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White Clinicians' Way of Being with Their Black Clients

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Abstract

Within the context of pervasive racial social inequality in mental healthcare (Lund, 2020), this dissertation sought to explore how white people who inherently hold racial bias according to critical whiteness theory (Olcon, Gilbert, & Pulliam, 2019), navigate this within their therapeutic work and relationships as clinicians with Black clients. Using the framework of clinician *way of being*, the conscious attitudes and beliefs that clinicians hold towards clients (Fife, Whiting, Bradford, & Davis, 2014), this phenomenological study used semi-structured interviews with key informants, practicing white clinicians (N=19). Content analysis of verbatim transcripts suggests that whiteness and conscious navigations of emotions and pre-judgements about race influenced clinicians' *ways of being, therapeutic relationships, and techniques with Black clients* oriented on a continuum from ignoring to reckoning with race. Findings suggest further research on how whiteness is implicated in interracial clinical dyads and offer insights into white clinicians' need to interrogate their own whiteness.

Keywords: Racial Bias, Clinician Way of Being, Common Factors, Cultural Competence, Critical Whiteness Theory

Dedication

This dissertation is dedicated to the countless individuals working to dismantle white supremacy within mental healthcare, and the BIPOC clients who endure it while we try.

And most of all, to my clients, who have stuck with me through my years of bumbling through uncomfortable conversations and taught me what it means to be a white woman clinician working with Black clients. I am forever grateful for your patience, forgiveness, and vulnerability.

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Chapter 1: Introduction

Problem Statement

In alignment with the current social and political context of our nation, mental health practitioners are crucial for providing leadership towards reckoning with white supremacy (Abrams, 2020). The events of 2020, including disparities in COVID-19 outcomes and police brutality towards the Black community build on the existing context of challenges that Black people face in physical and mental health spaces, underscoring the need for quality and racially just mental healthcare for the Black community (Lund, 2020).

Black Americans face discrimination and systematic oppression in the mental health field in the overarching structure of the treatment system itself, as well as in the interpersonal therapeutic relationship (Jones, Huey, & Rubenson, 2018). On the individual service delivery level, Black clients experience misdiagnosis at higher rates than other races (Schwartz & Feisthamel, 2009) and racial bias in treatment (Chang & Berk, 2009; Snowden, 2012). Evidence of these multilevel barriers to quality care include low rates of engagement in treatment and early treatment termination (Smith & Trimble, 2016). On the systemic level, Black people are just as likely as white people to have mental illness, yet they are less likely to have access to mental healthcare (US DHHS, 2001; Snowden, 2012) or be insured (Kaiser Family Foundation, 2012). Black people are often misdiagnosed and diagnosed with more severe mental illnesses than their white

counterparts (Schwartz & Feisthamel, 2009); yet they are less likely to be offered therapy and medication for mental illness, and are disproportionately incarcerated as compared to white people (APA, 2017). Though the Surgeon General committed to addressing these systemic issues (US DHHS, 2001), they still exist (APA, 2017). Likewise, there is a dearth of clinicians of color. Only 2% of APA members identify as Black (APA, 2017) and social workers who are Black are concentrated at the bachelor's level, signifying existing barriers to becoming a Black clinician.

As a way to understand these systemic issues, critical whiteness theory (Jeyansingham, 2012; Olcon, Gilbert, & Pulliam, 2019) holds that whiteness is an invisible ideology and social norm which organizes society around whiteness and provides identity and unearned privileges for white people (Jeyasingham, 2012; Olcon, Gilbert, & Pulliam, 2019). Despite this power and unearned privilege being invisible to them, white people are often very invested in this white identity and feel negative feelings when it is threatened (DiAngelo, 2011; 2018). One way is through racial bias, which the Kirwan Institute defines as "negative associations that people unknowingly hold… [which] affect individuals' attitudes and actions, thus creating real-world implications" (Staats, 2013). Through bias, white supremacy also plays an invisible role in the clinician-patient relationships with white clinicians and clients of color (Jones, Huey, & Rubenson, 2018). This study works from the assumption that implicit bias is a part of all white peoples' experience. From this understanding, this study seeks to understand white clinicians' lived experience of navigating the conscious emotions, thoughts, and experiences that they have with race and whiteness as they enact their way of being with their Black clients specifically.

