 5.1. SG3 Research Link *As the last in the trilogy, this study (SG3) aimed to reconcile different findings in SG1 & SG2 by investigating racial identity attitudes that have been claimed to feature in Black (potential) clients' differential strength of preference for counsellors who resemble them. Different levels of commitment to one's 'race' in the Black community could explain why some Black individuals (who attach high priority to their racial identity) place importance on having a racially similar counsellor, whereas other Black individuals (who assign it low status) are not concerned if they are not matched with an ethnically similar counsellor. A logical starting point would be, where appropriate, to make use of a tool that adequately clusters different levels of racial identity attitudes in Black individuals and makes predictions about counsellor preference. Before such a tool can be used, its robustness with a Black British sample would need to be assessed. SG3 begins this process by investigating the psychometric properties of such a tool ('RIAS').*

5.1.1. A case for within-group differences of racial identity attitudes

The preceding two studies (SG1 and SG2) provided mixed support for the hypothesis that Black clients preferred a racially similar counsellor. When asked about ethnic matching, potential clients in SG1 did indeed state this preference. Although not statistically significant,

there was another group of participants in SG1 whose responses were sizeable enough to be worthy of comment. They indicated that the 'race' of the counsellor would not influence whether or not they engaged in counselling should they wish to receive therapy. With regard to actual clients in SG2, there was no significant difference in early attrition -rates between Black clients and White clients per se or the amount of sessions they had. Neither was there a difference in SG2 between Black clients who were seen by a Black counsellor and those who were not seen by a Black counsellor. The varied results from SG1 and SG2 clearly indicated that it was not accurate to portray Black people as one homogenous group, or all with the same psychological characteristics. This was aptly summed up by Ponterotto et al (1988):

> "Despite generally consistent findings regarding Afro-American subjects' preference for same race counsellor, extreme caution must be exercised in interpretation of these findings...preference for the race of the counsellor is not necessarily a function of the client's race but instead a function of variables within the race" (Ponterotto et al, 1988:175).

From SG1 it became obvious that the importance of racial difference between counsellor and client varied amongst participants. Black participants' responses to the question of ethnic matching between counsellor and client and their counselling attendance patterns indicated that to pair counselling dyads solely on the basis of visible racial similarity would not necessarily improve counselling outcome more than if they were seen by a White counsellor. There are clearly some Black participants for whom a White counsellor would be barrier to engaging in counselling with that counsellor, but it cannot be assumed that this is the case for all Black clients. Counsellors and service planners must bear this in mind, since the issue is not about simply drafting in Black counsellors to work with Black clients.

The option of placing a Black client with a Black counsellor is compounded by the reality that there is a paucity of Black counsellors available (Banks, 1999). Hence, the challenge is to appropriately match Black clients with Black counsellors when this significantly increases the likelihood that the Black client will benefit from therapy, over and above cross-racial counselling. This points to the importance of considering within group differences amongst Black people, before making assumptions about their attitude towards ethnic matching in counselling. Although researchers have used different types of constructs of 'within group differences' to explain premature termination amongst Black clients (e.g. level of mistrust, Maultsby, 1982; Terrell & Terrell, 1984; level of self-disclosure in counselling, Ridley 1984 & 1989), these studies are all connected by their acknowledgement of the relevance of the client's racial identity attitude in this process. Other studies have focused more on this underlying

theme as a construct to be researched in its own right e.g. commitment to one's racial, ethnic or cultural group; (Ponterotto et al, 1988; Atkinson and Lowe, 1995). This is illustrated by Atkinson and Lowe: *"The variability in counsellor preference amongst Black clients has been framed as one of within group differences of racial identity attitudes"* (1995: 395).

In recognition of the contributions made by Johnson (1981) and other researchers to understanding the variety of identities and existences of Black people, Cross & Fhagen-Smith wrote:

> "These findings suggest that the self-concept of African Americans may be configured in a number of ways. In some configurations, positive self-esteem and strong ego-development may be associated with a strong Black identity. However, in other instances, positive self-esteem and strong ego development may be linked to an identity that is something other than race" (1996: 114).

Various levels of commitment to one's ethnic group exemplify racial identity within group differences. Black individuals who have a strong commitment have a stronger preference for an ethnically similar counsellor than Black individuals with either a weak commitment to their ethnic culture or a strong commitment to mainstream culture (Atkinson, Furlong & Poston, 1986; Ponterotto, Alexander & Hinkston, 1988; Ponterotto et al, 1986). Such differences would largely explain the different results reported by research in this area. For instance, studies whose samples consisted of adults (e.g. Shipp, 1986) who were probably in a different racial identity developmental stage than samples consisting of young people (e.g. Goldberg & Tidwell, 1990) would be more likely to state an expressed preference for racially similar counsellor.

In order to evaluate the effect of racial identity within group differences on counsellor preference, Ponterotto et al (1988) used a formal measure of Black racial identity, as operationalised by the Racial Identity Attitude Scale, RIAS (Parham and Helms, 1981; 1990). Parham and Helms (1985b) found a relationship between a Black person's racial identity attitude and his/her preference for a racially similar counsellor. They concluded that the *within-group* difference of level of racial identity development is a very, if not *the* most, relevant predictor of Black clients' preferences for counsellors (Parham and Helms, 1985). That is, preference for a racially similar counsellor was a function of the stage of racial identity. Indeed, the stage of the client's racial identity can affect premature termination of counselling (Carter, 1990).

The tool that Ponterotto et al (1988) used in their study has been used by practitioners and researchers in the field of therapy and psychology to provide them with insight into the relevance of the counsellor's ethnicity for Black clients and the role of this characteristic in the outcome of counselling such as drop-out rates. Helms' scales are based on models of racial identity development for Black and for White people (Helms, 1990). Research using the White racial identity scales in psychology has been conducted (e.g. in America, Helms, 1990; in Britain Buabeng, 2000). Of relevance to this thesis is the 'RIAS' which is based on '*Nigrescence Models'*, i.e. Black racial identity development.

5.1.2. Implications for current study

The main implication for the relationship between ethnic matching and premature termination in counselling is the claim that the stage of a Black client's racial identity attitudes could give some indication as to whether s/he would have a preference for a racially similar counsellor (Cross, 1991; Helms, 1990). In addition, by responding to this preference when it was revealed, psychological services could reduce attrition rates of Black clients in therapy compared to when Black clients with a preference for a racially similar counsellor were not ethnically matched. If there were early indications in therapy that a Black client may prefer a racially similar counsellor, then this could be discussed with the client and an appropriate referral made. Research cited above has shown that there are Black people who have stated that they are receptive to a White counsellor who is able to demonstrate cultural sensitivity. It may be that by the counsellor simply addressing the topic of 'race' when it appears to be an issue in counselling, this could reassure the Black client that the (White) counsellor is able to be sensitive and hence receptive to the client's 'race'-related issues.

5.1.3. Description of the RIAS family

> "Like other racial identity scales (e.g. Phinney, 1992), the RIAS attempts to capture a person's racial identity by investigating their attitudes towards statements that relate to areas of involvement and commitment to cultural expressions of their racial group. This typically involves areas around the extent to which they feel they belong to their racial group, partake in related activities and their attitudes to other racial groups" (Tinsley-Jones, 1997:88).

Helms' family of RIAS inventories was designed so that the subscales corresponded to Cross's (1971, 1978, 1991) stage model of Nigrescence which describes '*a psychological process whereby Afro-American individuals move toward self-actualisation and liberation within an*

oppressive society'. Four of Cross's stages are operationalised in Helms' scale: 'Pre-encounter', 'Encounter', 'Immersion-Emersion' and 'Internalization'.

Since her first instrument to measure Black people's racial identity attitude and development, RIAS (Parhman and Helms, 1981), Helms has revised this self-report measure a few times: The revised RIAS-B (Helms, 1990b), and later the RIAS-Long Form (RIAS-L, Helms, & Parhman, 1996). The original RIAS was a 30 item self-report measure to assess the attitudes reflective of each of Cross's (1971, 1978) stages of Black racial identity. The RIAS-B is composed of the same 30 RIAS items but with some items reassigned to different subscales. The RIAS-L contains the original 30 RIAS items plus 20 additional items and also involves redistribution of some original items. All versions are in use and researchers have used different versions. Of the RIAS, Cross (2001:39) writes it is "*the most important and heavily used scale in the study of Nigrescence*".

5.1.3.1. Why use this scale?

There are some valid reasons for the RIAS's popularity. The attractiveness of this scale is that "*it is designed to reveal nuances of identity development that are unique to the experiences of Black people*" (Cross and Fhagen-Smith, 1995: 110. Underline added). That is, it specifically measures a *Black* person's racial identity. Similarly to the generic models, it is also a multistage construct, but it is not a generic tool that measures the general concept of ethnic minority identity. In contrast to generic ethnic minority scales [e.g. *Multigroup Ethnic Identity Measure* (MEIM) Phinney, 1992)], the RIAS has as its target a specific racial sample, increasing the likelihood that items capture precise experiences and attitudes of members from that particular racial group: The 'Black race'.

A significant contribution made by the RIAS is the research opportunities it has made available. It is now possible to empirically test earlier hypotheses that a relationship exists between types of racial identity attitudes and particular affective states (Butler, 1975). Participants' responses on the RIAS are used to make predictions about the correlation between their racial identity status and interpersonal relationships with members of their ethnic group and members of other ethnic groups. Such connections between 'race' and 'in-group' – 'out-group' dynamics also have significance for counselling psychology practice. Practitioners, if they want it, now potentially have available an additional source that provides insight into the therapeutic process between same 'race' dyads and also cross-racial counselling dyads when

the client is Black (Helms, 1995). Specifically: *"Diagnosis of the particular racial identity statuses governing participants' [i.e. counsellors' and clients'] behaviours can make interventions potentially more relevant"* (Helms, 1995:191).

The racial identity attitude scales have also been hailed as making a significant contribution to counselling research and practice. Fischer, Tokar & Serna (1998) stated that Helms (1984, 1990a) instigated *"groundbreaking work applying racial identity development to counselling process and outcome"* (p212). The impact of the RIAS on the cross-cultural counselling psychology arena has helped build up its reputation as a construct of choice for many researchers in this field for operationalising Black racial identity development and identifying within racial group differences. In Britain, Alladin (1986) stated: *"Helms (1984) outlined a model of racial identity, focusing on the dynamics of cross-racial dyads so that the counsellors can acquire a better understanding of how best to treat the culturally different client".* So these scales can be of enormous benefit to counsellors, especially those working cross-culturally with Black clients (though Helms's White Racial identity Attitudes scales can also be of benefit to White counsellors and non-White counsellors alike who work with White clients). Indeed, Helms and Carter (1991) claim: *"Insofar as Black clients are concerned, the construct of racial identity attitudes has become useful for explaining why some Black persons have strong preferences for counsellors of their own race, whereas others do not"* (p446).

5.1.3.2 Evaluation of the RIAS

5.1.3.2.1 Evidence in support of the RIAS

Links between type of Black racial identity (as operationalised by various forms of the RIAS), and a number of personality and counselling related variables have been indicated e.g. coping (Neville, Heppner & Wang, 1997); depression and high levels of somatisation (Munford, 1994); general psychological functioning and well being (Pyant & Yanico, 1991); self-actualisation and affective states (Parham & Helms, 1985b); self-esteem (Parham & Helms, 1985a); perceived sensitivity of counsellor (Pomales, Claiborn & LaFromboise, 1986); preference for counsellor 'race' (Helms, & Parhman, 1991; Parhman and Helms, 1981; Pomales, Claiborn & LaFromboise, 1986). Significant relationships have also been reported in the expected directions between some subscale scores and scores on measures of self-derogation, self-esteem, ethnic identity, racial designation, and locus of control (Martin & Hall, 1992). Support has also been found for construct validity for the different subscales (e.g. Helms 1990; Helms Parham, 1985; Lemon & Waehler, 1996) and reliability for one month

subscale stability estimates ranging from 0.52 to 0.66 (Lemon & Waehler, 1996). Preliminary support for RIAS-L's construct validity has also been found (Lemon & Waehler, 1996; Martin & Hall, 1992). The above reported significant relationships provide preliminary evidence of the RIAS-L's construct validity. However, popularity also attracts negative criticisms.

5.1.3.2.2 Weaknesses identified with the RIAS

Whilst Fischer, Tokar & Serna's (1998) positive comments on Helms' contributions reflect the views of many counselling psychologists, there have been mixed receptions concerning the integrity of the psychometric properties of the various editions of the RIAS/RIAS-L. Ponterotto & Wise, (1987) found some support for the internal structure of the RIAS, though they had difficulty distinguishing items that were specific to an Encounter stage, suggesting a three-factor rather than the four factor model as proposed by the instrument. Similarly, of the four stages on the RIAS, Ponterotto et al (1988) could only report on two groups, ('Encounter' and 'Internalization'), since there were insufficient numbers for the other two groups ('pre-encounter' and 'immersion-emersion'). In addition, whilst Tokar and Fischer (1998) found that the Pre-Encounter, Immersion-Emersion and Internalization subscales displayed acceptable reliabilities, they questioned the internal consistency reliability of the Encounter subscale which had an inadequate alpha of 0.34. This and other such findings challenge the construct validity of the RIAS-L, which could suggest that it is actually measuring some artefact of racial identity development e.g. *"A contaminating influence of a socially desirable response set"* (Yanico, Swanson, & Tokar, 1994), which would account for the reported skewed distributions for two of the four subscales. Pre-Encounter scores were positively skewed, and the Internalization scores showed a negative skew (Yanico, Swanson, & Tokar, 1994). This would seem to suggest that the majority of respondents disagreed with the Pre-Encounter items and agreed with the Internalization items (Tokar and Fischer, 1998), and a possibility that social desirability was acting as a moderator variable (Yanico, Swanson, & Tokar, 1994; Fischer, Tokar & Serna, 1998). However, Parham and Helms (1981) had not found evidence to support this 'desirability' theory.

In general, it must be emphasised that it is the model, not the scale that indicates under what circumstances, for instance, self-hatred and low self-esteem can be expected at the Pre-Encounter stage. The RIAS is currently the best attempt available at operationalising the stages and attitudes connected to those stages, and undergoes modification in light of new empirical evidence.

5.1.4. Rationale for current study

5.1.4.1. Differences compared to American samples

"*Negro-to-Black identity conversion*" (Black racial identity) models were created and devised by Black psychologists living in America. In addition Helms' Black racial identity attitudes scales (e.g. RIAS) have been developed and tested on Afro-American samples. Hence, they reflect the psychological and social context in which they were developed. Before they can be used as a convincing measure of within group differences in this country, their appropriateness for a British sample needs to be verified.

At present researchers are not able to comment on the usefulness of the RIAS for counselling in Britain. To date, no study has been publicised in this country that investigates the robustness of the RIAS on a Black British sample with a view to considering if there is a relationship between racial counsellor preference and Black clients' premature termination in therapy. Whilst acknowledging questions and concerns about why there is a lack of British research in this area, it is not the focus of this thesis to dwell on such neglect. However, it would seem reasonable to evaluate an inventory that claims to help counsellors understand Black people's counsellor preference, which is pivotal to whether or not they engage in the therapeutic process. In Britain Alladin, (1994) stated:

> "The construct of racial identity attitudes has become useful for explaining why some Black persons have strong preferences for counsellors of their own ethnicity, whereas others do not..." [and campaigned for the] "...need to consider the effects of within-racial-group differences on clients' differential strength of preference for counsellors who resemble them" (Alladin, 1994:14).

British studies (e.g. Alladin, 1994; Banks, 1999; Ferrell, 1995) have raised the profile of Helms' Black racial identity attitude scales, though they have not actually evaluated the RIAS's psychometric properties with British samples. The majority of British studies that have looked at the relationship between psychological well-being and racial identity have nearly all operationalised racial identity by using Helm's RIAS as a measure of within group variance amongst racial groups. That is, they have used the scales *on the assumption* that they have acceptable psychometric properties with Black British samples.

As can be seen by the above review, American studies have presented mixed appraisal of the validity and reliability of Helms' family of racial identity scales. When this is coupled with the lack of evaluation of the RIAS in Britain, curiosity develops as to how well this scale would transport across the Atlantic. The question arises as to which of the two camps (either

American psychologists supportive, or those critical, of the psychometric properties of the RIAS scales) will provide a closer model for Black British samples. The results from a British sample could support the confidence in reliability and validity of the scales as reported by Helms and many others. However, it could be that results from a British sample produce similar findings to those by Fischer, Tokar & Serna (1998) who were not convinced *all* four scales had acceptable psychometric properties. This is complicated by the question of whether the items in the RIAS are of relevance to a British community that live in a country where class seems to be more of a demarcation amongst the population rather than 'race'. This is not to say that there is no 'race' divide – similar to America, continual reports of racism and racial attacks attest to oppression of Black people in Britain (Macpherson, 1999; Owusu-Bempah, 1989). However, the potent impact of a consistently high profile of 'race', such as the many racial landmarks and civil liberties statutes inscribed in the American constitution, are not to be found in Britain (Fernando, 2000). Adams supports this:

> "The feeling-tone of the 'colour complex' in America is different from the feeling-tone in Britain. Although both Britain and America are multi-cultural countries, the histories are different. In Britain the dominant historical facts are colonialism and imperialism; in America, slavery. I do not believe that there is less racism in Britain than in America. I merely believe that history has 'coloured' racism differently in Britain and America. In America race is fundamentally a black-white issue"(0 1997:xxii).

Similarly, Onwauchi writes: *"The concept of the 'Negro' is an 'American concept based on...White America's idea of the African type of Black person...and is socially derived, politically sanctioned, and economically abused"* (Onwauchi 1996:290). By localising certain key notions of Blackness, such as the *'Negro'*, the implication is that concepts inherent in the RIAS are encapsulated in a context which may not be as relevant or meaningful in Britain as it is in America, and, hence, for Black British people. In addition, material on the Afro-centric view has been put forward mostly by Americans (e.g. Nobles, 1976; White, 1972; 1984). For Britain, it may be more of a Caribbean viewpoint that is relevant.

5.1.5. Objective of SG3

Following on from the rationale, the aim of this study is to

> Investigate the application of an American measure of Black racial identity, the RIAS, to a British Black sample.

5.2 Method

5.2.1. Design

This was a correlation design that used Cronbach's coefficient alpha to conduct a reliability analysis of the RIAS.

5.2.2. Participants

Participants were selected from a group of delegates at a three-day residential conference in North England of which the researcher was also in attendance. The theme of the conference centred on providing appropriate alternative mental health and therapeutic services for Black people.

5.2.3. Materials / measures

The racial assessment package contained a recruitment letter to participants, a demographic questionnaire and a slightly modified RIAS.

5.2.3.1. Recruitment letter (see appendix 5).

This was addressed to delegates. The letter introduced the researcher and contained instructions on how to complete the questionnaires, and where to return forms. It was made clear that the study was not related to the conference; participation was voluntary, and would not influence delegates' status at the conference; that all information would be anonymous and treated with the strictest of confidence.

5.2.3.2 Demographic questionnaire (see appendix 6)

The researcher devised this specifically for the present study. The items asked details about participants' gender, self-reported ethnic identity, place of birth, age group and occupation.

5.2.3.3 The Racial Identity Attitude Scale ('RIAS') (see appendix 7)

This was a self-report questionnaire with 50 items that consisted of statements designed to assess Black people's attitude towards their own racial identity. Due to the RIAS been of American conception, the wording on a few of the items was slightly modified to harmonise with standard British English language. The RIAS claims to be able to identify 4 levels of racial identity that Helms and Carter have based on those outlined by Cross's (1971; 1991)

Nigrescence model. In descending order, Helms found reliability co-efficients of 0.80 for the Internalization sub-scale; 0.76 for the Pre-Encounter sub-scale; 0.69 for the Immersion-Emersion sub-scale and 0.51 for the Encounter sub-scale (Helms, 1990).

Scoring: A scoring key and its corresponding instructions were received directly from the creators of the RIAS, along with permission for the present author to use the inventory in her research. The response format of each item was a Likert scale ranging from 1 ('strongly disagree') to 5 ('strongly agree') to indicate the extent to which the respondent agreed with each statement (Likert, 1932). Hence, the highest individual score a respondent could receive for any of the items in the four subscales was 5, the lowest was 1. The subscales of the 4 racial identity attitudes were achieved by grouping certain items. A participant's score for each sub-scale was calculated by summing his/her responses to the items in the relevant subscale and then dividing this total by the number of items that made up the subscale. The higher a participant's score for a subscale indicated a higher commitment to the corresponding racial identity attitude.