Clinician cultural competence is the oft-used framework in mental health to address racial and other intersectional differences within the clinician-patient relationship (Chu, Leino, Pflum, & Sue, 2016; Jones, Huey, & Rubenson, 2018). Cultural competence is defined as obtaining broad knowledge about diverse intersectional identities and using this knowledge to work more skillfully with those populations (Chu, Leino, Pflum, & Sue, 2016; Sue, Zane, Hall & Berger, 2009). Literature suggests that current cultural competence frames do not sufficiently focus on white clinicians' introspection and racial bias (Abrams & Gibson, 2007; Jeyansingham, 2012). For instance, Garran and Rozas (2013) highlighted the need to incorporate intersectionality, or the understanding of how different identity markers such as gender and others in addition to race, intersect to form a person's identity and experience. A recent framework of cultural competence stated that two key areas of focus are the therapeutic relationship, and the client's feeling known and seen by the clinician (Chu et al., 2016). The unacknowledged centrality of whiteness and bias within cultural competence is at odds with the need to form a therapeutic relationship where Black clients feel known and seen by the white clinician, who may not acknowledge their own racial bias or its impact (Abrams & Gibson, 2007; Olcon, Gilbert, & Pulliam, 2019).

Of the many ways to articulate what happens in the clinician-patient relationship, the TPM frames aspects of this relationship in the construct of clinician *way of being* (Fife, Whiting, Bradford, & Davis, 2014). Clinician way of being is the conscious, "in-the-moment attitude that therapists have toward clients" and precedes both the therapeutic relationship and the models and techniques used in therapy (Fife, et al., 2014, p. 24). This clinician way of being creates the foundation for a therapeutic relationship

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that the client ideally perceives as validating, open, and nonjudgmental (Fife, et al., 2014). Though the authors state that clinician way of being can be an attitude that is "genuine and open to the humanity of the client, or it can be a stance that is impersonal and objectifying" (Fife, et al., 2014, p. 24), they do not name racism as a potential influence on way of being despite racism being a form of judgement and objectification. In fact, racial bias has never been explicitly researched within white clinician way of being with Black clients, despite the aforementioned evidence that racial disparities and bias are a problem for many of the 4.8 million Black Americans with mental illness (SAMHSA, 2018).

Purpose of the Study

In the context of multilevel challenges for Black clients within the mental healthcare macrosystem and treatment microsystem by majority white clinicians, the purpose of this study is to explore how the race of the client may inform white clinicians' way of being. Both common factors and the cultural competence framework stress the importance of the clinician as an instrument and the therapeutic relationship as key aspects of therapy (Chu et al., 2016; Martin, Garske, & Davis, 2000), but do not adequately address whiteness, white supremacy, or racism. Critical whiteness theory suggests that white clinicians may actually be invested in their racial bias as it maintains white supremacy, even as they also try to dismantle it (Abrams & Gibson, 2007; Olcon, Gilbert, & Pulliam, 2019), thus presenting a potential challenge for white clinicians developing an open and nonjudgmental way of being with Black clients. How white clinicians navigate their whiteness and racial bias as they attempt to develop their way of being and build strong therapeutic relationships and technique with their Black clients, in

the context of a white supremacist mental healthcare system, is yet unexplored. This

study seeks to address that gap by exploring the lived experience of white clinicians who

are working with Black clients and navigating racial bias within their *way of being*.

Chapter 2: Literature Review

Racial Disparities in Mental Healthcare

4.8 million Black Americans report having a mental illness (SAMHSA, 2018). Yet the mental healthcare system is rife with discrimination and systematic oppression, according to the Surgeon General's report from the Department of Health and Human Services (2001) and the 10-year follow-up report (Snowden, 2012). While roughly the same amount of Black and white Americans suffer from mental illness, Black Americans face many structural and systemic obstacles to accessing and engaging in mental health services (US DHHS, 2001; Snowden, 2012). For example, as of 2018, 11.5 percent of Black Americans were uninsured as compared to 7.5 percent of white Americans (Kaiser Family Foundation, 2020). That same year, less than half of Black people who reported having a mental illness reported receiving treatment (CDC, 2019). Black people are also offered therapy and medication less often than the general population, yet Black people with mental illness are more likely to be in prison than people of other races (APA, 2017). Compounding the distrust of the healthcare system due to a long history of deception and abuse (Woods, King, Hanna, Murray, & 2012), there is also a high level of stigma against mental illness in the Black community (Ward, Wiltshire, Detry, & Brown, 2013). In addition, Black patients are more likely to receive care in community mental health centers where there are less resources, and a high rate of clinician turnover means changing providers frequently and seeing providers who have lower skill levels, not to

mention disrupted continuity of care and having to repeat difficult or traumatic experiences introductorily multiple times (Primm, & Lawson, 2010).

These systemic issues create and are reinforced by lack of quality and racially appropriate care within the microcosm of therapy services as well (Jones, Huey, & Rubenson, 2018). Of those who do receive mental health services, Black clients are more often misdiagnosed or are diagnosed with more severe mental illnesses than white counterparts (Schwartz & Feisthamel, 2009). One example of this, the American Psychological Association (2017) recently found that for the same set of symptoms, Black people are diagnosed with schizophrenia more often and mood disorders less often than white people. Not surprisingly, due to these barriers, Black clients have the lowest rates of engagement and retention by race (Smith & Trimble, 2016), often terminate treatment early (Snowden, 2014), and report experiencing racial bias in treatment (Snowden, 2012). The complexity of this issue is highlighted by persistent racial differences in treatment utilization and dropout rates, even after multiple studies controlled for socio-demographic aspects (i.e., SES) (Alegría, et al., 2002; Snowden, 1999).

These chronic issues with engagement, retention, and racial bias in treatment, point to changes that need to be made in therapeutic services and their delivery on all levels. Despite working in a context of systemic oppression and racism, clinicians can address these challenges at the individual treatment level to some degree (Chu, et al., 2016). The therapeutic relationship, also referred to as the therapeutic alliance, has long been established as the most influential of the common factors of effective psychotherapy when using any model or technique (Martin, Garske, & Davis, 2000). However, as will

be discussed later in this chapter, in order to address systemic oppression and racism within the individual treatment system, white clinicians must acknowledge their own power as people possessing white privilege and benefiting from white supremacist institutions in ways their clients do not (Crenshaw, Gotanda, Peller, & Thomas, 1996; Olcon, Gilbert, & Pulliam, 2019).

Some scholars have suggested that racial disparities be addressed using an "experiential match" within the therapeutic relationship, which is the client's experience of being known and understood by the clinician, as if the clinician's experience matches their own (Chu, et al., 2016). One piece on cultural competence explored whether ethnic or racial matching between clinician and client is the only way to create an experiential match for clients (Chu, et al., 2016). Research generally supports the effectiveness of ethnic matching of client and clinician, as a mechanism of creating this experiential match (Jones, Huey, & Rubenson, 2018) and states that Black clients tend to prefer an ethnically and culturally matched clinician (Cabral & Smith, 2011). Studies have shown that Black clients within an ethnically matched dyad make attributions about the clinician such as competency, credibility, and trustworthiness (Cabral & Smith, 2011; Karlsson, 2005). They may also be more likely to disclose more sensitive information (Ibaraki & Nagayama Hall, 2014) and to rate the alliance more highly within an ethnic match (Cabral & Smith, 2011; Karlsson, 2005). These ethnic clinician-client matches positively influence outcomes such as engagement (i.e., attendance), retention (i.e., lower dropout rates), and symptom reduction (Cabral & Smith, 2011), though this body of research has limitations such as small effect sizes (Ibaraki & Nagayama Hall, 2014), lack of clinical trials or experimental designs (Karlsson, 2005), and potential uncontrolled variables

within the groups (Karlsson, 2005; Jones, Huey, & Rubenson, 2018). Taken together, this research on racial matching supports Black clients feeling trusting and safe, but is unclear if this is about the race of the clinician or other concurrent factors.