5.2.4. Procedure

The researcher approached the chair of the conference and explained the purpose of the research and the materials. The chair gave permission for the use of the materials and at the plenary session on the first day of the conference, and the organisers announced that there would be a questionnaire, which it would be appreciated if it were completed. 163 packets that consisted of the standard order of recruitment letter, demographic questionnaire and the RIAS were distributed. Consistent with the recommendation of Helms & Carter (1990), to 'minimise participant reactivity', the questionnaire was introduced as one that investigated participants' social attitudes. Conference members were advised that questionnaires could be returned to a dedicated box that was left in the general meeting hall where delegates met at least twice a day for seminars and performances. Questionnaires from the box were collected daily.

5.2.5. Statistical analysis

Racial identity was operationalised using the RIAS.

Reliability analysis: Cronbach's coefficient alpha, was conducted to investigate the internal consistency of reliability of the four subscales of the RIAS by comparing participants' responses to each item with other items in the scale or subscales (item to item correlation). This was chosen since *"alpha ...provides a measure of reliability which can be obtained from one administration of a questionnaire"* (Morgan & Griego, 1998: 125). Whilst Kline (1993) stated

that the alpha should be 0.7 or above, others have left the decision of the level of reliability to the user of the measure (e.g. Pedhazur and Schmelkin, 1991). However, in accordance with Clark-Carter (1997) who points out *"the 0.7 level is quoted so frequently that you would have to argue quite strongly to go below this level"* (1997:338), this thesis will use 0.7 as the criteria for an acceptable reliability. SPPS version 10.1 was used to analyse the raw data.

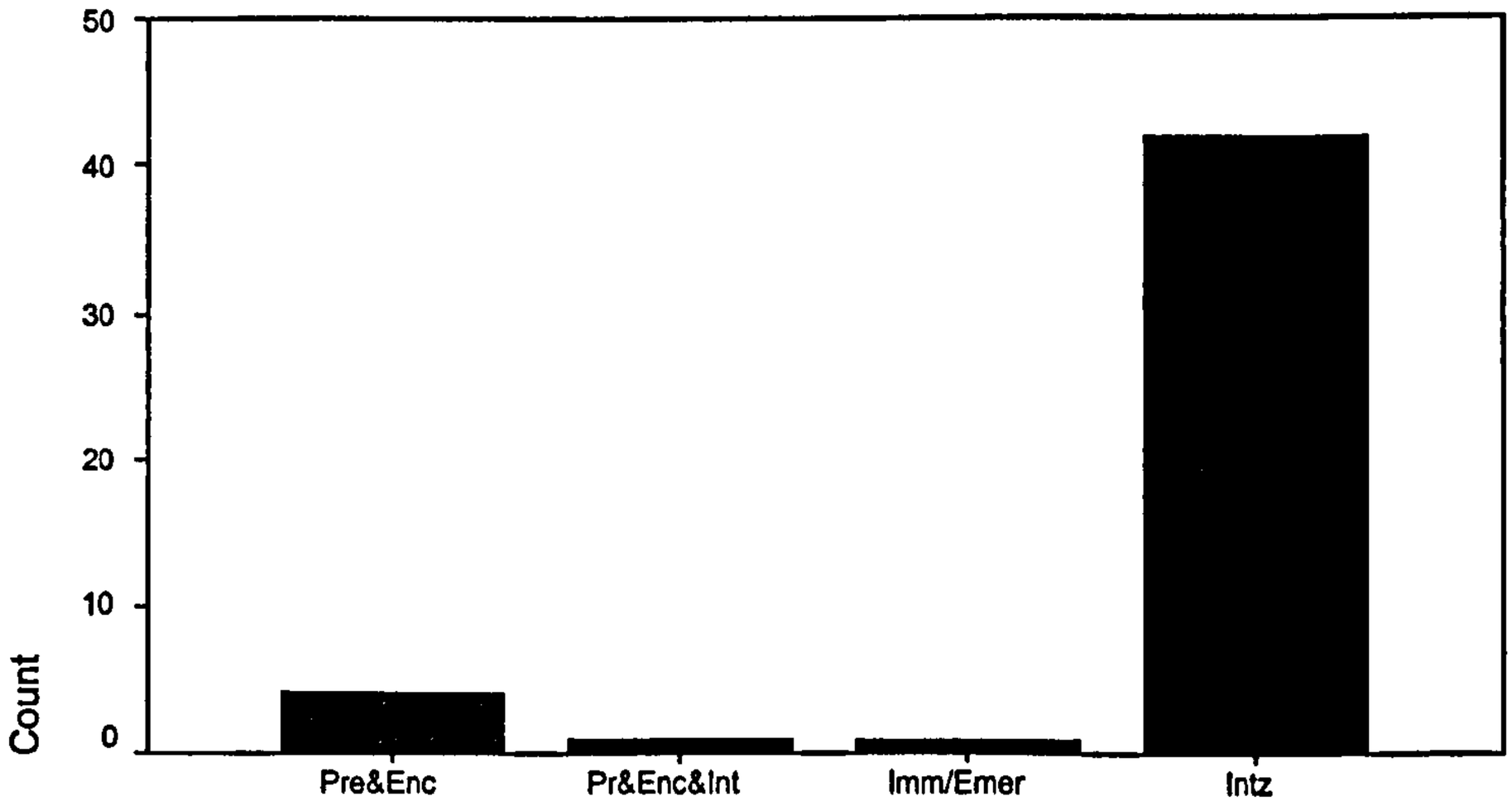
5.3. Results

5.3.1. Participants

61 questionnaire packages were returned, of which 13 were discarded because they were not adequately completed. The eventual sample therefore consisted of 48 self-identified racially Black delegates. The majority of delegates worked in one of the helping professions. The mode age group was 36 – 42 years (43.8%). 32 (67%) of the participants were male and the remaining 16 (33%) were female.

5.3.2. British Responses to the Racial Identity Attitude Scale

FIG. 5.1 Responses to the RIAS



KEY: Pre&Enc = Pre-Encounter and Encounter; 'P&Enc&Int' = Pre-Encounter and Encounter and Internalization; 'Imm/Emer' = Immersion –Emersion; 'Intz'= Internalization

Fig 5.1. shows that, as a group, participants most frequently gave their highest responses to items that were from the Internalization stage. On average they mostly *'agreed'*, and some *'strongly agreed'* with the items in this sub-scale, and responses by 87.5% of participants' (i.e. 42 out of 48) located them in this stage. None of the participants were located exclusively in either the Pre-encounter or Encounter stages. Participants who had either Pre-encounter or Encounter attitudes as part of their identity shared the same score with another racial identity attitude. One participant was located in Immersion-Emersion attitude.

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5.3.3. Reliability

5.3.3.1. RIAS sub-scales

TABLE 5.1: Reliability Analysis of the Racial Identity Attitude Sub-scales

RELIABILITY STATISTIC	RACIAL IDENTITY ATTITUDES SUB-SCALES			
	Pre-Encounter	***Encounter***	***Immersion-Emersion***	***Internalization***
OVERALL RELIABILITY COEFFICIENTS	0. 4653 (alpha) 0.5305 (standardised item alpha)	0. 1344 (alpha) 0.0494 (standardised item alpha)	0. 4580 (alpha) 0.5742 (standardised item alpha)	0. 5619 (alpha) 0.5710 (standardised item alpha)
POTENTIAL RELIABILITY (by removing items)	0.5143	-0.4159	0.5735	0.5865
SUB-SCALE MEAN (Possible total score)	21.5208 (sd .5709) (70)	13.2917 (sd 2.8055) (20)	24.8958 (sd 5.8026) (45)	48.9362 (sd 5.4350) (60)
AVERAGE RESPONSE	1.5372 (range 1.6042)	3.3229 (range 1.6875)	2.7662 (range 2.6875)	4.0780 (range 2.3830)
AVERAGE INTER-ITEM CORRELATION	0.0747 (variance 0.0225)	0.0128 (variance 0.0394).	0.1303 (variance 0.0311)	0.0998 (variance 0.0319)
NUMBER OF ITEMS WITH CORRECTED ITEM-TOTAL CORRELATION 0.4 or ABOVE	1 (0.4688) (there were also 2 items in the 0.3 range)	0 (there was 1 item in the 0.3 range)	3 (0.4080;0.4149; 0.4732) (there was also 1 item in the 0.3 range)	1 (0.4494) (there were also 2 items in the 0.3 range)
NUMBER OF ITEMS	14	4	9	12

Table 5.1 shows that the Internalization racial identity attitude had the highest reliability coefficient and the Encounter stage had the lowest. Inter-item correlation was low for all the sub-scales, and only one of them had more than 30% of its individual items that correlated with other items above 0.40, which was well below the alpha cut-off point of be 0.7.

(a) Pre-Encounter: The reliability for this sub-scale was low at 0.4653 (standardised item alpha = 0.5305). The mode response was *'disagree'* and responses to items in this sub-scale ranged from 1.19 to 2.79. The correlation matrix revealed some low correlations between the items for this sub-scale, e.g. the highest correlation was between item 29 and item 41 at 0.4317, and the lowest correlation was between item 29 and item 47 at -0.0016. There did not seem much advantage in removing any of the items to improve the inter-item correlations. This would still have kept the correlations in the 0.4 region. Only one item would have increased the correlation to the 0.5 region (at 0.5143) if it were deleted. The mean for this sub-scale was 21.5208(sd 4.5709) (out of a possible total score of 70). The mean inter-items correlation was 0.0747 (variance 0.0225).

(b) Encounter: The reliability for this sub-scale was the lowest of all the sub-scales at 0.1344 (standardised item alpha = 0.0494). However, in comparison to the Pre-Encounter sub-scale, it's correlation matrix revealed a higher minimum correlation at –0.0344. Though its highest inter-item correlation was lower than that of the Pre-Encounter sub-scale at 0.2738. Of its 4 items, 2 of them were pulling down the correlation of the Encounter scale. To remove them would increase the reliability of the subscale to the 0.4region. The sub-scale mean was 13.2917 (sd 2.8055; out of a total maximum score of 20). The item means for this sub-scale was 3.3229 (variance 0.6622), and the inter-items correlation was 0.0128.

(c) Immersion-Emersion: The reliability for this sub-scale was low at 0.4580 (standardised item alpha = 0.5742). Its inter-item correlation ranged from 0.0191 to 0.5968. The inter-item correlations were spread out, with the majority in the 0.1000 and 0.2000 region. Of its 9 items, 2 were slightly lowering the sub-scale's overall reliability and if one of them were removed its reliability would increase to 0.5735. This sub-scale's mean was 24.8958 (sd 5.8026; out of a possible total of 45).

(d) Internalization: This sub-scale had the highest reliability amongst the 4 sub-scales, though it was still low at 0.5919 (standardised item alpha = 0.5710). The inter-item correlations ranged from -0.0085 to 0.5741. Of the 12 items in this sub-scale, one seemed to be slightly lowering the overall reliability of this sub-scale. By omitting it, the overall reliability of the

Internalization scale increased to 0.5865. The mean for this sub-scale was 48.9362 (sd 5.4350; out of a possible total score of 60).

5.3.3.2. Overall reliability of RIAS

Item to item correlation was too low for the individual items to be considered reliable which rendered the overall reliability too low for the scale to be considered acceptable for this group of participants. The results showed a skew ness in the responses and kurtosis, indicating that the responses were not normally distributed.

5.4. Discussion

5.4.1. Summary of findings

The majority of participants' scores on the RIAS located them in the Internalization stage, and one was in the Immersion-Emersion stage. A few participants hovered in both the Pre-encounter and Encounter stages. The RIAS' sub-scales were not normally distributed. The items within each sub-scale had low item-to-item correlation, which resulted in low reliability for all of the sub-scales. This impacted on the overall reliability of the RIAS, and resulted in a low reliability.

5.4.2. Evaluation of scale

Although the results supported the pecking order of Helms' reported reliability of the sub-scales, with the Internalization sub-scale having the highest correlation, and Encounter the lowest, there was a difference in magnitude. In this study, the highest level of reliability was 0.5619 (Internalization) falling as low as 0.1344 for the Encounter stage. (As a reminder Helms' reliability co-efficients were 0.80 and 0.51 respectively). As with previous studies (Ponterotto & Wise, 1987; Yanico, Swanson Tokar, 1994), the current study seems to suggest that the RIAS is working with a three-factor model, not the four distinct sub-scales that it proposed. Similarly, in the current study, it was the Encounter sub-scale whose internal consistency with regards to its low reliability was problematic. At 0.13, it was even lower than the inadequate alpha of 0.34 reported by Tokar and Fischer. Similarly, skewness was also found for these sub-scales, with participants' responses to the Pre-encounter sub-scale negatively skewed, and for the scores for the Internalization sub-scale positively skewed.

There were also difficulties with scoring. A typical one was whether to treat subscales as discrete or continuous. The problem arises with regards to assignment of respondents to stages when it was only by a slight difference of one point that located them in a sub-scale, or when they had scored equal points for more than one sub-scale. Ponterotto et al (1988) acknowledged that one of the limitations of their study was that they scored participants responses to the RIAS as if they used discrete subscales, when later emphasis has been placed on the continuous nature of such sub-scales (Helms, 1986) for looking at counsellor preference. Interestingly, in the current study only a few participants' responses presented this type of problem, as the majority were consistently giving their highest scores for the Internalization stage.

There were 50 items in the scale, yet the assignment of items to sub-scales was skewed. For instance the Pre-Encounter sub-scale contained 14 items whereas the Encounter sub-scale had only 4 items. Whilst it is acceptable that few psychological measures have sub-scales that each have the same amount of items, it is curious as to whether a ceiling effect of 70 (for the Pre-Encounter stage) is fully comparable to a ceiling effect of 20 (for the Encounter stage). However, it could be argued that since the participants' average score on each subscale is used, rather than their total score, the scores they achieved for each sub-scale were comparable. This is illustrated by the fact that even though the Pre-Encounter sub-scale had the most amount of items assigned to it (70), participants average scores were higher for sub-scales with less items: The Immersion-Emersion sub-scale had 25 items less than the Pre-Encounter and the Internalization sub-scale had 10 items less, though their means were 24.90 and 48.94 respectively compared to the mean of 21.52 for the Pre-Encounter sub-scale

5.4.3 Discussion of British participants

It could be argued that the majority of this group of participants would be expected to be located in the latter part of the Immersion-Emersion stage ('Emersion'), or in the Internalization stage. They had all met for one particular aim: To attend a conference on 'race' related mental health issues. This was an event aimed at attracting those who wanted to improve the psychological well being of ethnic minorities, especially those of African and Caribbean descent. Since this was the theme, being in an atmosphere that focused on Black issues may have increased the level of 'Black mindedness' amongst Black delegates. It is probable that they had struggled with both personal and professional issues of discrimination. This is characteristic of the Emersion stage.

However, delegates' scores on the RIAS indicated that overall profile of the respondents was characteristics of those in the Internalization stage. It is probable that their primary focus at the conference had transcended their own personal racial experiences. Their motivation was to improve the situation of Black people. One of the reasons for considering alternative forms of mental health facilities is because of the institutionalised racism that Black people, especially Black mental health sufferers, have been subjected to. This meant that in a significant amount of cases Black people have been denied appropriate forms of treatment that would improve their recovery. Delegates would have been aware of this, and would probably have wanted to champion the causes of Black people.

Since, it was unlikely that 'race' and culture were of little significance, which is the core feature of the Pre-encounter stage, very few participants, if any would be expected to be located in the Pre-encounter stage. However, it was surprising that not more participants were located in the Immersion-Emersion stage. One of the features of this stage is the reaction to the realisation that Black people have been unfairly treated and that the Black person has misjudged his/her own 'race', which is manifested in the increasing appeal of belonging to their 'race' and the adoption of ways to promote it. Informal conversations with the delegates revealed that they had felt the need to redress the inequitable services available to Black people using the mental health service. Cross (1971, 1990) states that positive experiences that can occur in the Encounter stage including attending an event (e.g. a conference or a march) that enlightens a person about the attractions of the Black experience, and motives him/her to embrace his/her Black identity. It is probable that the respondents were more advanced than being simply enlightened or motivated, and were now at the stage of 'action': working towards action as collective 'conscience', which is the essence of the Internalization stage.

Whilst there are some similarities between Afro-Americans and Black British people, which prima facie justify the appeal of using American devised tools with British samples, there are also culturally specific perceptions amongst each nation that could partly explain why the reported robustness of the RIAS for several American samples was not fully transported intact across the Atlantic. It is possible that the focal role given to racial issues in America may be slightly off-centre in a country such as Britain which, at least for the time being, centres on class and social structure issues, though it is only a matter of time before Britain 'catches up' with its ally. Moving to a wider debate, the results of SG3 highlight the need to proceed with caution when attempting to extrapolate results from one country to another even though both countries have some commonalities. In this case the results act as a reminder about the problematic nature of exporting American social survey research to British shores that has been warned about by British social scientists (Bulmer, 1998; Jowell, 1998).

5.4.5 Methodological evaluation of study

A main limitation to the research design of this study pivots around the sample: Notably sample size and sample selection. Fowler (1993:32) advised that *'The use of larger sample sizes (i.e. 150+ participants) increases the generalisation of the conclusions'*, but only up to a point, and then the benefits of a large sample size level off (Comrey, 1998; DeVellis, 1991). Amongst the consequences of the small sample of the current study, one was that a meaningful factor analysis could not be conducted. However, there were advantages of using the current sample of 'psychologically-minded' Black people. They represent a class of Black professionals who, though difficult to recruit for research purposes, are likely to consider therapy when faced with emotional distress. Due to the small community of Black counsellors, it is probable that they are familiar with each other, and when seeking psychological help would approach someone who was not familiar to them or part of their immediate community. Hence there is a possibility that they may consider entering into therapy with a White therapists, even though they would also make use of other outlets in the community to help them deal with 'race' related issues. This would be consistent with a Black client in the Internalization stage.

It is also acknowledged that results derived from Likert type response are not without their problems. It is obvious that such a format cannot access all of a person's attitudes (Webb and Salancik, 1970), or even measure one attitude in its entirety. It could be that it is only assessing a person's conscious attitude, possibly a bit more than a snapshot of time.

5.4.6 Recommendations

Generalisation would be increased if this research were conducted with a group of Black people who were not as proactive in issues to do with racial identity and psychological problems of Black people as those in the current sample. There needs to be further consideration of this scale on a larger sample. If such a scale were to be used in this country, there would need to be more work on improving its robustness, which includes its psychometric properties and its appropriateness to Black people in this country (i.e. reliability and validity). This may mean that focus groups are formed to find out Black British people's concepts of racial identity and then used to develop an inventory which would need to be standardised on Black British people. There is a role for counselling psychologists here since they have experience in conducting focus groups. They are also in a position to access psychological processes. However, it must also be acknowledged that racial identity is a dynamic concept and hence any such measure would have to be standardised and reviewed at regular intervals.

5.4.7 Conclusion

The current study demonstrated that the majority of participants were located in the Internalization stage. However, this needs to be interpreted within the context of the questionable internal consistency of the sub-scale. Clark-Carter (1997) pointed out *"No psychological measure is 100% reliable and therefore you need to know just how reliable the measure is in order to allow for the degree of error which is inherent in it"*. Due to limited number of participants in this study it would be premature to conclude that there was a large amount of 'error' in the scale without testing the scale on a larger and more varied sample e.g. a sample which included Black people who were not professionals involved in the field of mental health. A sampling effect may also partly explain the results. The current sample were a homogenous group in that they were professionals who worked in, and were very informed about, the mental health system, especially as it pertained to Black people. They had a clear attitude about the need of services for Black people. Hence, it could be argued that participants were not a fully representative sample of the Black people as a nation in Britain, and this was why the scale was skewed.

This study (SG3) demonstrated some of the major challenges facing those working in the field of psychometrics and questionnaire construction: Firstly, the complexity involved in establishing a quantitative measure of attitudes and social values about a sensitive and sometimes even elusive phenomenon as racial identity and, secondly, difficulties in creating a robust instrument that has reliability and full meaning beyond its cultural birth place. This is particularly important for counselling psychologists since many of them use assessment tools, such as questionnaires, in their work.

Whilst the results in SG3 are in line with other studies that found evidence to suggest low reliability, the suggestion that the tool is actually measuring some artefact of racial identity development e.g. *"a contaminating influence of a socially desirable response set"* (Tokar and Fischer, 1998:149), could not be so readily accepted. Although critical of the psychometric properties of the measure, Tokar and Fisher do not rule out that inconsistent reports of reliability could be due to *"genuine idiosyncrasies attitudes of the samples"* (p149). In SG3 the skewed distributions, where the majority of respondents disagreed with the Pre-encounter items and agreed with the Internalization items, could indeed capture the actual racial identity attitudes of the participants. After all, in terms of their general aim for attending the conference, they were a homogenous group.

Whilst appreciating the potential of the RIAS as a robust measure of Black individual's racial identity, it has to be recognised that this was not fully realised in this study (SG3). Until the RIAS's psychometric properties have been improved for a Black British sample, the aim to use it to appropriately ethnically match Black clients with Black counsellors cannot be achieved. Whilst this may be disappointing in that, for the time being, hopes of moving onto this next step have been (temporarily) frustrated, this study (SG3) has made a significant contribution by indicating some of the issues that need to be considered before confidently using the RIAS with Black British clients. Indeed, in addition, this study has elucidated measurement and assessment complications relevant in counselling and also psychology in general, and the complexity and challenges facing counsellors in understanding and working with different levels of individual differences amongst their Black clients.

Chapter 6: General Discussion

Passports to understanding

"Human beings are more alike than unalike, and what is true anywhere is true everywhere, yet I'm encouraged to travel to as many destinations as possible for the sake of education as well as pleasure...Perhaps travel cannot prevent bigotry, but by demonstrating that all peoples cry, laugh, eat ,worry, and die, it can introduce the idea that if we try to understand each other, we may even become friends".

(Maya Angelou, 1994: 11-12)

6.1 Overall summary of results

The first study ('SG1') indicated that the majority of former and potential Black clients had a significant preference for a racially similar counsellor when they were asked directly about this preference. This statistically significant preference was not shown by the sample when the 'race' of counsellor was not highlighted. Results from the second study ('SG2') did not indicate that Black clients had a significantly higher early attrition drop out rate than clients from other ethnic groups. Black clients' outcome in therapy (in terms of amount of sessions attended) was equally as favourable compared to their White counterparts. Also, no relationship was found between 'race' of client and 'race' of counsellor. That is, whether Black clients were matched with an ethnicity similar counsellor, or not, did not seem to have an effect on their rate of premature termination of counselling. An attempt to use an American psychometric measure ('RIAS'), that had been successful in America for categorising Afro-American's racial identity attitudes and their relationship to racial counsellor preference, was found to be problematic in the third study ('SG3'). The results were skewed indicating that the measure was not robust when used with a British Black sample.

6.2 Findings in context with previous research

These findings are not totally consistent with the majority of papers in the field that indicated that in general Black clients prefer an ethnically similar counsellor. Whilst the responses from the SG1 sample are consistent with other findings (e.g. Atkinson, 1983; Helms and Carter; Pedersen, 1988; Ponterotto et al, 1998), the results were probably due to a different process than the one described by Ponterotto et al (1988). Their sample was in a predominantly White environment with few Black senior professionals and no Black counsellors, whereas the sample in SG1 were located in an environment where nearly all the staff were Black, including the manager and deputy manager. Similarly, Black service users at the agency constituted about 95% of the overall user population at the agency. However, any tentative interpretation of mechanisms that may contribute to these participants' preference (e.g. environment of service

mechanisms that may contribute to these participants' preference (e.g. environment of service provision, geographical area) are complicated by the fact that these same factors are shared by the former client sample in the archival study (SG2), whose unremarkable attrition rate did not indicate that they had a strong preference for a Black counsellor. Both cohorts were similar in terms of age. Considering the close proximity between the service users' agency (SG1) and counselling agency from which former clients' data was collected (SG2), it is highly likely that some of the former clients in SG1 had attended the same counselling agency as those in SG2. Similar to the service users agency (SG1), the counselling agency was also situated in a highly Black populated area where most of the staff were Black including the manager and deputy manager.

In fact, the location of both these samples (SG1 and SG2) is more similar to the background from which Atkinson et al's (1986) respondents came (a predominantly 'Black' environment including senior Black professionals and Black counsellors); yet Atkinson et al's results and explanation of their own results are incompatible with the current findings for SG1. Following Atkinson et al's argument, participants who were in an environment enriched with Black professionals would not be so concerned with receiving therapy from an ethnically similar counsellor, as 'race' was not an issue. Whilst this may partly explain the results in SG2, this does not explain why participants in SG1 stated that the 'race' of the counsellor was important to them. .

To some extent it is not surprising that there are some discrepancies between the current findings (in SG1, SG2, SG3) and American findings. Although both countries speak the same verbal language and function on Western (e.g. capitalist and industrialised) principles, there are significant cultural and historical differences. It has already been acknowledged that 'race' issues are contextualised and approached differently in America compared to Britain (Adams, 1996), which may explain the different findings in the two countries. This was particularly highlighted in SG3 that relied on American concepts and nuances of 'race' been translated sufficiently clearly so that British participants could grasp the gist of the 50 item in the RIAS.

6.3 The multi-cultural competencies of White therapists as a factor in engaging Black clients

A fundamental reason why not all Black participants in SG1 expressed a preference for a Black therapist may be due to the competence of White therapists that they had encountered either as former client or through hearsay. This may also explain why Black clients in SG2 who received counselling from White counsellors did not have a significantly higher attrition rate than clients in general or Black clients who received counselling from a

racially similar counsellor. The White counsellors' repertoire of competences probably included their open-mindedness to working with a diverse range of clients, their ability to resist the pervasive influence of negative stereotypes of Black individuals clients, and cultural responsiveness.

The White counsellors that the Black clients (in SG1 & SG2) saw had *elected* to work in an area that has a high level of ethnic diversity, and in an environment where both the manager and the deputy manager were Black. This in itself would have influenced how the organisation was run and the attention and respect that were given to diversity. The success that non-Black counsellors had with Black clients, especially judging from the results in SG2, attests to their professional and multi-cultural competencies. This would be in keeping with research that indicated that there are racially unbiased White British counsellors (Pearce, 1997) enthusiastic to work with Black clients and capable of empathising with the position of Black clients in a social matrix (Banks, 1999). In addition, counsellors in SG2 were probably also aware of the significance of cultural and ethnic differences between counsellor and client in the counselling relationship: a potent force in the therapeutic relationship that has been emphasised for many decades (d'Ardenne and Mahtani, 1989; Farrar and Sicar, 1986; Largo and Thompson, 1989; Littlewood and Lipsedge, 1989; Nobles, 1976; Sue and Sue 1990).

However, it is also important to remember that a significant amount of participants did state that they would prefer an ethnically similar (Black) counsellor (SG1) and also that clinical records (in SG2) showed that in their first contact with therapeutic services, there were Black individuals who requested an ethnically similar counsellor. Furthermore, the participants in SG3 had all met to contemplate alternative therapeutic and mental health services for Black clients. All these indicate that there are a notable group of Black people who perceive White therapists as inappropriate to meet their psychological and emotional needs. Hence, it was probably the case that the White counsellors in SG2 were an unrepresentative sample of White counsellors and in the minority. This would support previous research that indicated that the few White counsellors who had positive attitudes to working with Black clients differ significantly from their other White colleagues (Banks, 1999). So it may be that it requires a certain type of White counsellor who can appropriately attend to the needs of Black clients.

6.4 Understanding the results in relation to Black people and within group differences

At first glance, it may appear that the results from SG1 and SG2 contradict each other since Black participants attached importance to a racially similar counsellor (SG1), yet the absence of

a Black counsellor did not impact negatively on Black clients attendance rates (SG2). Hence, the results can be placed along a continuum, which ranges from a worldview in which a person's 'race' is their primary identity to one where it has little bearing on their interpretation of events. This points to the relevance of within group differences, and was reinforced by participants' use of a range of self-assigned ethnic labels to identify themselves (SG1). However, an attempt to delineate these differences by use of an American psychometric tool (RIAS) that categorises Black individuals according to their type of racial identity attitude was not successful because of its unacceptably low inter-item reliability (SG3). This meant that it was not possible to empirically investigate the link amongst Black British individuals, that had been found amongst Black Americans, between within group racial identity attitude differences and racial counsellor preference (SG3). The problems with the robustness of this measure with a British sample raises the issue of whether the notion of within group differences, as operationalised by the RIAS, adequately captures the complexity of the influence of 'race' on the therapeutic process. After all, perceptions about 'race' are socially constructed. The notion of Nigrescence does not seem to emphasise the powerful impact that class and other socio-economic structures have on the individual's concept of identity as a whole. Hence, whilst the pursuit for a measure that gives an indication of within group differences for racial identity attitudes amongst Black people needs to be continued, it also needs to take account of the interaction of socio-economic forces with perceptions of 'race'.

6.5 Methodological Evaluation

6.5.1 Sample characteristics

The results in two of the current studies (SG1and SG3) relied on self-report measures, which means that they are prone to the usual criticisms applied to research that utilises such designs e.g. limits to generalisation, the uncertain relationship between reported intention and behaviour (La Piere, 1934), and the need for larger samples. However, there are some aspects of the design of the study that put it at an advantage over many published research that relies on questionnaires. Firstly an active recruitment of 'real people' was achieved in the sense that they were not 'fresh' students or, as in many studies, psychology undergraduates. The use of participants who were naïve to psychological research and design contributed to the ecological validity of the current study. In addition, this study avoided the reliance on postal questionnaires (which makes up about 80% of research findings presented in psychology peer reviewed journals, Ponterotto and Cassas, 1991). Questionnaires were personally distributed and the researcher was available for guidance if necessary. However, it is appreciated that structured questionnaires as a method that wishes to find out about participants' attitudes or feelings towards certain issues may only reveal a surface understanding of the issues that are really important to clients. In order to reduce limitations

contained in the different studies, different measures and research designs that do not share the same systematic errors (i.e. triangulation) were used to get a more accurate insight into participants experiences and perceptions of counselling.

6.5.2 Limitations of small sample size

All 3 (SG1, SG2, SG3) studies would have benefited from larger sample sizes. Small sample size limit the extent to which results can be generalised to other groups. The material provided by individuals in the sample may be biased e.g. only those interested or who felt strongly may contribute to the research. In some ways this was expected, though it may be that those participants who did not volunteer were also likely not to consider counselling as a viable option for them for psychological help. Hence, it is probable that those who did respond would be interested in attending counselling, so by default they possess the characteristics of those who counselling services would target.

6.5.3. The role of the researcher

It needs to be acknowledged that the researcher was a ***Black*** woman investigating the impact of 'race', more notably, her own 'race', on counselling. The advantage of this was that it gave participants the opportunity to freely disclose about the importance of racial issues. However, the disadvantage is that the presence of a Black researcher could bias the results. The potential for demand characteristics in SG1 has already been discussed. To some extent these could also apply to participants in SG3, though they were not necessarily in contact with the researcher. In SG2 the researcher had not intended to read the items out to participants, and by doing so reduced the level of anonymity that would have occurred had the original aim of self-completion of the questionnaires by participants occurred.

6.6 Recommendations for practice

Since the results in the current research indicated a variety of attitudes towards ethnic matching amongst Black people, counsellors need to take account of within racial group differences (SG3), and not to automatically assume that a Black person would want to be seen by a Black counsellor (SG1 & SG2). Instead, the option of ethnic matching as a worthwhile therapeutic intervention needs to be explored and clarified with the client from the outset, probably in the assessment session or through a postal pre-counselling questionnaire in which clients are asked if there are any counsellor characteristics for which they have a preference. In order for this to occur there needs to be a safe and acceptable environment for Black people to discuss such

preferences if indeed they have them. This does not mean necessarily having a Black counsellor. Once the White counsellor is non-judgemental and culturally responsive to the Black client a thriving therapeutic relationship can ensue. The difference in emphasis placed on the preference for a Black counsellor by participants in the current research demonstrates that there needs to be a range of therapeutic options for working effectively with Black clients.

6.7 Recommendations for further research

6.7.1 Different sample and different location

The results are based on research designs that deliberately selected geographical areas (inner city London and central Manchester) which were noted for their high ethnic diversity which included a numerically high representation of Black people in proportion to the overall national figures, including those who have senior positions in mental health agencies. However, it may be useful to look at more typical areas where there are smaller clusters of Black people, and few Black (senior) professionals, especially counselling psychologists and therapists. Possibly, in these type of locations there is an overwhelming desire by Black people to have an ethnically similar counsellor. It would be interesting to investigate whether participants in such areas responded similarly to those in Ponterotto et al's (1988) sample.

6.7.2. Before and after design.

Although the current research indicated that there is a significant group of Black people that would prefer an ethnically similarly counsellor, there still needs to be research to indicate whether Black individuals do not attend, or do not return to, counselling *because* this facility is not available. A possible form this research might take is to ask Black potential clients prior to counselling, whether they have a preference for a racially similar counsellor. Then, once they have attended their first session, note whether or not they returned for their subsequent session(s). Comparisons could then be made between return rates of those who received their stated preference for a racially similar counsellor (group 1) and those who did not (group 2). The return rates of Black clients who did not state a preference for an ethnically similar counsellor could provide the 'control' against which the other two groups would be compared. The current studies (SG1, SG2) attempted this but in a somewhat piecemeal fashion. That is, Black potential clients were indeed asked about their racial counsellor preference (SG1), and Black clients' different types of attrition rates in counselling were analysed on the basis of whether or not they received counselling from a racially similar counsellor (SG2). However, the

Black potential clients who stated their racial counsellor preference were not the same Black clients whose early withdrawal from counselling were analysed in SG2. There needs to be a study that continuously follows a group of clients from their status as 'potential clients' to actual clients who either return or not to counselling after their first session.

6.7.3 Follow-up questionnaires or interviews for Black clients who withdraw early from therapy.

Similarly, further research could get actual feedback from clients who did drop-out prematurely. There may be other factors that override client counsellor matching that explain these clients' early withdrawal from therapy, e.g. one session was enough for them. In the current study, analysis was made on the basis of archival data (SG2). So one aspect for further research would be to contact clients who dropped out prematurely and find out directly from them why they did not return for their subsequent session(s). As a psychologist who has researched into clients' satisfaction with therapeutic services amongst generic client groups in a large suburban district (Richards, 1995), the current writer is all too aware of the challenges in getting former clients form all ethnic groups to reveal their reason for early withdrawal from counselling. The enormity of this task is increased by the difficulty in recruiting Black former clients, who have left due to dissatisfaction with therapeutic facilities available (Cochrane & Sashidrahan, 1996). This may explain the dearth of empirical material available on a variety of profiles of Black clients, and how their psychological needs are (un)met.

6.7.4 Investigations into the profile of White counsellors who successfully engage Black clients

Since many Black clients remained in therapy with White counsellors, even though for some of them their preference was for a Black counsellor, there is a case for further research that considers the processes involved in successfully working cross-culturally. This recommendation supports similar suggestions in the field of counselling psychology e.g. '*It is important that future research attend to counsellor variables that might influence ethnic minority client perceptions of trust and other counselling process variables*" (Atkinson & Lowe, 1995:406). There may be special ways of working effectively with Black clients that are unique to certain types of (White) counsellors. Structured questionnaires or even in-depth interviews could be employed to investigate whether and, if so, how certain White counsellors modify conventional forms of therapy when working with Black clients. This material could be used to train other counsellors. It may have been more of the appropriate use of the self of the therapist (which is emphasised in humanistic counselling, especially the person centred approach) that made the most contribution to the therapeutic outcome. In addition these counsellors who have

successfully engaged Black clients are likely to have a genuine commitment to the well-being of Black clients and actively seek (creative and adaptive) ways to achieve this.

Similar to the way in which the current study (specifically SG3) attempted to understand Black individuals' racial identity, further research could extend this to the White counsellor. The aim of this thesis was to look at the counselling process and its outcome from the perspective of the client or potential client: In this case the Black client. However, the onus to facilitate the therapeutic relationship is firmly with the counsellor (Rogers, 1951, Banks, 1999). Hence, it seems logical to consider counsellors' White racial identity attitude a as contributory factor to the dynamics of counselling in a cross-racial dyadic therapeutic relationship. This would extend work on racial identity conducted in America (e.g. Helms, 1995; Rowe et al, 1994), and contribute to the almost non-existent work in this area in Britain.

6.8. Contributions of the current thesis

The current research has contributed to the dearth of British findings concerning accessibility and acceptability of British therapeutic service provision for a sample of Black people. It also built on, though somewhat contradicted, American research, which has found a difference in attendance rates between Black and White clients with the former having higher rates of premature termination in counselling, whereas in Britain this is mostly anecdotal material. These findings (from SG1, SG2, & SG3) reduce the need to explain patterns of behaviour in a British context by relying heavily on American findings that have been influenced by American culture and history. This was done by looking at termination rates of therapy of Black clients in relation to other ethnic groups; intentions of seeking and engaging in counselling of Black former and potential clients and looking at a within group measure that claimed to find a relationship between a Black person's racial identity, and his/her engagement in a therapeutic relationship with an ethnically similar or dissimilar counsellor. Although the numbers were not large, SG1, SG2 & SG3 provide some indication of British Black people's perception of counselling services available to them, the influence this may have on the therapeutic alliance when they enter therapy, their patterns of attendance and attrition rates in counselling.

The aim of the research was to answer the research question of what is the impact of 'race' on therapeutic outcome using a wide range of Black people. So this research has made use of archival data from Black clients; questionnaire administration to psychologically vulnerable Black people and former counselling Black clients whose characteristics (e.g. they suffer with severe mental health problems, have a psychiatric history, experience considerable mental distress) make them likely to be potential clients or to re-enter therapy; and instruments completed by middle class / professional Black people. It is accepted that these findings do not

'*prove*' that Black people want an ethnically similar counsellor or that these same participants who stated this preference will *actually not* attend counselling if this facility were not available. Any conclusions that are drawn from these findings have to acknowledge that "*...In psychology we would use terms such as the "likelihood" of something occurring or happening. In psychology we cannot predict exactly what will happen in a particular situation. Peoples' behaviour is too variable, and our theories are as yet too weak to allow very high level precise predictive power*" (Dyer, 1995:6). (Underline added).

Particular themes that were investigated in relation to the research question were whether Black people were deterred from considering counselling as a satisfactory option for helping them alleviate their psychological distress due to lack of an ethnically similar or dissimilar counsellor. In acknowledgement of the willingness, and even preference, of some ethnic minority individuals to receive counselling from racially dissimilar counsellors, attempts were made to find a robust measure of within group differences that might explain how variations in racial identity attitudes amongst Black individuals influenced the difference in importance attached to preference for certain counsellor characteristics (i.e. strength of counsellor preference) (Morten and Atkinson 1983; Parham and Helms 1981; Ponterotto, Anderson and Grieger, 1986). The research focused on those Black people who not only would benefit from counselling, but would also use this facility, as opposed to those who were more likely to get sufficient alternative emotional support elsewhere, and hence would not consider therapeutic services as a relevant strategy for helping them cope with psychological distress.

The claims of this research are modest, but they have provided counsellors with some insight into some of the obstacles to accessibility for counselling those Black clients and potential clients who want, and would benefit from, counselling. Though the sample numbers are small, this thesis has provided some empirical answers to mostly theoretical and anecdotal material in the field of British counselling concerning the actual status of Black people as a group with higher drop out rates than other racial client groups. Some material has been provided on Black individuals' views of what would attract them to mainstream counselling. In recognition that most clients, whatever ethnicity, are highly likely to receive therapy from a White counsellor (as there are very few ethnic minority counsellors and psychotherapists), an attempt was made in this thesis to offer some insight for counsellors and service providers as to when a cross-racial dyad (of White counsellor and Black client) is likely to arrest the client's progress, and likely to result in prematurely termination of counselling very early in the therapeutic alliance.

Chapter 7: Conclusion

Since the main focus of this study is around the initial stages of counselling, some conclusions can be made about the needs of Black clients at this crucial stage, which more or less determines whether or not the client will engage in the therapeutic process. Counsellors need to be aware that even though many Black people *say* that they prefer a Black counsellor, which is a significant influence in their decision to enter into therapy, they may *actually* attend therapy with an ethnically dissimilar counsellor. In addition, their attendance patterns are comparable to other ethnic groups. That is, they do not have a significantly higher drop out rate than their White client counterparts. This points to the power of the therapeutic relationship and, contrary to an ancient myth, that Black people are 'psychologically-minded' and can use counselling appropriately.

Since, in the current study there was not a higher attrition rate for Black clients who were seem by White counsellors than other client groups, may be there is something that the White counsellors did that somehow facilitated their Black clients' engagement with the therapeutic process and their commitment to counselling. The focus of interest then shifts to discovering what these White counsellors in this study actually did that managed to retain Black clients who may be reticent about trusting a racially dissimilar counsellor – especially one who belongs to a 'race' that has historically oppressed and violently controlled the Black 'race'. This achievement attests to the skills of these particular White counsellors. Though, of course, the question is whether the White counsellors in this study characterise a different 'breed' of White counsellors, or whether they represent White counsellors in general, who can sustain a strong therapeutic relationship with Black clients. Working effectively with Black clients is likely to have involved the White counsellors in adapting the conventional Western therapeutic methods they were taught to a more appropriate practice with Black clients. The White counsellors in this study were likely to be counsellors who were proactive in trying to find out more about Black people by selectively reading material on Black people and believed that they needed a different model to work with Black people, or that existing conventional Western models needed to be adapted to work with this client group, even though they may not have been sure how, in principle, this would be done (Banks, 1999).