Another body of research within the medical community, which is relevant to the experiential match, explains social concordance in the context of patient-physician relationships (Thornton, Powe, Roter, & Cooper, 2011). Social concordance is a measure of shared social characteristics that the patient and physician have in common. More social concordance seems to indicate positive patient affect and perceptions of care, as measured by higher ratings of global satisfaction with office visits and recommendations to friends (Thornton, et al., 2011). The authors suggest that physician-patient social concordance is impactful for health communication and outcomes and should be considered in a multi-dimensional way instead of simple emphasis on race. On the other hand, another study from this field which concentrated specifically on race showed that clinician racial bias negatively impacted health communication and lowered visit ratings particularly among Black patients (Cooper, Roter, Carson, Beach, Sabin, Greenwald, & Inui, 2012). These aspects indicate that it is important for white clinicians to understand how to navigate their power, social position, and racial bias within inter-racial clinician-patient dyads, which is also implied by the other research discussed above.

Even with this support, racial matching is not pragmatic because there are far fewer Black clinicians in the mental healthcare system than there are clients. Though Black Americans are 13% of the US population, and 16% of Black Americans report having a mental illness (SAMHSA, 2018), the APA's Center for Workforce Studies found that only 4% of the psychology workforce identifies as Black or African American

(Abrams, 2020). Further, Black clinicians make up less than 2% of APA members (APA, 2017). In the field of Social Work, only 21.6% of social workers identified as Black, as opposed to 68.8% who were white, according to a report to CSWE and the National Workforce Initiative (Salsberg, et al., 2017). In addition, Black social workers were more highly concentrated at the bachelor's level (25.7% of the total) than master's level (19.1%) (Salsberg, et al., 2017). Though there are signs of growing numbers of non-white individuals entering the mental health professions such as psychologists (APA, 2017), there are still not enough Black clinicians to simply match with all Black clients. Thus, research must address how white clinicians can work more effectively with Black clients.

Some evidence shows inter-racial clinician-patient dyads to be effective when the clinician appropriately manages issues of implicit bias, power and privilege (Chang & Berk, 2009). For example, Chang and Berk (2009) qualitatively examined non-white clients' lived experience of interracial clinician-patient relationships with white clinicians to ascertain how race matters in satisfaction, comparing satisfied client narratives to unsatisfied client narratives (n=16). Results revealed that clients were satisfied with clinicians who were sensitive, validating, and attentive, and, importantly, "culturally responsive and able to work through misunderstandings due to racial, ethnic, and cultural differences." On the contrary, clients were unsatisfied with clinicians who used cultural competence in ways that were "too textbook," dismissed the clients' experiences of oppression, or were unaware of biases they had that impacted the client (Chang & Berk, 2009). This research supports the effectiveness of inter-racial patient-client relationships with specific attention to enactment of cultural responsiveness on the part of the clinician. Further support comes from Owen and colleagues (2011), who found that therapeutic

alliance and clinical outcomes are negatively impacted when the client perceives that the clinician has committed microaggressions such as insensitivity or discrimination.

Additionally, clinicians can deliberately become aware of and actively navigate cultural differences such as worldview, emotional expression, communication style, and perspectives on illness, which would negatively impact the therapeutic relationship if mismatched or mishandled (Qureshi & Collazos, 2011). Other research points to interracial clinician-client dyads being effective because of cultural match, or other reasons where implicit bias would inherently be minimized. For example, Ibaraki & Nagayama Hall (2014) found that treatment utilization is moderated by the content covered in session, which is directly influenced by the matching cultural beliefs of the clinician and client, rather than the matching race or ethnicity. Cultural worldview and cognitive styles matching have also been proposed as useful alternatives to ethnic matching (Zane et al., 2005). Finally, studies show that clients reportedly prefer matching attitudes, personality, beliefs, and values to ethnic matching in a forced choice ranking (Atkinson & Lowe, 1991; Bennett & BigFoot-Sipes, 1995). Taken together, these findings support the need for white clinicians to actively understand and mitigate their own bias in the therapeutic relationship with Black clients, as they cannot rely on ethnic or racial matching to build the experiential or cultural match. Yet specific research on how they do this within the clinician way of being is lacking.