This thesis is not suggesting that the counselling psychology professional should adopt a sweeping stance of colour-consciousness in which all the client's problems are a result of his/her culture. To some extent this would be as potentially dangerous as taking a stance at the other extreme of the continuum (i.e. colour-blindness). Whilst acknowledging that the Black

person's 'race' or culture as a collective entity has historically been subjected to oppression and racism, the fact that participants in the current study did not all want an ethically similar counsellor supports Ridley's emphasis that to conclude that all Black individuals' problems stem from 'race' related issues (e.g. racism) is erroneous.

Whilst there are limitations to the current study (SG1, SG2 & SG3), it needs to be acknowledged that like any psychological research this thesis adds to a dynamic process of investigation and modification. Since the process is iterative, it is obvious that the intention of this research was not to be an investigation into *all* the possible connections that determine Black clients' engagement in the therapeutic process but to capture the essence of a relevant issue in counselling psychology that counsellors and psychologists alike seem to retreat from. To the author, this in itself indicates racial discrimination. The social scientist Moscovici very aptly pointed to the subtle ways in which 'outgroups' or powerless groups (in this case Black clients) can be marginalized in the media. The obvious way was to present them in a very negative light. A subtle way was not to include them at all. By not representing Black people the media ignored them and gave the message that they were not important to be included or considered. It is clear that the media has come a long way since them. Hwever, it appears that psychology has now to make those types of strides. Admittedly, there are less overt damaging statements or negative 'findings' about Black people, but their issues are still given little attention. When they are addressed, unfortunately, usually without question the responsibility seems to be heaped heavily at the door (and conscience) of the few (and relatively powerless) ethnic minority psychologists and therapists in the field and a handful of very committed White practitioners, out a large and powerful pool of White therapists.

The results of this thesis have implications for both the theory and the practice of counselling, therapy and psychology. The most obvious is that it is not appropriate to categorise 'Black' people as one homogenous group. Hence writers that present single theories and anecdotal material about 'the Black population' will no doubt have some relevance to some Black clients, but are also likely to be inapplicable to some parts of 'the Black population' they are hypothesising about. To avoid this 'hit and miss' scenario, theorists need to recognise the multi-dimensional qualities of the Black population. Similarly, counsellors in all areas of practice cannot assume that all Black people want to discuss their problems within a racial context, or that they would prefer to be counselled by a Black psychologist. However, at the other extreme, it would also be naïve to assume that the 'race' of the counsellor is not a significant factor in cross-racial counselling for many Black clients. Although, overall, no significant difference between the attendance rate of different racial client groups was found, there were enough individual entries that indicated that for some Black clients this was clearly a matter of importance. There are within racial group differences, though more research needs to be

conducted into how, if at all, these can contribute as predictors of service utility amongst Black clients.

The aim of this thesis was to provide insight into the needs of Black people as therapeutic service recipients. It is recognised that for this research to benefit this client group, progress must be made by service providers in therapeutic and psychological professions. Though of utmost relevance, it is not enough to focus exclusively on the perceptions and behaviour of this client group to meet their emotional needs. In some ways this could be seem as attacking only half of the problem, or just paying lip-service to a very pressing issue in psychology, which psychology has all too often been accused of with regards to marginalised and oppressed communities (Banks, 1999; Christie, 1995; Fernando, 1985; Owusu-Bempah and Howitt, 1999; 2000, Phoenix, 1999; Reicher, 1999). The findings have to be applied. In an attempt to meet the therapeutic needs of Black people, counselling professions must also acknowledge that they have a duty to provide a culturally responsive service to this group. The government has made some effort to respond to its shortage of therapeutically trained professionals by enrolling additional counsellors outside of the NHS (e.g. independent and private therapists) and creating new therapeutic titles for non-therapeutically trained staff working with the increasing population of Black people with emotional difficulties (e.g. 'psychological workers').

It has never been more apparent with the expansion of multi-cultural Britain that therapeutic professions must now also respond to the lack of appropriate therapeutic facilities for their ever-increasing Black clientele. This does not simply mean that therapeutic professions should make a more concerted effort to recruit Black workers. *They must!* But in addition, it is their responsibility to insist that *all* their members (qualified and 'in training') have culturally sensitive training. It is not enough to work towards an unrealistic utopia where one day there will be enough Black psychologists to work with Black clients. This could be interpreted as an attempt by non-Black psychologists to avoid their obligation of providing competent services for all of those who require it. Besides, strict and inflexible insistence on ethnic matching risks a danger of segregation, with White clients being seen only by White counsellors and Black clients only being seen by Black clients. It also goes against every thing that the counselling, therapeutic and psychological professions appear to promote: That they are open to all. In addition, it would inevitably lead to a 'ghettoisation' in counselling. In this case no absolution can be granted since, at the very least, it is clear that there are many potential and actual Black clients for whom the skin colour or 'race' of the counsellor per se is not a big enough issue to influence their engagement with the therapeutic process regardless of whether the therapist was Black or White.

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SECTION C:

CLIENT WORK

Harlem: A Dream Deferred

What happens to a dream deferred?

Does it dry up
Like a rasin in the sun?

Or fester like a sore –
And then run?

Does it stink like rotten meat?
Or crust and sugar over--
Like syrupy sweet?

Maybe it just sags
Like a heavy load.

Or does it explode?

(Langston Hughes, 1951)

CLIENT WORK

There is always something left to love. And if you ain't learned that, you ain't learned nothing...when do you think is the time to love somebody the most: when they done good and made things easy for everybody? Well, then you ain't through learning – because that ain't the time at all. It's when he's at his lowest and can't believe it hisself 'cause the world done whipped him so...Make sure you done taken into account what hills and valleys he come through before he got to whatever he is.

[Mama' (mother-in-law giving daughter advice about loving her husband) In '*Raisin in the Sun'(1959), (Act 3) play by Lorraine Hansberry]*

Case Study: Using Cognitive Behavioural Therapy to help a client overcome very real personal and financial dilemmas

In the interests of confidentiality all names and identifiers have been changed

1. Biographical information of the client and family history

The client, Alf, (47) was a married East End working class White male (and a heavy smoker). His children – son (24) and pregnant daughter (27) live alone. Both his wife and daughter suffer from epilepsy; consequently his daughter has mild learning difficulties. Alf's mother, (70) and his sister (49) live close by to him. His father died when he was an adolescent. Alf left school without any formal qualifications when he was 15 years old. His lifestyle began to change about 10 months prior to counselling, when he was 'unfairly' dismissed from his job of 23 years as an electrical engineer. Since then, he displayed many symptoms of depression (e.g. sleep disturbance), for which his GP prescribed Temazepan. Alf had not received counselling before.

2. Reason for Referral (client's reason for seeking help)

After assessing Alf, the psychiatrist wrote a brief referral lettering requesting that Alf be given counselling for depression.

3. The Approach taken, Rationale and Goals

3.1 The contract and structure of the sessions

3.1.1. Initial session. The counsellor wrote Alf a letter inviting him for an initial session.

3.1.2. Goals. These were largely determined by the assessment which is a *"way of identifying and defining a client's problems in order to make decisions about therapeutic treatment"* (Cormier and Cormier 1991:71). Hayes et al (1987) have also emphasized the importance of using the assessment for its *"treatment utility"*. The client and counsellor identified two main areas that could be addressed in counselling. The first was to reduce Alf's depression and the second was to improve his interpersonal relationships (family and friends).

3.1.3. Length of therapy. 15 weekly hour sessions were agreed.

3.1.4. Structure. Each session would take place in the agency where the counsellor was based.

3.1.5. Limits and Boundaries. The counsellor could be contacted during working hours (9am-5pm).

3.1.6. Confidentiality. Alf was advised that confidentiality would only be broken if he became a danger to himself or society. In addition, he was advised that other professionals involved in the counsellor's development would also have knowledge of the case. It was stressed that they were similarly bound by ethical codes (BPS, 2001), such as confidentiality (Bond, 1993). At the end of counselling the referrer would be sent a report of Alf's general progress.

4.The Process and Overall Content of the Sessions

Melaine Fennell's (1989) cognitive behavioural structure for therapy sessions for depression was followed. Generally this involved the therapist and client collaboratively working together (therapeutic alliance) to set an agenda at the beginning of each session. Items included establishing therapeutic goals and tasks; a discussion of any changes since the last session; an exchange between client and counsellor of any reflections on the previous session; a review of the 'homework', noting the outcomes, difficulties and what was leant; specific problems and strategies to be addressed as a major focus in the present session; setting the homework for the coming week, which was usually a concrete plan of action such as a behavioural experiment.

Using the ABC model (Ellis, 1977), Alf worked on identifying his dysfunctional assumptions, which included errors of logic, negative automatic thoughts (NATS), and underlying core beliefs. Following this, Alf was helped to challenge such thoughts. This enabled the counsellor to raise Alf's awareness as to the themes that arose during treatment, and their relevance to his daily psychological functioning and interaction with significant others in his life.

Alf then learnt how to restructure such distortions. This included substituting his negative thinking with more realistic thinking by using, for instance, hypothesis testing. Attention was also given to how to best adapt to the discomfort of realistic problem situations. The counsellor made regular summaries throughout each session to which Alf was encouraged to provide feedback. She also confirmed that Alf had an understanding of assignments' rationale and anticipated possible difficulties, so that in the next session he was able to share his observations, recordings, and assessment of the outcomes.

5. The client's definition of the problem and main concerns

Alf was dismissed from his job for 'suspected theft'. He believed that since the company had *"been taken over by a new firm two years ago"*, workers (like himself) on the old contract were gradually either dismissed, or made redundant and re-employed on a new, less attractive contract. *"It all seemed to come to a head..."* for Alf when his closest friend ('SJ'), who was also dismissed, suffered a near-fatal heart attack, and then soon afterwards was recently admitted as an in-patient to a psychiatric ward. Although Alf stated: *". . .At least I am not as bad as SJ"*, he did show signs of despair. He put this down to going through a male 'mid-life crisis' (Levinson et al, 1978; Neugarten, 1968).

In the assessment session Alf said, *"I think I have just come to the stage where I just don't care... Everybody has a goal in life... Mine has gone!...I am totally different to the way I was before I lost my job."* He illustrated his disruptions in functioning by describing his recent difficulty in relaxing, increased tenseness, irritability and high anxiety (behavioural symptom). He was concerned that now he was *"always"* very impatient, and initiated arguments with his epileptic wife who he either, continually shouted at, or totally avoided (all-or-nothing behaviour). He said one of the reasons for this was that he was ashamed of himself for letting her and his daughter *"down"* (emotional symptoms of guilt).

His current feelings of failure and worthlessness (cognitive symptoms) brought back memories of when his daughter had an epileptic convulsion at the age of 2 years old. By the time he got her to the hospital, she had suffered brain damage (mild learning difficulties). Alf commented, *"Although she is 27 years old, she has the thinking of a 15 year old"*. Alf recalled another *"painful"* incident for which he felt guilty. Simultaneously, in the early hours of the morning, whilst he was sleeping his wife was on her way to buy some groceries. She had an epileptic fit and was knocked over by a lorry. The injuries she sustained resulted in her been hospitalised for a year. Alf cited these episodes and his job loss as evidence of his failure to *"take care"* of the women in his family (both physically and financially) and that he was a *"useless"* person (theme of self-blame and inadequacy).

Alf describe ways in which he actively avoiding social situations (behavioural symptoms), and withdrew from his friends and family, since he preferred to be 'left alone'. For instance, he did not show any interest in his daughter's 5-week-old baby boy (his only grandchild). He had only visited them once and this was whilst they were still in hospital, soon after his grandson's birth. He also noticed a remarkable loss of pleasure (lack of motivational symptom). He now neglected his substantial collection of prize-winning orchids that he had spent considerable effort and money cultivating. Alf experienced an increase in his back pain that he believed had been aggravated by his dismissal (physical symptoms).

6. The Counsellor's definition of the problem and main concerns

Alf presented himself as tidily dressed man. His eye contact seemed inappropriate with about 70% directed to the ground and about 30% split equally between looking at the counsellor and around the room. Such non-verbal behaviour depicted a man with very low self-esteem and depression (APA, 1994).

6.1 Case formulation Using, Persons' (1989) model, it seems probable that somehow Alf had developed a core schema that there were specific components to being a man. The pinnacle underlying assumption seemed to be *" ...to be a man I must have a job and be able to financially provide for my family"*. Other related beliefs could be ' a man must be able to protect women (especially those in his family)'.

There seemed to be a variety of early experiences that could have shaped such core beliefs and continued to reinforce them, such as growing up as an East-End working class man. It is possible that when Alf's father died during his childhood, Alf assumed the role of breadwinner and protector of his family. Since his family consisted of women (mother and sister), who had obviously become vulnerable by the unexpected death of their husband/father, this may have reinforced Alf's belief that women are the "weaker sex", and need to be "taken care of" by men (Gilbert and Scher, 1999).

Many of these assumptions are culturally reinforced, and socially emphasised. Meth (1990) argues that on *"the road to masculinity"* (p3) boys are *"raised to work"* (Pasick, 1990:35). This partly explains *"the centrality of work in men's lives"* (Pasick, 1990:35). It becomes the most important part of their lives and the core of most men's identities. Just like other men, Alf's self-esteem is directly linked to his vocation and income. Such rigid stereotypes (e.g. 'real men' have jobs) produced by such a socialisation process can be damaging (Goldberg, 1976). For most men, their degree of job satisfaction and job security strongly impacts on how well they relate to other family members. This type of contextualisation of the problem seemed to fit Alf's behaviour towards his family.

It appears that, until recently, Alf has been able to survive potential threats to his perceptions of his manhood (e.g. his wife's accident, and his daughter brain injury). However, the critical incident (of losing his job) clashed with his underlying core belief ("I am nothing if I do not have a job"). Such irrational beliefs (Beck et al, 1979), because they are rigid and resilient to change, can eventually result in emotional disorders (Ellis, 1962). The significance of this critical incident is underlined by the objective situation that concerns over financial dilemmas are very REAL problems now that Alf has lost his job. This quandary only served to reinforce Alf's dysfunctional assumptions. His *'cognitive triad'* (Beck, 1970) was one of shame and guilt with himself (self); perceived irrevocable breakdown of relationships with significant others e.g. wife, family and friends (the outside world); and a despair that at his stage in life, his situation was more likely to get worse than better (the future).

Since he seemed to be 'failing' and getting *'everything wrong that I put my hand to'*, Alf had become despondent. It was as if he seemed to think that it would be better not to attempt anything than get it wrong. This indicated the extent of his fear of 'more failure', which resulted in his lack of confidence in himself and low self-esteem. In addition, he seemed to be feeling 'safe' with his almost accustomed-to behaviour. His was currently lethargic and had retreated behind his inactivity to avoid interaction with others. This culminated in Alf becoming depressed. However, it was also clear that Alf had not given up totally. His willingness to engage with the therapeutic process indicated that his current approach to his situation was not fully entrenched in his hopeless attitude to his 'plight'. This seemed to indicate that there were still some residuals of the working-class protestant work ethic that he was able to rally in order for him to want to regain his pride and the respect (that he thought he had lost) of significant others, and, of course, another job.

7. The approaches strategies and techniques adopted with the client

Due to the limited time, the counsellor was aware to focus on specific issues that would make a difference in the client's life. Choosing the most meaningful problems entailed narrowing the client's range of problems to those that could be addressed within 15 weeks. Egan states that *"this often helps clients move beyond the problem-and-miserly mind-set they bring with them and develop a bit of hope"* (Egan, 1998: 28). Whilst interviewing Alf, the counsellor satisfied herself that suicide ideation was not present. She thought that Cognitive Behavioural Therapy ('CBT') was suitable for Alf because it is time-limited. There was also a 'fit' between' Alf's description of his behavioural, emotional and cognitive symptoms and the CBT model for depression ('cognitive triad'). CBT is specifically formulated for dealing with the types of

'errors of logic' and 'cognitive distortions' (Beck et al, 1979) that Alf was vulnerable to committing (e.g. *"I am no good to any one"* – arbitrary inference'). In addition, CBT has a high success rate for alleviating depression (Beck & Shaw, 1986; Blackburn & Moorhead, 2001; Greenberger & Padesky, 1995; Sacco & Beck, 1995; Williams, 1992).

At the beginning of counselling the CBT model was explained to Alf. The counsellor explained that the aim of CBT, as a self-help therapy (Blackburn, 1987), was to get him to improve his own self-effectiveness, which included trying homework assignments. Alf stated that he was willing to work in this collaborative way (e.g. *'I am desperate, I'll give anything a go'*). Fennell and Teasdale (1987) suggest that if the client is willing to accept the CB treatment rationale then s/he is more likely to respond well to therapy. Alf frequently asked the counsellor, especially in the assessment session. *"Am I crazy?"* She first encouraged him to generate functional alternatives and then asked him to consider whether changes in his feelings and thoughts were due to him suffering from depression. Such 'Information Giving' has been identified by Trower et al (1988) as an effective verbal method for modifying maladaptive thinking.

7.1 Behavioural Interventions

In a dejected tone, Alf said, *"I just sit around doing nothing"*. Fennell (1989) suggests that to *"encourage hope and foster engagement in the treatment"* (p186), it is essential that at the beginning of therapy the client works on problems that are most open to change. Hence, it was decided to increase Alf's activity level using 'activity planning', which is a useful method for dealing with inactivity and apathy (Beck et al, 1979). This was done by using *graduated exposure tasks* (Marks, 1981), which re-engaged Alf in his 25-year hobby of orchid cultivation. In addition, Alf's activity was increased by working towards his aim of sharing more quality time with his wife such as going out for walks together. Completing these tasks directly contradicted Alf's self- defeating (maladaptive) beliefs that he could not accomplish anything. It also motivated him to try out new suggestions and tasks on other aspects of his depression.

Another major area that Alf identified as priority was his sleep disturbance. Alf and the counsellor explored Alf current coping strategies. This information was complemented by a sleep questionnaire (see appendix 8) to help clarify the extent to which Alf's sleeping habits had changed. Homework assignments included a sleep diary (see appendix 9) to help Alf monitor his current sleep patterns. His biggest difficulty was "falling" asleep. In conjunction with Alf's sleeping tablets, the counsellor used relaxation training over several sessions. These reduced Alf's overall stress, which mostly alleviated his sleep problems.

7.2 Cognitive interventions:

In parts of the session where Alf seemed particularly 'low' in mood (e.g. feeling guilty about neglecting his daughter and grandson), the counsellor regularly used the mood induction procedure to help Alf understand that negative thinking can actually produce a negative mood ('Mood congruity'). Alf came to realise that he could change his mood by providing (positive and realistic) functional alternatives to his negative inferences and evaluations.

The counsellor used Socratic questioning (Padesky, 1993) to challenge Alf's global negative self-evaluations and feelings of shame (e.g.. 'What's the evidence that you are a failure?' 'How does it follow that if you cannot financially provide for your family, then you are totally useless?'). The counsellor then shared her hypothesis with Alf that may be one of his core beliefs (dysfunctional assumptions) was that 'to be a man you must have a job, and hence if you did not have a job you were not capable of carrying out male roles 'properly', such as been a husband and a father'. After some reflection, Alf agreed that he did think along these lines, and stated that it was *"how I was brought up; it's second nature to me"*.

The counsellor and Alf then worked on disputing Alf 's unreasonable core belief and finding a realistic alternative belief (Padesky, 2001) on that theme that he could apply to all the situations in which he had self-defeating thoughts. The counsellor noticed how Alf's self-blame was causing him considerable distress. One of the strategies the counsellor used to deal with this was to get Alf to gather evidence that eventually led him to conclude that to 'err is human', but this did not mean he was a worthless human being.

The counsellor encouraged Alf to generate functional alternatives to explain interactions with significant others. For instance, Alf was convinced that his wife was going to leave him. Recognising the sensitivity of this situation, the counsellor explored this arbitrary inference in an empathetic and non-confrontational manner. The counsellor did not dismiss this possibility and acknowledged it as an understandable and reasonable fear, considering the deterioration of their relationship since Alf lost his job. Due to the nature of CBT, the counsellor did not encourage Alf to over-speculate as to his wife's reasons for her behaviour, but encouraged him to also consider the role he played in the relationship, including his interpretation of events when there may be other explanations for their occurrence. Carkhuff (1987) states that if clients are to manage problem situations they must own them ("personalisation") and recognize the contributions they make to them. This approach enabled Alf to consider that there were a variety of alternative conclusions he might draw from the same premise, and also that his thoughts and behaviour could affect events from start ('antecedents') to finish (consequences). Indeed, he did produce alternative suggestions as to other possible reasons for his current relationship with his wife. Trower et al (1988) argue that this is a good method because the client does the work and

owns the alternatives. This ensured that the beliefs Alf had generated stood a better chance of fitting into his overall schema. He began to feel like an active partner in the relationship and became more involved in doing things with his wife.

The counsellor regularly commended Alf for at least attempting homework. This strategy of positive reinforcement is especially effective for depressed individuals who have experienced a reduction in the opportunities to receive such reinforcement (Costello, 1972).

8. Progress, difficulties encountered and attempts to overcome them

8.1 Progress: Changes that Alf noticed included significant increase in motivation and activity e.g. spending time in his green house with his prize orchids; an increasing interest in his grandson; spending more quality time ("doing things together") with his wife with fewer arguments, and a more realistic view of his marriage.

8.2 Difficulties: Alf felt very despondent when he did not complete an assignment to his own satisfaction and then would be reluctant to attempt other tasks. This seemed to be related to an underlying theme of his fear of failure. In addition, Alf stated that he had hoped counselling would help him re-enter the job market. He reflected that whilst he was pleased that his relationship with significant others had improved and that he was he more active, he was somewhat disappointed that by the end of counselling he felt that he was no where nearer to finding gainful employment than he had been when he entered counselling.

Another difficulty for the counsellor revolved around Alf's extreme fear that his wife was in the process of leaving the marriage. This was a very sensitive issue for the client and the counsellor did not want to dismiss it or subject it to 'hypothesis testing' in such a way that increased the client's anxiety about what could have been a real fear.

8.3 Attempts to overcome difficulties: Although not completely resolved, the counsellor partially overcame Alf's difficulty in sometimes completing out of session tasks that he had suggested in the session. This was done by continually considering with Alf the obstacles to completing the homework and non-completion was presented as a learning experience (Burns 1980). She helped Alf understand that not succeeding was an important part of CBT, and that unsuccessful attempts were progressive steps on the way to successful attempts.

The counsellor agreed that Alf had not as yet found employment since being in counselling, though she emphasised that it was not the role of CBT to 'find' him employment. She explained that CBT could help him prepare himself for employment (e.g. by helping him to become more active; to demonstrate to him how he could transfer his problem solving skills that he learnt in

therapy to the work situation; to become more realistic about his cognitive triad and hence to have more realistic explanations about what occurs in his life).

With regards to the counsellor's dilemma about how to successfully and sensitively employ CBT with Alf's relationship problems, the counsellor found supervision and her own therapy very useful. From supervision she learnt to help the client increase his responsibility in the relationship and for him to consider the role that both his thoughts and actions contributed to the outcome of events. Therapy was useful since it helped the counsellor realise, and refrain from, her own enthusiasm to be more directive than is needed using a CBT model, and to want a 'happy ending'.

9. The development of the therapeutic relationship and notable aspects or difficulties with this

The aim of the therapist was to develop a strong working alliance (Greenson, 1967) with the client, which was "*a collaboration between the counsellor and client based on their agreement on the goals and tasks of counselling and on the development of an attachment bond'* (Bordin, 1979, in Egan, 1998: 41; underline added). Both client and counsellor have to be committed and motivated to work together to produce the desired outcome. Counsellors share their competence with their clients, and it is clients' responsibility 'to act on what they learn through the alliance' (Egan, 1998:41)

The counsellor valued the client as a person, and made efforts to communicate unconditional positive regard and emphatic understanding so that the therapeutic relationship could develop between the counsellor and client (Rogers, 1961). The counsellor was aware that there were noticeable differences between herself and the client which included gender, age (the counsellor was considerably younger than the client), 'race' (the client was White British, and the Counsellor was Black British); socio-economic class (in that the client was a working class unemployed electrical engineer, and the counsellor was a middle calls employed psychologist). Whilst the client did not seem to be affected by this, the counsellor was appreciated that her outlook was different to the client's and was cautious not to make judgements based on her perception of superiority of her worldview.

9.1.Termination Throughout the sessions Alf showed some dependence on the counsellor. He regularly reflected that: *"I come here once a week and I speak to you more in one hour than I do the whole, of my family in one week"*. The counsellor encouraged Alf to address aspects that he felt he could not cope with once he did not receive counselling, and explored how best he could maintain the progress he had made in therapy and also make use of his supportive network of family and friends to help him. It was acknowledged that engaging with counselling was actually the client's strategy to help him to be able to talk openly to his family. By reframing his

response in this way, the counsellor helped Alf consider that his family were supportive of him and in that sense they were all working towards a common goal. It was for him to 'let them in' more than he had.

As a 'weaning process', towards the end of counselling the last 4 sessions were spaced out fortnightly. However, in retrospect, the counsellor felt that she did not deal adequately with this part of the therapeutic relationship. Trower et al (1988) suggest that such dependency should be treated like any other maladaptive belief hypothesis and challenged. For instance Alf could be encouraged to consider the successes he has had with counselling and how to consolidate his therapeutic gains. This would have demonstrated to him that he had made enough progress in counselling to enable him to maintain his improvement once he was no longer in counselling.

10. Evaluation

10.1 A critical assessment of the effectiveness of the counsellor's interventions

This was partly appraised by the counsellor asking Alf what he found to be most useful or unhelpful. The counsellor assessed her effectiveness by considering the fit between the CBT approach and the extent to which she convincingly used it as an intervention to alleviate Alf's depression (main goal). The counsellor felt she had not fully facilitated Alf's use of cognitive interventions whereas more progress was made using behavioural interventions. By the end of counselling, behavioural interventions had effectively increased Alf's sense of "mastery" and "achievement" (Lewinsohn, 1974). This helped him prove to himself that he did have control over his life and went some way to lifting his self-esteem. Indeed, his eye contact seemed appropriate, in contrast to when he first started counselling.

Alf seemed to have developed a reasonable understanding of the principles and practice of CBT, and with some effort was able to apply the skills of problem solving the CBT way unprompted, e.g. identifying and challenging negative dysfunctional thoughts. For instance, in one session, Alf said that he noticed that he was able to reframe his achievements in more realistic terms and that he was not as prone to over generalise (make global negative evaluations). Rather, he could reasonably, negatively evaluate parts of himself (single behaviours or traits) without generalizing to himself as a whole (Ellis & Dryden, 1987). This suggested that the counsellor had been effective in helping Alf become realistic about his abilities and that he could accept himself as a person who has some weaknesses and would make some mistakes, but that this did not mean that he was a '*bad person*'. However, because of Alf's limited applications of these cognitions to mostly within the sessions, the counsellor did wonder about the long-term

effectiveness of her interventions. One of CBT's major aims is to facilitate the client building up his own capacity to problem solve in the future.

Possibly, the counsellor did not convincingly "sell" the CBT rationale. This is a prerequisite for Socratic questioning which can be perceived as somewhat threatening. One of the main reasons may have been that the counsellor was not comfortable with pathologising Alf's situation. Rippere (1994) argued that some clients' depression seems entirely appropriate to their depressing circumstances. Alf's depression may be because many of his efforts to achieve his goal had failed 'in front of' significant others. So, when dealing with clients it is important to take into account the possibility of a genuine depressive feedback from their environment (Bradley & Power, 1988).

11. Professional Issues

11.1. Self Evaluation of the counsellor's development of skills and psychological understanding

11.1.1. Personal development of the counsellor. To help me understand Alf's situation, I used the role reversal technique (Twaddle & Scott, 1991) on myself. At one point it appeared that I might not be able to find the money to undertake further studies. I remembered how painful this felt. My hopes were dampened and I was disappointed with myself. This exercised enable me to increase my empathy for Alf, though I appreciated that his problems (and consequential pain) were much bigger in contrast to mine. His reactive depression (Leema, 1996) was realistic. He was facing real life issues (e.g. financial problems). Understandably, Alf was feeling disoriented due to loss of a cherished identity (Abramson, Seligman & Teasdale, 1978) that had been replaced with the label of 'thief', and hence the real possibility of a premature end to his working life.

Whilst working with Alf, sometimes I felt that, as a therapist, one is prevented from feeling deeply sad with the client about unfortunate circumstances, since this paralyses him from 'leaping' into action (e.g. activity planning). Indeed, Trower at al (1988) see this as colluding with the client. In retrospect I felt that Alf's depression was quite well founded. My role as counsellor was to use CBT to help Alf develop skills that would help him reduce those aspects of his depression that resulted in a maladaptive and an unrealistic negative view of himself and his situation. It was not to deny the existence of a very depressing situation. This was quite painful for me since it meant that I could not 'cure' him or produce a happy ending (i.e. totally alleviate his depression). But then in my eyes he was not really "ill".

11.1.2 Psychological understanding:

> "Regardless of the therapeutic approach, each clinician brings to his work attitudes toward, and about, men that have the potential to interfere with effective therapy. It is essential that therapists be aware of these attitudes and use this awareness to enhance, their ability to help men change" (Meth, 1994:iv).

I felt that with regards to psychological development I was aware not only of the psychological component of Alf's world but also the powerful gender conditioning, myths and social constructions that create expectations for all of us in society. This helped me develop a therapeutic approach that was ecologically valid. That is, one that fits in with the client's world.

12. The contribution of supervision to aiding my understanding of psychological processes

Supervision was weekly and was provided on an individual basis. The most useful aspects of supervision for this case included developing my counselling competencies in dealing with relationship issues using the CBT model. In addition, the supervisor's emphasis that reviews of Alf's progress should be made throughout the sessions, was useful, and helped me focus with the client on the 'here and now' aspect of the model. *"Evaluation has the effect of showing clients that progress has been made in counselling"* (d'Ardenne & Mahanti 1989:7). This ensured that both counsellor and client consistently worked towards agreed goals.

13. The counsellor's modification of views and reflections about the case over time

Whilst CBT is effective with depression, it uses the therapeutic relationship as a vehicle for conducting interventions, rather than dwelling exclusively on the relationship. In retrospect, I wonder if, in my eagerness to use CBT interventions, I had sometimes missed the subtleties of Alf's reference to our racial difference. For instance, after one of the between session assignments which involved him in doing more activities with his wife, Alf returned and commented on a shopping trip with her. He spent some time talking about the different types of food on sale for Black people, and how they spoke '*loudly*', though there did not seem to be any criticism in the tone of his voice. At the time it sounded to me like a 'neutral' observation. He commented on how I seemed different to 'them' ("...*More like one of us"*). However, at the time I did not understand the relevance of this short, seemingly throwaway remark. I focused on agenda setting and asking him what he had learnt from this activity with his wife. May be it was *me* who could have learnt something from Alf's observations.

With hindsight, it has occurred to me that Alf was willing to accept me as his counsellor, despite the fact that I was of a different 'race' to him, because he *perceived* me to be similar to him,

when in fact there was very little I shared in common with him. I now wonder whether, even though materialistically I was more advantaged that Alf, for him it was his membership of a more powerful 'race' than actual individual possessions that made him feel able to make this comment. After all, the way he phrased his comment, implied that to be an 'honorary' member of his (White?) 'gang' was an advantage.

In revisiting the philosophy of the CBT approach, especially the emphasis on a therapeutic alliance, and a collaborative relationship where client and counsellor work as partners, I wondered about the concerns that have been expressed by some other therapeutic approaches about the potential that CBT has to be a controlling and powerful tool. At the time when I was working with Alf, I thought I had been naïve by believing that an equal partnership actually existed between herself and him, since as the (directive) therapist I was the more powerful of the dyad in the counselling situation (Masson, 1989). However, what I had not considered in enough depth was that, whilst therapists have some type of power over their clients in the cocoon of the counselling relationship, the power of certain group memberships in the wider society interact and influence the power (in)balance of the therapeutic dynamics. Although *I* did not feel either superior or inferior to Alf, I got the impression that our 'race' difference was not an issue for him because he belonged to a 'race' whose power have, in many instances, afforded them the 'comfort'of not having to contemplate their own ethnicity (Gorell-Barnes, 2002; Thomas, 2002). So by 'including' me in that group, it would not seem relevant to discuss racial differences since we were 'the same'.

From a CBT perspective I would liked to have tested out this hypothesis. In addition, I am curious as to whether it was Alf's identity as a member of the White 'race' that made him feel powerful enough to make this statement and whether a Black client (a member of the minority culture) would have felt powerful enough to make such a statement to a White counsellor (Richards, 2004).

Since I did not challenge Alf on this comment, it is mere speculation as to whether he felt some type of superiority because he belonged to the majority culture and I was an ethnic minority in that culture. However, what was very clear was that regardless of the obvious differences between myself and this client, of which there were many, what mattered was the *client's perception* of my similarity with him. It was this perception that enabled him to benefit from therapy. Hence, this illustrates that it is the process of how differences are negotiated that influence the therapeutic dynamics and the client's progress (Rothenberg, 1990).

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SECTION D

LITERATURE REVIEW

So You Think I'm a Mule?

But hold on right there
If you Dare mutter mulatto
hover around hybrid
hobble on half-caste
and intellectualise on the
"mixed race problem"
I have to tell you:
take your beady eyes offa my skin;
don't concern yourself with the "dialectics of mixtures",
don't pull down that strange blood crap
on me Great 'White Mother'

Jackie Kay, 1984: 53-4

Literature Review

Understanding and meeting the psychological needs of mixed-race individuals of Anglo-African/Caribbean parentage

1.Introduction

Counsellors, therapists and psychologists alike are becoming increasingly aware of the growing *'mixed-race'* or *'biracial'* population in Britain (Barn, 1999; Fatimilehin, 1999; Phoenix and Owen, 1996; Tizard and Phoenix, 1996), and the implications this will have for their practice (Banks, 1995; Goldstein, 1999).'Mixed-race' individuals constitute 11% of the ethnic minority population and they contribute 0.8% of the total UK population (ONS, 2002). In addition, as young people, mixed race individuals are disadvantaged in the care system, disproportionately over-represented and more likely to be admitted into local authority care than other young people (Barn, 1999; Barn et al, 1997; Batta et al, 1975). Hence, counsellors are likely to come into contact with mixed race individuals during the course of their practice.

However, researchers in Western industrialised countries have met with similar resistance by many interracial families to being studied [e.g. in the USA, Poussaint, (1984) and Wardle (1987) and in Britain, Tizard and Phoenix (1993)], which according to Root (1992) has served to perpetuate common myths, prejudices, stereotypes, and negative attitudes concerning biracial individuals (Kerwin and Ponterotto, 1995; Shepherd, 1997). Hence, counsellors will probably, if they have not done so already, find themselves in a professional and 'practice dilemma'. On the one hand, they will receive referrals to provide therapy for mixed race individuals. Yet, therapists are also likely to encounter difficulties, including lack of pertinent resources, when attempting to work with biracial individuals (Adermann, 2000; Henriksen, 1997). Indeed, Milan and Keiley (2000) comment that this is typical of the shortcomings of clinical resources for work with this growing population.

2. Mixed race / biracial individuals

Typically, and for the purpose of this essay, the terms *'biracial'*, *'mixed race'*, *of mixed parentage'* and *'of mixed heritage'*, will be used interchangeably to allude to individuals of *'Black'* and *'White'* racial heritage. This usage is common in the therapeutic and psychological literature (Banks, 1995; Brown 1990; Johnson, 1992; Owusu-Bempah and Howitt, 2000; Sebring, 1985;

Tizard and Phoenix, 1996), not least because *'almost half of this group are from White and Black Caribbean backgrounds'* (Annual Local Area Labour Force, 2002), [3] indicating their increasing numerical significance (Adermann, 2000; Gibbs, 1998; Herring, 1995; McFadden, 2001; Nishimura, 1995; Quintana, 1999; Root, 1996; Ross, 1996; Zwiebach, 1999). The number of interracial marriages in Britain has increased. Nearly 30% of people of African Caribbean origin under the age of 30, who were married or cohabiting, had a White partner Travis (1997). For every two out of five children with a parent of African-Caribbean descent, their other parent was White.

In line with the general objectives of other components of this thesis, this literature review aims to understand common problems of people of African descent in Western societies to provide some insight into how their emotional and psychological needs can be met in such societies. Hence, this 'quest' could not ignore the mixed race community. Part of their heritage as individuals of African-Caribbean descent seems to be have been given more emphasis in the psychological literature than their Anglo-Saxon heritage (Banks, 1992; Carter, 1995; Goldstein, 1999; Owusu-Bempah & Howitt, 2000), and it is this emphasis in society (and by some mixed race individuals) that has led to them sharing many similar experiences with other people of African-Caribbean descent. In a racist society they are considered as Black (Tizard & Phoenix, 1993), and treated accordingly. Mixed race people share with Black people experiences of racial discrimination and all the 'accessories' that come with it e.g. poor housing, limited access to financial resources (Barn, 2000) and denied opportunities e.g. in education and employment (Owusu-Bempah & Howitt, 2000).

Whilst is it accepted that mixed race individuals discussed in this chapter are of African descent, by virtue of having a Black parent, this review emphasises that any attempt to produce blanket sweeping generalisations about a so called homogenous group of people known as 'mixed race' must be avoided. It will become apparent as the literature is reviewed that the source of the data used will portray very different types of presentations of mixed race people. Considerable research has been produced by psychologists who work in clinical services, and hence research in that area will refer to the psychological problems and pathology of mixed race individuals, especially young people, often focusing on racial identity issues, whereas there is other research that challenges such a portrayal. This latter research is invariably, though not exclusively, conducted by psychologists who have access to 'non-clinical' samples of mixed race people who are progressing through their lives like other people from all ethnic groups and who experience similar 'normative crisis' (Erikson, 1968).

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[3]However, it is recognised that the 'mixed' category is not limited exclusively to offspring of this type of union of Black Caribbean and White.

3. Models of Biracial development

Henriksen's model captures the general trend of stages models and, like other theorist, whilst recognising the possibility that racial identity can be challenging for biracial individuals, he emphasises that they are capable of developing a 'positive expression of pride in being biracial' and proposes that professionals use his model to help them work with biracial individuals. The model typically portrays a biracial identity as emerging following a progression through several phases of development:

> "(a) neutrality, that phase when the individual is not aware of race; (b) acceptance, that period when the individual accepts being racially different; (c) awareness, that period when individuals become aware that they have no racial group with which to identify; (d) experimentation, that period when the individual begins to seek a racial identity; (e) transition, that period during which the individual begins to develop his or her own racial identity; and (f) recognition, that period during which the individual recognizes his or her Biracial identity" (Henriksen, 2001:149).

Other models on biracial identity development are consistent with these stages. Alderman stated that the narratives of her biracial participants progressed from a lack of awareness of race, to identifying racially, to distinguishing between race and ethnicity, to addressing ongoing issues related to ethnicity (Adermann, 2000). Root's model which, identified four general types of resolutions of biracial identity ('Acceptance of the Identity Society Assigns'; 'Identification with Both Races'; 'Identification with a Single Racial Group'; 'Identification as a New Racial Group') that the individual has to manage (Root, 1995) shares many similarities with the typical stage models of biracial development. These include Poston's (1990) five stage 'Biracial Identity Development Model' (1.'Personal Identity', 2.'Choice of Group Categorization', 3.'Enmeshment/Denial', 4.'Appreciation' and 5, 'Integration'); Kich's (1992) three stages model (1.'awareness of differentness and dissonance'; 2.'struggle for acceptance'; 3.'self-acceptance and assertion of an interracial identity'); Jacobs's (1977, 1992) three stages of 'Identity development in biracial children' (1.'Pre-colour Constancy: Play and Experimentation With Colour;' 2.'Post-Colour Constancy: Biracial Label and Racial Ambivalence', 3.'Biracial Identity'); the Kerwin-Ponterotto (Kerwin, Ponterotto, Jackson and Harris, 1993) six stage Model of Racial identity in biracial children (1.'Preschool', 2.'Entry to School', 3.'Preadolescence', 4.'Adolescence', 5.'College/Young Adulthood' and 6.'Adulthood'). There have also been scales developed e.g. five subscales of Atkins' Biracial Identity Development Inventory (BIDI). These are 'Lack of Salience', 'Conflict', 'Monoracial Identification', 'Appreciation', and 'Intergration' respectively. Atkins found that biracial individuals who obtained high scores of the earlier (first three) stages were more likely to have high levels of perceived alienation, which was not the case for the last two stages (Atkins, 1995). This supports Poston's model, which recognizes that the most difficult time of adjustment and

identification confusion is during the 'Choice stage' and the 'Enmeshment-Denial stage' (Poston, 1990).