Critical Whiteness Theory & Critique of Cultural Competence

Critical whiteness theory contributes to how this research understands the process of white clinicians' own introspection and navigation of racial bias when working with Black clients. The main idea of critical whiteness theory is that whiteness is a social norm

which comes with white privilege, and is invisible to white people (Jeyasingham, 2012; McIntosh, 1998; Nayak, 2007; Olcon, Gilbert, & Pulliam, 2019). Critical whiteness theory states that "whiteness implies a power structure, an ideology, and an individual identity, which is nevertheless mostly invisible to White people" (Olcon, Gilbert, & Pulliam, 2019, pp. 6-7). Despite being invisible to white people, it is a guiding principle for modern Western society (Nayak, 2007). Scholarship discusses varying actions that white people should take, including to "abolish, deconstruct, or rethink the meaning of whiteness and white identities as they currently stand," all avenues which require critical understanding and action on the part of white people (Nayak, 2007, p. 737). Critical whiteness is "a discipline working to 'destabilize the assumptions behind whiteness as a cultural norm'" (Foster, 2003, p. 30). Black people already see, understand, and navigate whiteness daily (hooks, 1992), and must do so with their white clinicians. Not only should they not have to do so in therapy, but this necessity could be an underlying reason for the disparities in engagement and retention cited earlier. Nayak states that "critical accounts of whiteness are recognized to be a vital and necessary corrective to a sociology of race relations that myopically explored color-based racisms with little attempt to reflect on constructions of whiteness" (p. 738).

In contrast to critical whiteness theory, which examines both the systemic and relational implications of whiteness, cultural competence focuses on the individual patient-clinician relationship as the locus of action. Research suggests that improving clinician cultural competence could decrease some of the above disparities (Jones, Huey, & Rubenson, 2018). A recent theoretical framework developed from a synthesis of the existing studies, provided the first empirically grounded theory of cultural competence

(Chu et al., 2016). Chu and colleagues' framework was built on the assumption that cultural competence is achieved by obtaining knowledge and special skill sets to work with diverse populations (2016; Sue, Zane, Hall & Berger, 2009). Jones, Huey, and Rubenson (2018) contend that there is no widely accepted definition of the term cultural competence but agree that the definition includes gaining specific knowledge and skills, citing Sue and colleagues (2009). To this end, the framework highlighted the therapeutic relationship and the clinician's approach as key areas of focus for creating culturally competent experiences for non-white clients (including Black clients who are the specific focus of this dissertation).

According to Chu and colleagues' framework (2016), cultural competence works because it allows the client to feel known and empowered. However, this framework does not engage deeply enough with the implications of white clinicians' racial bias and whiteness within their work with Black clients. For instance, it cites the "therapist multicultural orientation" (Owen, et al., 2011), and having cultural humility or cultural empathy, for the purpose of making clients feel known and empowered. Cultural humility is the continuous process of challenging one's own assumptions that one's cultural values are superior, and instead cultivating a humble openness to the other (Hook, et al., 2013; Tervalon & Murray-Garcia, 1998). To this end, Roysircar (2004) developed a clinician self-awareness instrument and Vázquez & García-Vázquez (2003) discuss the fears of psychology professors questioning their biases about diversity within the field. However, these sources do not speak to excavating and challenging racial bias if it is detected, the clinician's ability to articulate their own biases, or the necessity of decentering whiteness in the therapeutic relationship, as critical whiteness would suggest (Olcon, Pullinam, &

Gilbert, 2019). Similar self-introspection work has been described in other work on clinician training and supervision as Person of the Therapist work (Aponte et al., 2009), and Self of the Therapist (DeMaria, Bogue, & Haggerty, 2019), and will be expanded and reconceptualized in the later discussion of clinician way of being (Fife, et al., 2014). But even in these writings, race and bias are not addressed.