From these models it is clear that the issue of whether to identify primarily with one racial group or to integrate both parents' racial heritage, and how to achieve this successfully, is a debate that is exclusive to biracial identity (Bowles, 1993; Newsome, 2001), and is aptly illustrated by the title of Hall's paper *"Please choose one: Ethnic identity choices for biracial individuals"* (Hall, 1992b). Biracial individuals have the unique challenge of first resolving their underlying attitudes toward their dual racial heritage, before successfully integrating the other development tasks (e.g. sexuality and sexual partners, Gibbs, 1990; Overmier, 1990) in the areas of identity achievement (Adermann, 2000; Kerwin and Ponterotto, 1995).

Although they accept that there are certain racial identity issues unique to biracial people, most models of biracial development indicate that mixed race individuals are proactive in constructing a healthy racial identity (Mahtani, 2002), are proud of their biracial identity, (Henriksen, 2001), receptive to both the Black and White communities (Bowles1993; Kerwin, Ponterotto, Jackson and Harris, 1993; Overmier, 1990; Pinderhughes, 1995; Streeter, 1996) to the extent that many of them wished to emphasis the uniqueness of their family, for instance, with celebrations or rituals (Winn and Priest 1993). Similar to other racial minority groups, racial identity issues for biracial individuals are part of a 'normative crisis' (Erikson, 1959), and their disclosure of distress, related to such issues were within normal limits which meant they were not different to other racial groups (Harrison, 1997; Owusu-Bempah and Howitt, 2000).

The assertion of a positive biracial identity is an emotional process (Collins, 1997), which the majority of mixed race individuals go on to resolve. School counsellors did not consider their counselling needs to be greater than other races (Nishimura and Bol, 1997). British biracial individuals' (12-19 yr olds) ability internalise a healthy and positive biracial identity, which reflects both their heritages, increased with age and was associated with high self-esteem (Fatimilehin, 1999). Similarly, few biracial individuals held negative stereotypes of one part of their heritage (Segal, 1997). In fact, they perceived many advantages to being of 'jewel' heritage (Fatimilehin, 1999). This included an open-mindedness to diversity, that meant they were racially tolerant, willing to consider different perspectives and able to 'bridge' cultures (Ross, 1996).

4.The plight of some biracial clients considered in this review

> "...although much of the focus (here) is on the process of identity wounding and thus 'worst case scenarios' to express the effect of racial oppression upon individuals from a clinical viewpoint, *it is assumed that the reader understands that biracial people often have a very positive identity* (Hershel, 1995: 169)

In agreement with Hershel, this review accepts that the majority of mixed race individuals have an emotionally secure developmental process and continue to have psychologically healthy lives in adulthood. However, it also needs to be highlighted that there are a small, but sizeable proportion of mixed race individuals, who due to disadvantage (especially racial discrimination, poverty, poor housing/homeless, low-socio-economic status, family problems) become psychologically vulnerable. This review will focus on this group of mixed race individuals who, during childhood and young adulthood, have the highest entry rate into care systems compared to monoracial Black, Asian and White young people (in one study up to eight times more likely, Batta et al, 1975) and other mixed race combinations (Barns, 1999; Tizard & Phoenix, 1993), and are the youngest age entrants (Folaron, 1993). They also have higher incidences of academic and behavioural problems in school (McRoy & Freeman, 1986), and these emotional problems seem to persist well into adulthood. These are the types of individuals that have a high likelihood of presenting themselves for therapeutic help.

According to clinical literature, the mental distress of such mixed race individuals, like those above, pivots around their ambiguous racial identity (Gibbs, 1998), partly because they may be perceived as 'lacking *full* affiliation' to either of their racial (Black and White) groups (Johnson, 1992:45), both of whom subject them to constant racial 'legitimacy testing' (Adams, 1997). A possible outcome is rejection by both groups (Adermann, 2000; Herring, 1992 McFadden, 2001), even though biracial individuals struggle for acceptance (Brown, 2000; Maxwell, 1998), but still remain *'between a rock and a hard place'* (Cauce, Hiraga, Mason, Aguilar, Ordonez, & Gonzales, 1992:207). These consequences of 'marginalisation' (Kich, 1996; Overmier, 1990; Root, 1990), as the outsider, or 'other' (McFadden, 2001), relegate biracial individuals to an 'invisible race' (Hall, 2002) status, or worst still, as *'an invisible monster'* (Nakashima, 1992: 162). Such hurtful branding indicates why this sensitive topic of the development of mixed race individuals has led to it been aptly labelled as constituting and emotionally *laden discourse on multiracialism'* (Rockquemore and Brunsma, 2002: ix). Vulnerable members of mixed race individuals are more likely to receive some form of psychological intervention than other racial groups, as was indicated in Milan and Keiley's (2000) comparison of a biracial ethnic group's functioning with other ethnic groups by using a public archival data that included interviews of 6,504 adolescents and their 4,600 parents from all ethnic groups.

5. Social issues 'inherited' from parents

Whilst most interracial couples will work towards cultivating a healthy psychological development in their children, like other couples who have different backgrounds (e.g. different faiths), there is likely to be some conflicting concepts on childrearing practices. Exposure to these can signal mixed messages to their offspring (Hsu, 2002). Biracial offspring have higher chances than other monoracial offspring to grow up in an environment where their parents, like other interracial couples, have higher levels of distress and difficulties that can potentially result in parental separation (Kohn, 2001).

Parental separation may not necessarily be due exclusively to relationship difficulties between the couple, but also because of stress from social pressures. Interracial couples are confronted with racism and hostility over their relationship by onlookers (Datzman and Gardner, 2000; Fulton, 2001; Glaser, Dixit, and Green, 2002; Killian, 2001), and 'social retribution' (Goodwin, 2002). They experience intrusiveness (Dainton 1999), and disapproval by extended family members (Folaron, 1993; Ross, 1996). It is the Black partner who is more likely to be aware of these attitudes (Killian, 2001). Wilson reported that this attitude towards interracial couples could be traced back to when '[for] *a substantial and influential section of English society, miscegenation was regarded as a threat to the structure of that society'* (Wilson, 1987:2). This was (and to some extent still is) related to the taboos about interracial sexual intimacy (Moran, 2001; Owusu-Bempah, 2003; Root, 1992; Root, 2001; Walvin, 1973). The above paints a depressing vision of society's negative and narrow-minded attitude to interracial relationships, whereas the majority of interracial marriages/unions reflect the willingness of those partners to accept difference and also to simultaneously assimilate with other cultures, yet retain their own racial identity (Perel, 2000). The presentation of unsuccessful and also satisfactory interracial relationships to some extent demonstrates that, like all marriages, interracial unions have successes and failures (Root, 2001). There may also be differences in research design. For instance, Kohn's interracial couple sample that reported the distress and challenges, for which interracial relationship are notorious, had been together for a maximum of 18 months, whereas La-Taillade's interracial sample, who on the whole reported similar levels of satisfaction and psychological adjustment in their relationships as intraracial couple samples in the study, had been in longer term relationships (La-Taillade, 2000).

6. Society's classification of mixed race individuals

Biracial individuals are faced with society's attempts to 'shoehorn' them into traditional monoracial categories (Brown 2000; Ramirez, 1996; Root, 1995; Williams 1996; Winn, and Priest, 1993). Many of them find this simplistic reductionism problematic (Zack, 1995),

especially the idea that biracial individuals have an 'essential' Black identity (Tizard and Phoenix, 1995). For instance, Cater stated, *"Essentially, I am suggesting that a person who is biracial should become grounded in the devalued racial group as a foundation for facilitating the merging of the two racial groups"* (Carter, 1995:120). In Britain, writing from a postmodernist Black perspective, Goldstein concludes that *"Black, with a White parent"*, is the most appropriate racial self-concept for biracial individuals (Goldstein, 1999).

There is indeed evidence that some mixed race individuals felt obliged to succumb to the pressure to which Carter refers (Brown, 2000), and identified themselves as Black, rather than of mixed race heritage (Cooke, 1998; Gillem, Cohn, and Thorne, 2001; Quintana, 1999). Similarly, some parents (especially White mothers) socialised their biracial children to adopt a monoracial identity that sided more with a Black identity (O'Donoghue, 2001). To some extent, such a tactic is understandable considering that Black people are less rejecting of mixed race children (typically seeing any child as a blessing) (Barr, 2001; Lewandowski and Jackson, 2001). In addition, given the hierarchy of racial groups, a biracial person is likely to experience oppression from the higher status (White) social group (Root, 1992). Therefore, it could be psychologically damaging for mixed race person to initially assume a White identity, unless their physical features and denial of their Black heritage allow them to 'pass' (i.e. where non-White individuals - in this case biracial individuals - who are capable, due to their White racial appearance, of either temporarily or permanently, abandoning their Black racial heritage in order to embrace a White racial heritage and all the privileges it bestows (Daniel, 1992; Streeter, 1996)]. Carter argues that a primary White identity will not prepare the mixed race person for the common experiences of racism, oppression and discrimination, whereas a Black racial identity is likely to do so (Carter, 1995). This was illustrated by Freire's case of a biracial 45 year-old man who hated his Black parent and Black heritage (Freire, 1992). The client's obsession with his racial status and identification with a White ego manifested itself in *'an identify drama'* where the individual was *'caught in a paroxysm of narcissistic humiliation and despair'* (Freire, 1992: 219). On the other hand, Fieire's case seems to supports Root's argument that to have a healthy racial identity, a biracial person must accept both sides of his/her racial heritage (Root, 1995).

Biracial individuals' resemblance to their parents' physiognomy (Harrison, 1997), especially skin colour, has been another criteria for categorising mixed race individuals into one racial category. Indeed, Segal (1997) stated *'Phenotype is related to interpersonal perception'*. This was encouraged and biracial individuals themselves also used this strategy (Overmier, 1990; Quintana, 1999). For instance Zwiebach labelled *'Synthesizers'* those biracial individuals who resembled their White parent and were more likely to identify with their White parent's group.

The other group, '*minority identifiers*' perceived their physical appearance as most similar to their minority parent and related more to this parent's racial group (Zwiebach, 1999).

Whilst the logic of classifying mixed race individuals as Black can be appreciated as a way to help them survive in a racist society, an inflexible insistence on this type of categorisation for all mixed race individuals or its employment as an automatic, permanent label should be avoided. Although it is accepted that there are mixed race individuals who identify themselves as Black, and they do not have any problems with racial identity, such compartmentalization is not without it repercussions. Nonetheless, some of the clinical material seems to be stating that mixed race individuals *should* identify themselves first and foremost as Black. Therefore, many mixed race individuals are denied the opportunity to identify themselves, and this could result in racial identity confusion. Similarly, many young mixed race individuals have chosen their own dual race identity (Tizard and Phoenix, 1993), so any attempts to help them re-assign their established racial identity could damage their self-concept (Owusu-Bempah, 2003). It seems that whilst psychologists are suggesting these strategies to 'protect' mixed race individuals in a racist society, paradoxically this type of classification has the potential to produce the same negative outcomes, such as racial identity confusion, that they aim to circumvent, or at least minimise. Moreover, by yielding to societal pressure, biracial individuals would be negating their White ancestry (Brown, 1995; Cooke, 1998). This is likely to result in continually seeking racial category endorsement, possibly reflecting internal questions about their 'Blackness' (Martinez, 2000).

This review has highlighted the pressure in contemporary society that biracial individuals experience to identify with one racial group. This typically results in them adopting society's classification system in which they are considered exclusively as members of their minority race side. However, there is also a historical context to this assignment. Daniel describes the history of the hypodescent ("one-drop") rule in which individuals who had 'one drop' of 'Black blood' were classified as racially Black. This was regardless of whether the majority of their racial composition was overwhelmingly of White European ancestry, on the grounds that they did not have 'pure' 'White blood' (Daniel, 1996). An outdated 'law' which hails back some three or four centuries still seems to have immense impact in contemporary society, and on the perceived physical appearance, and hence identity, of biracial individuals.

7. Therapeutic work with biracial clients

Counselling and psychotherapy literature available on work with biracial clients highlight attempts to integrate the context of cultural as well as racial issues into the case formulation and

therapeutic interventions for biracial clients. Therapeutic material varies from unusual and exotic cases (e.g. in the case of Takeuchi's study of a biracial 13 year old adolescent female with a culture-bound syndrome, *'fakamahaki'*) (Takeuchi, 2000), to the use of established therapeutic techniques for standard psychological problems. An example of this would be Rittenhouse's presentation of a biracial client's recovery from posttraumatic stress disorder (PTSD) employing eye movement desensitization and reprocessing (EMDR) (Rittenhouse, 2000). Rittenhouse highlights the importance of paying attention to the interaction between ethnicity and phenotype as well as diagnostic and treatment considerations. Whilst Rittenhouse's case follows a more directive approach, the majority of research in this area is mostly on using insight-orientated therapies with adolescents. For example, in Shorter-Gooden's (2000) case of a biracial adolescent female, the psychodynamic processes in psychotherapy were used to focus on the client's developmental process. Similarly, Terrell's use of psychodynamic and family systems with an 18-yr-old biracial female with bulimia nervosa uncovered a relationship between the client's struggle with her eating disorder and her experience of her biracial heritage (Terrell, 1996).

Other suggestions for interventions with biracial individuals include raising their awareness of their identity (Benedetto and Olisky, 2001), but not steering the individual to becoming exclusively consumed by it so that other complementary and salient identities are not fully appreciated (Adermann, 2000). Therapeutic interventions also included working with parents, especially single White mothers, of biracial individuals. For instance, Banks's (1996) use of an integrative psychodynamic and cognitive-behavioural therapy model with White mothers of biracial individuals. Areas worked on included loss, isolation, familial rejection and issues around mother's feelings about their offspring's biracial identity. Other interventions included identifying therapeutic goals that promoted the development of a healthy biracial identity, (Benedetto and Olisky, 2001), and that instil pride and acceptance in biracial individuals' total heritage (Wardle, 1996).

Although therapeutic material typically takes the form of one (possibly two) detailed case studies such as Hart-Webb's case study of a 25-year-old biracial male university student (Hart-Webb, 1999), there are also other studies that try to look at clusters of cases together. One was in the style of an outcome study of group work (Cooper, 2000), whereas another (Gleason, 2000) was an exploration study that relied on a collection of reflections by three psychotherapists who practiced traditional individual psychotherapy. Cooper's study found a positive effect of Internal Family Systems Therapy, in that it provided symptom relief for difficulties manifested by psychological issues rooted in racial identity struggles of biracial individuals. Gleason's qualitative study asked insight-oriented psychotherapists to talk about their work with their

biracial patients. An underlying theme was the influence of the relationship with parents on biracial identity formation. Therapists' use of processes such as transference, counter-transference, and intrapsychic conflicts revealed that their biracial clients had internalised early life experiences such as parents' communication about their offspring's racial path. These development experiences then shaped clients' object-relations and defensive styles employed, to manage current issues related to biracial development (Gleason, 2000).

Considering the rather sparse published material available on what therapists actually do in therapy with biracial individuals, the above studies are in a very influential position. Together they are very seductive in that they provide a range of approaches with different durations of therapy. For instance Cooper's was an evaluation of short-term therapy (eight weeks), whereas Gleason's participants traditionally used long-term therapy. Their attraction is increased by the fact that they are contemporary research. However, they do have their limitations. Geason's study is limited in that it is the perspective of only 3 psychotherapists who were each requested to draw on clinical material from not more than two biracial clients. Since a total of only 4 cases were discussed, this study's ability to truly represent clinical work with an increasingly growing and diverse biracial population is restricted. Similarly, Cooper's study (2000) contained only 5 biracial individuals (ranging in age from 19-35) in the group. Self-reports by participants and the therapist's observational reports were used as the method of identifying positive effects that Internal Family Systems Therapy had on issues related to biracial identity development. It could be that conclusions were based on invested interests on the part of the therapists and demand characteristics on the part of the biracial clients. Whilst the above studies do have their value in that provide insight into therapists' practice with biracial clients, it is not clear how they came to the conclusion that their clients were suffering from racial identity issues.

8. Identity issues versus social factors in meeting the psychological needs of mixed race individuals

The research indicates that counsellors are likely to see mixed race individuals with a variety of problems (e.g. eating disorders, PTSD), though most of the clinical work presented is on their racial identity issues. It is accepted that the majority of mixed race individuals achieve a healthy self-concept, and that some will indeed have racial identity issues. Interestingly, in the same study that indicated that the majority of mixed race children are proud of their dual heritage, the authors also reveal that '*Although only a minority of the mixed-parentage sample experienced problems with their racial identity, the proportion that did so was twice as large as it was in the case of those with two Black parents*' (Tizard & Phoenix, 1993:162).

If counsellors do see mixed race individuals with racial identity issues, then they should familiarise themselves with identity and developmental models and other available research on biracial individuals (Coleman, 2001; Henriksen, 1997), with an aim to assisting biracial individuals to develop a healthy positive racial identity (Benedetto and Olisky, 2001). Coleman advocates that

> "clinicians [should] familiarize themselves with local resources available to biracial individuals; to educate themselves around the developmental tasks faced by biracial individuals in order to support and guide their parents and the children themselves; and to consult, as necessary, with outside sources who have expertise on the topic of biracial identity" (Coleman, 2001:139).

Similarly, counsellors can help biracial clients to build their self-esteem as unique individuals by recognising and supporting the biracial client's positive coping mechanisms, abilities, and interests independent of racial heritage (Herring, 1992). It is important to treat the biracial client's issues around racial identity similarly to issues experienced by clients of any other racial group, yet also appreciating the uniqueness of biracial identity development (Aderman, 2000; Owusu-Bempah and Howitt, 2000). Hence, therapists should *"normalize biracial [clients issues] by identifying and rejecting the forces that pathologize them"* (Goldstein, 1999:295).

The above advice to therapists to help biracial resolve their identity issues would appear to fill the much needed 'gap' concerning how to attend to the psychological needs of this client group. However, it runs the risk of luring counsellors into a false sense of security as it gives the impression that there is a ready made formula with a set of interventions that can (or, as recommended by Small (1991) and Thompson (1993), *should*) be applied to working with mixed-race individuals. By implication, the message is 'expect these individuals to have problems with racial identity and how to successfully integrate their dual heritage'. It would seem that the legacies from two to three centuries ago of the 'mulatto hypothesis' and that of the 'marginalized man' have seeped into contemporary society, and worst still into therapeutic professional practice. Owusu-Bempah (2003b), who fervently opposes these views, reminds the reader that *"the former holds that 'mixed-blood' individuals are inferior to others, while the latter portrays them as culturally, socially and psychologically wretched"* (p7).

Whilst it is extremely unlikely that it is the intention of well meaning psychologists to blight the psychological development of mixed-race individuals', by suggesting racial identity work with individuals on the basis that they are mixed-race could be (mis)interpreted to mean that there is something inherent in them that leads them to have problems with racial identity. Furthermore, studies that presented professionals who work with mixed-race individuals with identical case vignettes apart from the race of the subject in the vignettes (i.e. White, Black, Anglo-African/Caribbean) demonstrated that these professionals were significantly more biased to formulating the problems of the mixed-race subject in terms of identity crisis. For instance, whereas *'85% of those who responded to the vignette involving the child of mixed-race*

parentage attributed his difficulties to identity-crisis, 59% and only 25% of those who responded to the vignettes involving the Black and White child respectively mentioned identity crisis as a causal factor in the children's difficulties' (Owusu-Bempah, 2003b:8). Another telling indication of the bias that some professionals have towards what they think should be the psychological needs of mixed-race individuals was demonstrated in their therapeutic recommendations: *"Identity-work was the commonest recommended intervention for the child of mixed-race parentage (55%); to an extent this was also true for the Black child (35%), whereas identity-work was hardly recommended for the White child (9%)"* (Owusu-Bempah, 2003b:8).

Probably even more distressing was the finding that *"the provision of information about cultural heritage was virtually not mentioned in the case of the White boy (3%), but was recommended for the boy of mixed-race parentage (39%)* (Owusu-Bempah, 2003b:8). It is worrying that other types of logical and legitimate reasons for the children's difficulties such as social and environment issues, were considered for the White child, and less so for the Black child, but were more or less ignored for the mixed-race child. Hence, whilst all the children faced the same problem, its aetiology was located in the mixed-race child, and to some extent, though less so, in the Black child, but not in the White child. This unwittingly sends the message that such problems are due to something faulty within the mixed-race child, so the mixed-race child needs to be 'fixed' (i.e. identity crisis work), whereas it is social and environmental issues that need to be taken into consideration when meeting the psychological needs of White children.

It needs to be highlighted that, like other ethnic minorities and individuals of African descent, mixed-race individuals experience considerable racism, sometimes from both of their parents' racial group. (McFadden, 2001). They are especially frequently exposure to prejudiced comments against one half of their ancestry: Black people (Martinez, 2002). Society maintains a hostile attitude towards their parents who are interracial couples (Segal, 1997), especially Black-White unions, who are labelled as "inappropriate", and receive considerable stigmatisation (Brown, 1990), which has been defined as *"the marking of individuals as inferior by virtue of their membership in socially devalued groups"* (Gaines and Leaver, 2002:68). People who are stigmatised have thwarted opportunities with regards to e.g. jobs, housing, social welfare, education, economic and financial resources (Goffman, 1971; McFadden, 2001; Owusu-Bempah and Howitt, 1999). This type of experience, especially the cases of ostracism, would upset most people regardless of race, so it is not surprising that such attitudes by society can contribute towards emotional problems in biracial individuals and blight their path of a positive identity and self-esteem (Alibi-Brown & Montague, 1993; Banks, 1995; Barn, 1999; Root, 1995; Sawyerr, 1995). Hence, a counsellor who is presented with a biracial client who complains of problems with identity and self-esteem may need to look further than the individual to

understand his problem and help him/her find the best solution within the clients' means to address this problem.

9. Methodological Evaluation

One of the probable reasons for the emphasis on biracial identity struggle could be due to the fact that the mixed race population in Britain is a relatively young expanding group. Although there have always been persons of mixed race heritage in British society, the statistics show that in contemporary society there has been a prolific growth in mixed race children [40% of those of mixed ethnic origin were children under 10 years of age compared with 34% of the Bangladesh population, 30% of the Pakistani population, 17% of the West Indian population and 12% for the White population (LFS)]. Hence, most researchers can only access groups of young people. Most of the samples in the above studies consist of young adults and children, such as Ross's (1996) sample of 12 children; Tizard and Phoenix's (1995) British biracial sample were 58 adolescents (aged 14-18 yrs); Banks (1996), Barns (1999) and Fatimilehin (1999) all used samples of young people from the British social care system; Harrison's (1997) study used 53 biracial girls aged 11-22 years; Quintana, (1999) and Basu (2000) used student samples. In addition Jacobs's (1977, 1992) stages were developed from research on mixed race children between the ages of 3-12 years old in which the research instrument used was a doll-play task (Jacobs, 1992). Although the Kerwin-Ponterotto Model of Biracial Identity Development (Kerwin et al 1993) has 6 stages ('Preschool', 'Entry to School', 'Preadolescence', 'Adolescence', 'College/Young Adulthood' and 'Adulthood'), it seems to concentrate mostly on biracial identity in the earlier stages.

According to Erikson (1959) a key developmental task at the stage at which the majority of these samples are located would be to develop a personal identity (sense of uniqueness and self-esteem). Therefore, it seems inevitable that most theories of biracial identity would include struggles to achieve a satisfactory (racial) identity (which could be related to the individual's personal identity). Considering that identity, including racial identity, is now perceived as a dynamic life span process, the reliance on young samples limits generalisation. However, some studies used adults samples e.g. Adermann, (2000); Atkins, (1995); Coleman's (2001) sample were aged 23-28; Buxenbaum, (1996) used larger age range (18-55 years). In addition William's (1992) study had a sample of 43 mixed race individual's aged 16 to 35 and Kirch's (1992) qualitative study consisted of 15 mixed race adults aged 17 to 60, which was a heuristic developmental model of biracial identity stages of biracial, bicultural identity development

10. Conclusion

Since, it has been demonstrated that mixed race individuals are subjected to sub-standard housing, poverty, low socio-economic status and racial discrimination, counsellors working with

biracial individuals need to acknowledge the part that society plays in the biracial client's current problems. However, this does not mean that an individual's role in his/her psychological problems should be denied, or that s/he should be rendered a passive recipient. In fact, the opposite would be true. Therapy would then proceed in a way that empowers the mixed-race individual and enables him/her to be an active agent in his life. For instance, exploring how the client can develop effective and psychologically healthy strategies for dealing with racism. The therapist would, of course, have to be mindful not to collude with the client in focusing on racism at the expense of marginalising or ignoring very real emotional problems that the client has (Alladin, 1994). This is why a careful assessment would need to be conducted, which would need to take into account significant others in the client's life and an understanding of his/her worldview. Therapists using this approach would not deny or trivialise the real impact that racism has on a person's psyche, but also take into account the possibility that the mixed race client's problems may be related to their racial identity, or some other psychological problem. However, counselling professionals have a responsibility to prepare individuals to live and work cross-culturally (McFadden, 2001), which would involve dealing with the racism they face (McFadden, 2001). What is clear is that mixed race individuals are not a homogenous group. There are indeed those who do have problems with racial identity, though this may be created by racism. In addition, there are other mixed race individuals who have psychological problems that are due to issues that would cause psychological problems in any individual regards of race (e.g. PTSD, eating disorders, problems with attachment, rejection, poverty, low socio-economic status). Issues of racism can be related not only to rejection by society, but also the poverty of such groups due to the denial of opportunities.

Counsellors should examine their own attitudes regarding biracial clients and how this is communicated, both verbally and non-verbally, to the client (Nishimura, 1995). For instance, psychologists may have entrenched beliefs that the mixed race client should be seen as mostly Black (e.g. Carter, 1995; Goldstein, 1999), whereas there are others who argue that the client should identify him/herself as biracial. It should be up to the client to work out his/her self-concept and racial identity, and for the counsellor to support the client in achieving a racial identity that is in keeping with his/her chosen self-concept. Counsellors need to avoid the stereotyping that accompanies many intercultural marriages and families (McFadden, 2001; Root, 1992). The focus on identity issues would also seem to indicate that the presence of mixed-race individuals challenges notions of fixed, homogenous racial categories (Harris, Blue, and Griffith, 1995). Instead, pluralistic racial identities (Gibbs and Hines, 1992) point to the need to shift society's thinking from "either/or" to "both/and" (Daniel, 1992), in order to adopt more inclusive labels to reflect the dual racial heritage to which biracial individuals are entitled (Jones, 2000).

Working with Biracial clients can evoke counter-transference processes in counsellors about this group of clients. Black and White counsellors alike may relate exclusively to the Black or White 'half' respectively of the client, ignoring the other 'side' of the biracial client's racial identity, especially if the client's racial features resemble those of the race to which the counsellor belongs. Thus, the potential in treatment for a variety of dynamic interactions and unconscious responses will develop depending on how the difference between client and counsellor is perceived by both of them (Owens-Patterson, 2000). For instance, as had been indicated, there are therapists who propose that mixed-race clients should be treated as members of the Black 'race'. In addition, they insist that such sensitive therapeutic work should be the domain of Black therapists as White therapists are not perceived to be 'equipped' to deal with these issues (e.g. Banks, 1993). To some extent, there is some logic to this argument though of course it exonerates White therapists from their duty to work with all sectors of the community. This obviously has implications for the therapeutic dynamics and will be different compared to if the counsellor was biracial. For instance, there are biracial counsellors who reflect on their own experiences and use this in therapy (Rucker, 1996; Williams, 1999). They also share how they challenge others expectations that all biracial individuals, including counsellors, should 'fit' into one racial category (Fukuyama 1999). This issue of who is appropriate to provide therapy for certain client groups revisits the larger debate on around ethnic matching.

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Appendix 7 The Racial Identity Attitude Scale ('RIAS')

Appendix 8 Sleep questionnaire

Appendix 9 Sleep chart/diary

Appendix 1 – Glossary of Terms[4]

Introduction to Glossary

'When *I* use a word', Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean – neither more nor less'.
'The question is', said Alice, 'whether you *can* make words mean so many different things'.
'The question is', said Humpty Dumpty, 'which is to be master – that's all'.
From *Through the Looking Glass,* Lewis Carroll (1871)

Counselling psychologists state that terminology is related to the contemporary discourse and the context in which it is used (Rawson et al, 1999). In discussing research in psychology, Dyer (1995:18) explains that an

> "Operational definition...is highly specific – i.e. it represents a particular and highly specific decision by the researcher on the way in which an underlying variable is to be observed in a particular situation...[and cautions that] the fit between the variable and its operational definition can never be perfect".

The quote from Carroll, with which many counsellors are familiar, indicates, the flexibility of words. Similarly, Dyer points out that the choice of definitions is dependent on the nature of the author's inquiry and the precise hypotheses being tested. Hence, whilst recognising that there are established definitions of most terms, variations are expected in the manner in which these terms are applied to facilitate a particular type of discourse. Delineating core terminology serves the function of elucidating the specific meaning of the terms as they are used in this thesis and, where appropriate, indicates the operationalisation of the underlying constructs pertinent to the research.

Skellington and Morris (1992: 13*)* note that:

> "There is no one agreed set of terms in use among researchers in this field [of cross-cultural counselling] for different minority ethnic groups...a classification may be based on skin colour, or country of origin or descent. Terminology is also problematic because, over time, terminology shifts: some terms fall into disuse and disrepute, while others change. Many terminological uses are controversial, and probably none without its drawbacks".

Similarly, definitions can be deceptive in that they can give the impression that they have been built on an objective foundation. This is rarely the case, partly because there are various meanings for the same term and each term is steeped in various historical, social contexts and conflicting domains of politics and race relations.

The current author is aware that, whilst the glossary in this thesis serves the purpose of classifying or operationalising concepts for counselling psychology research, defining such

[4] References for this section can be found in the references for Section B (pp 162-178).

terms as ethnicity, race or culture is a task that requires sensitivity. These terms are commonly perceived as emotive, especially by ethnic minority groups who may feel marginalised, stereotyped or portrayed in negative terms, depending on the way in which these terms are presented. The role power plays in these descriptions was emphasised as it probably contributes a large part to how individuals feel about racial and ethnic labels. It is invariably those with economic, social and political advantage who have the power to define less privileged groups, and to decide on how they are viewed and treated in society (Thomas, 2002). This may explain why many psychologists do not concern themselves with such areas as race and racism, perceiving them to be more appropriate for political and social structures of society rather than intra- and interpersonal issues. Therapists may therefore feel justified in avoiding addressing the psychological impact of racial and ethnic labels on their Black clients in order to minimise the potential uncomfortable or even overwhelming feelings these issues may present for themselves (Alladin, 1986; Banks, 1999).

Hence, psychologists and therapists are encouraged to appreciate the presented glossary of terms in this thesis within the social and political context (and constraints) they dwell. In addition, they are encouraged to use their skills as professional helpers to aid their Black clients in dealing with the fundamental underlying psychological and emotional issues raised by experiences attached to these labels.

'Black' people

'Black' or 'Blackness' is not a term that reflects the make up of an ethnic or cultural group. There is not one race that is literally Black in skin colour. Deciding on an expression that adequately represented one of Britain's largest ethnic minority communities was a big challenge, not least because it was impossible to find a word or phase with which all members of that group were comfortable. The only logical option was to utilise terminology that is widely used in the psychological and therapeutic arena, and a word that has enough popular usage in contemporary Britain, that although not used by everyone, symbolises a similar meaning no matter which member of society uses it. So, in this thesis 'Black' is used do denote people of African or (Afro-) Caribbean descent who, as a whole, have a shared experiences of racism, discrimination and oppression (Mama, 1992). In addition, this thesis focuses on Black people of African and Caribbean descents who live and operate within Western socio-economic structures This is not to ignore that Black people are a heterogeneous group of individuals with a range of lifestyles, and personal experiences. Following the tradition of other British (Banks, 1999; Ferrell, 1995), and American psychologists the names of racial groups will be capitalised to capture the entity of socio-political 'racial' groups i.e. Black and White.

Counselling Psychology / Psychological Counselling / Counselling / Psychotherapy (therapy)

Defining the above terms is a very challenging task, even for seasoned practitioners (Feltham, 1995). Cross and Watts (2002) make a distinction between counselling psychology and psychological counselling:

> "Counselling Psychology constitutes a discipline and therefore is represented by a body of theoretical knowledge. Counselling, including Psychological Counselling, by contrast may, however be best considered as an activity or practice, constituted by practical knowledge, which may or may not draw on formal theory" (Cross and Watts, 2002:295).

In describing counselling psychology, the BPS place *"emphasis on the systematic application of distinctively psychological understandings of the client and the counselling process"* (BPS, 1998:1).

The British Association for Counselling and Psychotherapy ('BACP'), formerly known as the British Association for Counselling ('BAC'), define counselling as an enterprise where

> "People become engaged in counselling when a person, occupying regularly or temporarily the role of counsellor offers or agrees explicitly to offer time, attention and respect for another person or persons temporarily in the role of client. The role of counselling is to give the client an opportunity to explore, discover and clarify ways for living more resourcefully and towards greater well being" (BAC 1985, Information Sheet No.4).

Although Rogers first introduced the term '*counselling*' in the 1940s (Rogers, 1942) to distinguish it from the already established psychotherapy [a term that was probably first used in the late 1880s (Efran and Clarfield, 1992)], the debate as to whether counselling and psychotherapy (therapy) are actually different enterprises, or even if such professions actually exists (Mahler, 1995), is still ongoing. Originally, the differentiation rested on the grounds that psychotherapy proceeded within a medical model framework of cure so it aimed to treat 'pathology', whereas counselling used a humanistic model. This approach rejected the notion of pathology and the client was seen as the expert in his/her experiences, and hence the focus was on the counsellor walking beside the client as a guide to assist the client in achieving his/her self-defined optimal level of psychological well-being. No doubt, the discussion will be forever ongoing, though the trend in contemporary therapeutic circles seems to be to see the two practices as analogous enterprises (e.g. counselling psychologists Banks, 1999; Dryden and Mytton, 1999; Feltham, 1995; Hahn, 1953; Patterson, 1986):

> "It is concluded that there are no essential differences between counselling and psychotherapy in the nature of the relationship, in the process, in the methods or techniques, in goals or outcomes (broadly conceived) or even the kinds of client involved" (Patterson, 1986:16).

Similarly Dryden and Mytton state *"we [use] the two terms[counselling and psychotherapy] interchangeably as we do not perceive any real differences between them. This is in line with the British Association for Counselling which has acknowledged that no final distinction can be made between the two labels"* (1999: 5).

So, it can be gathered that, the therapeutic activities of counselling psychology, psychological counselling, counselling and psychotherapy (therapy), mean a meeting , or meetings, between a group of at least two people, in which one person who is a skilled professional trained (or in training) in dealing with people's emotional and psychological distress (the 'counsellor' or 'therapist'), for which the other person(s) ('client') is (are) seeking psychological relief, formally, shows respect for the client(s), and facilitates the client(s) in discovering and developing resources for survival and adaptation in the *client(s)'s* environment and context that has the potential to be psychologically challenging for that particular client(s).

For the purpose of this thesis, whilst acknowledging that there are differences between particular therapeutic orientations and that some distinctions have been made between the activities of counselling psychology, psychological counselling, counselling (Cross and Watts, 2002) and psychotherapy (therapy), these terms shall be used interchangeably. These are for two very noteworthy reasons. Firstly, in this field the majority of academics and practitioners follow this trend [e.g. Cross, in Cross and Watts (2002), writes that he had *"often [used] either of those terms interchangeably (Counselling Psychology or Psychological Counselling)"* (pp293-294)]. Secondly, and just as pertinent to this research, clients and purchasers of such services also do so.

Counselling psychologist, (psychologist), Counsellor, psychotherapist (therapist),

Following on from the above definitions, the terms *'counsellor, therapist, counselling psychologist, psychologist'* will be used interchangeably to mean a *" person [who] attempts to help another person...to understand and deal with his/her problems in aspects of everyday life"* (Verma, 1985: 83-84, in Banks, 1999: 2). The person must be a qualified practitioner who practices counselling / therapy within the boundaries of a therapeutic relationship with the aim of reducing another person's, or group of persons', emotional dis-ease or psychological distress, so that they have improved psychological well-being (BPS, 2001).

Cross-cultural, intercultural, multicultural and transcultural counselling

There are subtle variations in the meaning for each of these terms [(e.g. British psychologists d'Ardenne and Mahtani (1989) use *'transcultural;* Kareem and Littlewood, (1992) use '*intercultural'*; whereas terms such as '*multi-cultural counselling'* are more popular with American psychologists (e.g. Flowers and Richardson 1996; Pedersen, 1985), and in many cases they are used interchangeably. However, psychologists do explain why they use particular terms. For instance, d'Ardenne and Mahtani, (1999) state: *"We use the term 'trans' as opposed to 'cross' or 'inter' cultural counselling because we want to emphasise the 'active' and*

'reciprocal' process that is involved. Counsellors in this setting are responsible for working across, through or beyond their cultural difference" (p5). *'Cross-cultural counselling'* seems to be adopted globally, and is used mostly in this thesis. It refers to a therapeutic dyad in which the counsellor is typically, from the dominant (industralised) culture and the client, is from an ethnic minority (non-industralised) culture. Like the other approaches it refers to the active and continuous interchange between the counselling process and the socio-cultural environment of both the client and the counsellor.

Culture

As early as 1952, Kraben & Kluckhohn identified more than a hundred definitions of the term culture. Anthropologist Herskovit (1948) provided one of the classical definitions of culture as *"that part of the environment that is created or shaped by human beings"*. This includes physical artefacts and other tangible aspects of culture. Herskovit's definition appears to under emphasise the manner in which culture also influences human beings. Laungani (1999) states that all cultures posses a set of core ('primary') features and a set of peripheral ('secondary') features. *'Core features'* constitute the essential requirements of any culture such as a past history (recorded or oral), or a set of core values and traditions to which people of that society subscribe and which they attempt to perpetuate. *'Peripheral features'* of a culture include a common language and socially accepted dietary, health and medical practices although it may vary from culture to culture.

Culture can be considered the 'personality of a society' (Peabody, 1985), so that its members share certain features of that personality which was originally formulated within specific political, social, economic, physical and geographical environments. It consists of a common set of shared values which *"are the currently held normative expectations underlying individual and social conduct"* (Laungani 1999:44), such as what constitutes right and wrong, good and bad, normal and abnormal, appropriate and inappropriate, rules, laws, symbols, rites, taboos, religion and family customs, roles, patterns and networks of communication and fundamentally how its members should live their lives. These values are transmitted from generation to generation (Segall, Dasen, Berry & Poortinga, 1990), through a process of socialisation of its young members. By conceptualising culture as something *"that is in our heads"* (Triandis, 1972), it is possible to appreciate the psychological consequences of socialisation. Many cultural nuances are effortlessly and unconsciously absorbed by observation and incidental learning making values so ingrained and pervasive that it may not be possible for the individual from a certain culture to offer a plausible explanation of why there is such a high level of commitment

to a belief. The deep-routed disposition of culture has even led to the proposition that it may be a survival tool that is built into the 'hardware' of the brain (Erchak, 1992).

Ethnic matching

In theory, this term means pairing a counsellor with an ethnically similar client. In practice it is usually translated into pairing a counsellor with client who appears to share the same physical 'racial' characteristics (Alladin, 1994). It is recognised that ethnic matching is slightly different to race matching but one of the strong arguments put forward for using these terms and processes interchangeably is that an individual's ethnicity is invariably assumed from his/her (racial) physical features.

Ethnic minority / minority culture

The term '*minority*' used in this thesis does not only refer to the numerical meaning, but also, of more importance, it politically describes a group that are oppressed either overtly or subtly (Ponterotto and Casas, 1991). Controversy exists over the use of the term 'ethnic minority' to describe non-White people, not least because, globally, individuals of Anglo-Saxon and European descent who are 'racially' 'White' are statistically a minority. Hence, the term can be perceived as numerically inaccurate and also insensitive when it is used to describe non-White people in areas where they are not the smaller group (Rawson et al, 1999). However, this thesis retained the term '*ethnic minority*' in recognition of its political and statistical meaning in the Western context (e.g. North America, Europe and especially Britain). This is, in order to emphasise that, as a group, Black people are seen, and treated, as less important than individuals from mainstream society, they are referred to as (ethnic) minorities. In addition, as an ethnic group in Britain, they are statistically a minority compared to the White group and its majority culture (See chapter 2 on *'The Psychological Needs of Black people'*). These characteristics contribute to the marginalisation and lack of influence of Black people in contemporary British society.

Ethnicity

Ethnicity accommodates both the racial and cultural characteristics distinctive to a group (Thorndike and Barnhart, 1991). These include language, customs, and culturally focused celebrations that have been deeply entwined in the consciousness through years of socialisation with an ethnic group (Cashmore, 1996). Ethnicity is not always immediately apparent but ethnic group members self-identify with the ethnic group and see themselves as distinct from other

ethnic groups (Morris, 1968). To this extent, ethnicity provides a sense of belonging. Race appears to be the larger grouping, whereas ethnicity is a division of these groups at another level [a subdivision of race (Banks, 1999)]. Ethnic group affiliation, which is distinguished by cultural characteristics, is more of a conscious decision to be part of one's group: There is a feeling of coherence and solidarity with group members who share common interests and origins (Banton, 1988, in Banks 1999:35).

Alladin (1999) and Laungani (1999) point out that academics and practitioners use the terms 'race' and 'ethnicity' interchangeably and there is a reasonable explanation why the terms are seen as synonymous. There are overlaps between the concepts, as they are both referring to similar aspects of a person's identity that alludes to common origins and similarities with cultural and other identities (Rawson et al, 1999). Like many other trends in psychology, the style of substituting race for ethnicity has filtered down to the general population so that members of the general public (e.g. research participants and clients) use the terms interchangeably. This makes it difficult to indicate precisely when to use either term (Rex, 1986). This difficulty is dealt with in this thesis by treating the terms as synonymous, as a 'unitary concept' (Tinsley-Jones, 1997), unless specifically stated, and also reflects the trend amongst other writers in the field. More importantly, by adopting this strategy the language used is more amenable to clients and research participants giving them the option to respond using whichever term is most meaningful for them.

Ethnocentrism

Whilst sharing some overlap with racism, this related term has some differences (Wetherall & Potter, 1992):

> "Similarly to racism [ethnocentrism] is based on the irrational premise that one's cultural and racial in-group is superior to other out-groups, which are to be disliked and to be disadvantaged (Aboud, 1988). In addition it is attached to the belief that since one's own cultural and racial group is the nucleus of the universe, then its characteristics should be the marker by which all other groups are rated and judged (Summer, 1906)" (in Banks 1999: 42-43).

A specific example of ethnocentricism is 'Eurocentrism'. Individuals who display this type of view are typically descendants of the White dominant majority from Europe and North America. Descendants of this 'in-group' (Tarjfel, 1987) advocate conventional European culture (e.g. individualism and individual identities, autonomy and independence, promotion of the nuclear family, material wealth, secular society, are rooted in the present, with some consideration of the future) which is promoted as the gold standard. However, there are many in the out-group who aspire to Eurocentrism and try to acculturate completely to achieve this goal.

Identity

As a psychological construct, identity refers to how an individual perceives his/her uniqueness and sameness in relation to other individuals and also groups (Erikson, 1968). Similarly, it also relates to how s/he experiences others' perception of his/her connection to other individuals and groups. From this, it can be seen that identity is simultaneously a self-categorisation process and an interactive entity (Erikson, 1968). Identity occurs at both the individual and the group level: Harmony is achieved when an individual's personal identity is consistent with his/her group identity. Laungani (1999) states that:

> "The quality of an individual's psychological adjustment is dependent upon their personal identity (i.e. one's feelings and attitudes towards oneself), their reference group orientation (i.e. the extent to which one uses the value systems and culture of special groups to guide one's feelings, thoughts and behaviours) and how they ascribe identity (i.e. an individual's conscious affiliation or commitment to a special group)".

The majority/dominant or host culture or group

"The majority group are the group that holds the largest part of the economic and political power" (Tinsley-Jones 1997:8). In Britain, other parts of Europe and North America this usually means White people (Ponterotto and Casas, 1991:12), particularly middle and upper class males. Since the dominant group possess power, they decide what is acceptable and what is normal, which of course will include images of themselves, and their idiosyncratic practices. As Tinsley-Jones' definition indicates, the notion of 'majority' (and therefore 'minority') is defined in terms of power. In Britain, White people as a majority group have power, and this power, when abused, is utilised to oppress and restrict, if not deny minority groups (e.g. Black people) certain benefits that White, as a group, people enjoy.

Race

Race defined on biological grounds

Historically, this term seems to have come into existence around the16th century (Montague, 1964), and conventionally it was used to categorise and differentiate groups on 'biological' terms. For those who conceived it as a biological reality (Eisenman, 1995; Jensen, 1995; Levin, 1995; Rushton, 1995), race referred to *"a subgroup of people possessing a definite combination of physical characteristics, of genetic origin, the combination of which to varying degrees distinguishes the sub-group from other sub-groups of mankind"* (Krogman, in Ponterotto and Casas, 1991:9).

Against purely biological descriptions of race

A description of separate and distinct racial groups in exclusively biological terms has been dismissed. Kaessmann Heissig, von Haeseler, and Pääbo, (1999) emphasised the superficial nature of 'genetic races'. In reality the notion of genetic difference, on which race is supposed to be based, is reduced to phenotype, i.e. visible differences in gross appearance such as facial features, distribution and texture of hair, and skin pigmentation (Lyon, 1972; Yee et al, 1993). In that definition there no acknowledgement of interracial relationships and offspring of mixed race parents, which again points to the blurring of the 'races', and the nonsense in identifying those from so called 'pure' (superior) races (Brown, 2000; Root, 2002).

From a purely biological argument, the notion of distinct 'races' is a fallacy (Shreeve, 1994). The recent unravelling of the entire human genome provides evidence that, genetically at least, there is only one 'race': The human race. The manifestation of the genome pattern officially verified in 2001, hypothesised long before then, demonstrated that each 'race' shares more than 99.9% of its genes with all the other races (Ventur, 2001). Of particular relevance to the cross-cultural counselling research on Black client-White counsellor therapeutic dyads is the fact that biological and genetic research (Kaessmann, et al, 1999; Ventur, 2001) has shown that any noticeable differences, are due more to the <0.1% variances within the 'races' than between them. Yu,, Chen, Ota, Jorde, Pamilo, Patthy, Ramsay, Jenkins, Shyue,, and Li emphasise that *"The genetic differences between non-Africans [e.g. White people] and Africans [i.e. Black people] are on average smaller than the genetic differences within Africans"* (Yu, et al, 2002: 273). This points to the socio-political nature of the concept of race.

Race defined as a socio-political concept

From a socio-political perspective, many psychologists argue that race is not static but a dynamic contextual entity whose parameters and privileges are decided by those in power (Fish, 1995; Root, 1992; Tinsley-Jones, 1997). For instance, Montague (1964) argued, *"the social idea of 'race' implied that cultural achievement of individuals was determined by race"* (in Banks, 1999:32). Its meaning is constrained by social and political values (Rawson et al, 1999). *"Race is thus not the product of an antecedent set of cognitive or affective processes causing individuals to miscatergorise a non-racist world. On the contrary, race is a historical product"* (Tinsely-Jones, 1997:101). Tinsely-Jones' comment indicates that any differences professed to be of importance on 'racial' or biological grounds actually function to serve the interests of those who oppress other groups and treat them unfairly. Racial distinctions do not occur at a neutral level with the observation that all groups are separate but equal. The status of an individual's physical (racial) appearance is largely determined by his/her social heritage (Root,

be of importance on 'racial' or biological grounds actually function to serve the interests of those who oppress other groups and treat them unfairly. Racial distinctions do not occur at a neutral level with the observation that all groups are separate but equal. The status of an individual's physical (racial) appearance is largely determined by his/her social heritage (Root, 1992). Hence, any attempts to understand 'race' and culture need to extend the analysis beyond these parameters alone to include the social impact of these divisions (Bacchi, 1990; Cashmore 1996). For instant, Tinsley-Jones warns her fellow psychologists that

> "To study or to conceptualise about race, one must always keep in mind that it is essentially a socio-political notion, created by society to classify individuals, and that it creates social, emotional, economic and political consequences for those individuals, because inaccurate conclusions may be drawn and damaging characteristics ascribed to human beings" (Tinsley-Jones, 1997:30).

Similarly, Dole advocates, *"Psychologists should retain race only in relation to attributed group membership or studies of attitudes"* (Dole, 1995:40). Dole and Tinsley-Jones emphasise the key role of psychology in understanding the impact of race on people's lives, and the back seat, if any, place that biology should take in this endeavour.

Psychologists who highlight race as a socially constructed concept suggest that when its so-called biological definition is used as a basis for understanding groups, its contribution is meaningless (Pope-Davis & Coleman, 1997). *"The elusiveness and oftentimes confusing quality of race, has led some [psychologists] to suggest that the notion be abandoned almost entirely"* (Tinsley-Jones, 1997: 7; e.g. Dole, 1995; Pope-Davis & Coleman, 1997; Yee et al, 1993).

Racial Identity

"Racial identity is the quality of a person's commitment to her or his socially ascribed racial group" (Helms 1990:446). The construct of racial identity is described, and its implications debated, in considerable detail in chapter 2 and investigated in chapter 5.

Racism

Banks (1999:40) writes

> "Racism is not an easy concept to define, empirically measure or investigate. For this reason, perhaps, British law (1976 Race Relations Act) [and its successor, the 'Race Relation (Amendment) Act', 2000] has confined itself to the behavioural outcome of racism in practice, that of 'discrimination'. Hence, within this framework, for a person to identify another person/ institution as racist, s/he must first be able to provide 'concrete evidence' of specific action(s) that demonstrated consequences in which the 'victim(s)' was denied entitled opportunities, services or resources. The next step would then be to 'show' that this inequity occurred because of the person's/group's 'racial' membership. In practice, these two components are difficult to prove".

"In psychotherapy, a more clinically sanitised term of 'xenophobia' has been used to refer to racism and its psychological processes" (Bank, 1999: 41). Racism is both an attitude and a behaviour to particular racial groups: The behaviour is the manifestation of the attitude. It is a dislike of other 'racial' groups based on fear of such groups and illogical beliefs that they are inferior to certain other racial groups (Rawson et al, 1999).

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Appendix 2

Table I. Comparative Worldview Schematic between Europe and Africa

EUROPEAN **WORLDVIEW**	**AFRICAN WORLD VIEW**
Psycho-behavioural modalities: • Individuality • Uniqueness • Difference	***Psycho-behavioural modalities:*** • Groupness • Sameness • Commonality
Values and customs: • Competition • Individual rights	***Values and customs:*** • Collective responsibility • Cooperativeness and Interdependence
Ethos: • Separateness and Independence • Survival of the fittest • Control over nature • Experiential community	***Ethos:*** • Survival of the tribe • One with nature • Experiential community

Source: Nobles, 1976: 24 in Banks, 1999: 94

Appendix 3: 'Help With My Problems Inventory' ('HWMPI')

CONFIDENTIAL

HELP WITH MY PROBLEMS INVENTORY

Instructions

I am interested in your views about counselling. This is not about offering you counselling. Imagine that you are thinking about seeing a counsellor, and then answer the questions that follow. What you say will be kept in the strictest of confidence. There is no space for you to write your name down or any other personal information about yourself. What you write will be included with other people's answers, so that when the answers are being reported they will be reported as a group and no one will know what one person said specifically, in particular.

.....

If you had a problem who would you go to see about it (an emotional / distressing problem)?

How do you currently solve your problems

Both of these people are counsellors. If you were to see one of them for counselling, which one would you prefer to see about your problems? **X / Y**
Why do you say that?

What type of things would make you more likely to see a counsellor?

What type of things would make you not want to see a counsellor?

Why do you think people see a counsellor?

Why do you think people do not see a counsellor when they have problems?

If you were to see a counsellor, would you prefer to see a counsellor of your own race? YES / NO

Why did you say that

How would you want a counsellor to help you, e.g. what support would you want / help for, what type of issues?

Have you ever received counselling in the past YES / NO

Are you currently receiving counselling ? YES / NO

Was / Is the counsellor of the same race as you? YES / NO

Would you consider going to see a counsellor in the future? YES / NO

Age..... Male / female How would you describe your ethnicity / race

(e.g. Black British / African / West Indian / Black / Afro – Caribbean / Other)

Where were you born .....? When did you first arrive in Britain?

Are you currently in a steady relationship? Y/ N Living with the person Y / N

Do you have any children? YES/NO Do they currently live with you? Y/N

What is your diagnosis.....? On medication.....?

When did you first have an admission.....(year)? And how did it happen? (e.g. did you go to the hospital or did someone guide you to go to hospital...)

About how many admissions have you had?..... Last time you were in? .....

Do you feel coming to [Drop-in Service] helps you? YES / NO

Why do you say that?

Is there anything that you would like to ask me or is there anything that you feel that I have missed out?

Appendix 4 Counsellor photos stimulus

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

X

Y

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

X

Y

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

X

Y

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

X

Y

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

X

Y

Both of these people are counsellors. If you were to see one of them for counselling which one would you prefer to see about your problems.

Appendix 5: Recruitment letter

Dear Fellow Attendee

I am a counselling psychologist in training at City University (London), under the research supervision of Dr Charles Legg in the psychology department. I need your help. As part of my training I have to complete a research project. For my research, I would like to look at people's social and political attitudes. At the moment I am asking people to provide some basic details about themselves and to fill out a questionnaire (which should take up no more than 10-15 minutes of your time), which you can put in an envelop provided with my name on it. I will be circulating throughout the conference so that you know who I am and how to get your questionnaire to me without me identifying you. Ideally, I would like to have collected them all by Saturday evening. I would be very grateful if you could comment on how you felt about answering the questions e.g. did you find the statements interesting, or did you find some of them intrusive, offensive or just confusing? You can be frank as the questionnaire is both confidential and anonymous as it can be detached from this sheet. So rest assure, even though I am a psychologist in training, you don't have to worry that I will walking around with the knowledge of your inner thoughts or able to read your mind (That comes later!). I won't know who you are or what you have written – unless you want to tell me. I am willing to talk to anyone who wants to talk to me about my research ideas and I always welcome additional input. In addition, you may want to contact Dr Charles Legg at *c.legg@city.ac.uk*

I realise that some people may not want to fill in this questionnaire, and that is understandable considering the brilliant events on offer at this conference. All I ask is that you return the questionnaire to me even if it is not filled in. It would be useful for me if you could indicate why you decided not to fill it in. Whatever you decide, I hope you enjoy the conference, and I look forward to exchanging ideas with as many people as possible.

PLEASE NOTE – THIS QUESTIONNAIRE IS IN NO WAY CONNECTED TO THE ORGANISERS OF THIS CONFERENCE.

THANKS FOR YOUR HELP Gella

Appendix 6 Demographic Questionnaire to RIAS

What words would you use to describe yourself

What part of Britain are you from.....

Were you born in this country YES / NO. If 'NO' where were you born .....

With which ethnic group do you identify

.....

What is your present occupation

.....

Are you FEMALE __ or MALE __

Which of the age groups do you fall into? (please tick)

15 – 21__ 22 – 28 __ 29 – 35 __ 36 – 42__ 43 – 49__

50 – 56 __ 57 – 63__ 64 – 70__ 71 and above

Appendix 7 RIAS

Below are a set of statements, Please use the scale (ranging from 1-5) to indicate the extent to which you agree or disagree with each statement. For example, of you strongly agree with a statement, put a "5" in the corresponding box, but if you disagree with a statement, then put a "2" in the box next to the statement. There are no right or wrong answers, it is how you feel about these statements that is important.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

PLEASE PUT YOUR NUMBER HERE (1-5)

I believe that being Black is a positive experience

I know through experience what being Black in Britain means

I feel unable to involve myself in White experiences and I am Increasing my involvement in Black experiences

I believe that large numbers of Black people are untrustworthy

I feel an overwhelming attachment to Black people

I involve myself in causes that will help all oppressed people.

I feel comfortable wherever I am

I believe that White people look and express themselves better than Black people.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

PLEASE PUT YOUR NUMBER HERE (1-5)

I feel very uncomfortable around Black people

I feel good about being Black, but do not limit myself to Black activities

I often find myself referring to White people as 'honkies', 'pigs' etc

I believe that to be Black is not necessarily a good thing

I believe that certain aspects of the Black experience apply to me, and others do not

I frequently confront the system

I constantly involve myself in Black political and social activities (e.g. Art shows, political meetings, Black theatre etc.)

I involve myself in social action and political groups, even if there are no other Black people involved

I believe that Black people should learn to think and experience life in ways which are similar to White people

I believe that the world should be interpreted from a Black perspective

I have changed my life style to fit my beliefs about Black people

I feel excitement and joy in Black surroundings

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

PLEASE PUT YOUR NUMBER HERE (1-5)

I believe that Black people came from a strange, dark, and uncivilised continent

People, regardless of their race, have strengths and limitations

I find myself reading a lot of Black literature and thinking about being Black

I feel guilty and/or anxious about some of the things I believe about Black people

I believe that a Black person's most effective weapon for solving problems Is to become part of the White person's world

I speak my mind regardless of the consequences (eg. Being kicked out of school, being imprisoned, being exposed to danger)

I believe that everything Black is good, and consequently, I limit myself only to Black activities

I am determined to find my Black identity

I believe that White people are intellectually superior to Black people

I believe that because I am Black, I have many strengths

I feel that Black people do not have as much to be proud of as White people do

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

PLEASE PUT YOUR NUMBER HERE (1-5)

Most Black people I know are failures

I believe that White people should feel guilty about the way that have treated Black people in the past

White people can't be trusted

In today's society if Black people don't achieve, they have only themselves to blame

The most important thing about me is that I am Black

Being Black just feels natural to me

Other Black people have trouble accepting me because my life experiences have been so different from their experiences

Black people who have any White people's blood should feel ashamed of it

Sometimes, I wish I belonged to the White race

The people I respect most are White

A person's race usually is not important to me

I feel anxious when White people compare me to other members of my race

I can't feel comfortable with either Black people or White people

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

PLEASE PUT YOUR NUMBER HERE (1-5)

A person's race has little to do with whether or not she/he is a good person

When I am with Black people, I pretend to enjoy the things they enjoy

When a stranger who is Black does something embarrassing in public, I get embarrassed

I believe that a Black person can be close friends with a White person

I am satisfied with myself

I have a positive attitude about myself because I am Black.

Once again <u>THANKS</u> for your help. Best wishes <u>Gella</u>

Appendix 8 Sleep questionnaire

10	At what time do you usually get up?		
11	How refreshed do you usually feel when you wake up in the morning (tick one)?	Very refreshed Quite refreshed Unrefreshed Tired Shattered	☐ ☐ ☐ ☐ ☐
12	In general, how much sleep do you think a person your age needs?		
13	How long have you had your present sleep problem?		
14	What do you think is the cause of your present sleep problem? (answer in your own words)		
15	Have you ever had serious trouble with your sleep in the past?	Yes No	☐ ☐
16	Have you gained or lost weight in the last few months? (tick one)	Yes, I have gained weight Yes, I have lost weight No, I'm about the same	☐ ☐ ☐
17	Before the present problem how would you have described yourself (tick one):	A very good sleeper A good sleeper An average sleeper A poor sleeper A very poor sleeper	☐ ☐ ☐ ☐ ☐
18	How would you describe yourself now?	A very good sleeper A good sleeper An average sleeper A poor sleeper A very poor sleeper	☐ ☐ ☐ ☐ ☐
19	Do you usually take a nap during the day?	Yes No	☐ ☐
20	When do you usually nap? (give length of each nap)		

Thank you for completing this questionnaire.

—Sleep Questionnaire—

Below are some questions concerning your sleep. Please answer all the questions. If your times for going to bed and so on vary greatly, give ranges (eg. 10–11pm, 30–60 mins)

1	For how long do you usually sleep at night?		
2	After settling down, how long does it usually take you to fall asleep?		
3	How often do you wake up too early in the morning? (tick one):	Never Seldom Sometimes Often All the time	☐ ☐ ☐ ☐ ☐
4	Do you usually wake up during the night?	Yes No	☐ ☐
5	If Yes: What usually awakes you? (answer in your own words)		
6	How many times (on average) do you awake each night?		
7	For how long are you awake on each of these occasions?		
8	At what time do you usually go to bed?		
9	At what time do you usually wake up (in the morning)?		

Appendix 9 Sleep chart/diary

R PERSON

Very refreshed	
Quite refreshed	
Unrefreshed	
Tired	
Shattered	

.eds?	
.able Yes	
No	
have gained weight	
. have lost weight	
m about the same	
y good sleeper	
od sleeper	
verage sleeper	
or sleeper	
ry poor sleeper	
ry good sleeper	
od sleeper	
verage sleeper	
or sleeper	
ry poor sleeper	
Yes	
No	

ionnaire.

eproduce this page as necessary

Daily Sleep Chart

Sleep latency (minutes)	120+																									
	60																									
	50																									
	40																									
	30																									
	20																									
	10																									
Total sleep (hours)	8+																									
	7																									
	6																									
	5																									
	4																									
	3																									
	2																									
	1																									
Sleep quality	Very good																									
	Good																									
	Average																									
	Poor																									
	Very Poor																									
Day		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15										
Start Date																										