This cultural competence framework highlights the clinician's self-awareness and approach to the therapeutic relationship as key areas of focus but fails to engage with the deeper meaning and implications of the white clinician's whiteness in these areas. Cultural competence rests on the idea of multiculturalism, which is inherently othering, centers whiteness, and affords the white clinician the privilege of invisible and unexamined power in their whiteness (Abrams & Gibson, 2007; Olcon, Gilbert, & Pulliam, 2019). Though some other terms including cultural humility (defined above) have been used, the idea of simply gaining knowledge and skill in working with other, diverse cultures is problematic because it rests on the assumption that whiteness is the central norm, and every non-white race is other in reference to that whiteness (Nayak, 2007). Multiculturalism thereby ignores structural inequalities and their impacts on all levels of the clinician and client's experience (Abrams & Gibson, 2007), which have already been cited as key factors in establishing successful treatment (Chu, et al., 2016).

Cultural competence also comes with the possibility of the white clinician making Type I and II errors without the critical whiteness perspective's addition of scrutiny of their own positionality and power. A Type I error is made when a true null hypothesis is rejected (Padgett, 2016); in this instance, this would occur if a clinician assumed that something they learned about a culture was contributing to a client's case presentation,

when in fact it was not relevant to the client. A Type II error is made when a false null fails to be rejected (Padgett, 2016); in this instance, this would occur when cultural factors are significant to the client but are overlooked by the clinician. Type I and Type II errors are avoidable if a white clinician is able to decenter their whiteness and, instead of approaching other racial and cultural factors as special or somehow extraneous to the case presentation, get curious about each client's unique intersectional identities and experiences and their influence on their case presentation.

By centering whiteness and labeling non-white as diverse, cultural competence also excuses the white clinician's reflection about their own culture, and their culture's often violent and oppressive relationship to other cultures, particularly with Black Americans (Lee & Bhuyan, 2013). For white clinicians working with Black clients, this lack of reflexivity can be an invisible (to the clinicians) source of harm to the client, who is likely very aware of painful navigations around the clinician's whiteness (hooks, 1992). As Fanon wrote, "I am being dissected under white eyes, the only real eyes. I am *fixed*...they objectively cut away slices of my reality. I am laid bare" (Fanon, 1967, p. 95). This testimony speaks to the importance of research on how white clinicians can navigate, with their white eyes, their way of being with their Black clients.

Clinician Way of Being

The Therapeutic Pyramid Model (TPM), where the construct of clinician way of being originated, is a helpful framework to use when examining the role of racial bias in interracial patient-clinician dyads because it proposes a relationship between the clinician's consciously understood and expressed values and affect toward the client, the dyadic relationship, and the chosen interventions (Fife, et al., 2014). In the TPM, the

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foundational piece is clinician way of being, which is the "in-the-moment attitude that clinicians have toward clients" (Fife, et al., 2014, p. 24). Way of being can be "genuine and open to the humanity of the client, or it can be a stance that is impersonal and objectifying" (Fife, et al., 2014, p. 24). To elaborate, clinician way of being is not merely a stance. It is the clinician's consciously understood values as well as their attitude and affect toward a particular client, expressed implicitly through nonverbal communication as well as explicitly through verbal communication and action. It is as much a mindset or intentional approach to therapy as it is an enacted stance with one client in any given moment. The authors articulate that clinicians should take care to cultivate within themselves and express to the client a genuine and open way of being, but do not explicitly acknowledge the role of conscious or unconscious racial bias in undermining way of being, except for mentioning that clinicians should work on their "issues and areas of reactivity". (Fife, et al., 2014).

In the TPM, the clinician way of being lays the groundwork for a healthy therapeutic relationship where the client feels known, seen, and cared for by the clinician as a unique individual (Fife, et al., 2014), which was mentioned in cultural competence literature as an important factor (Chang & Berk, 2009; Chu, et al., 2016). Though common factors research purports the therapeutic relationship as foundationally important (Martin, Garske, & Davis, 2000), Fife and colleagues (2014) use their model to propose an expanded conceptualization where clinician way of being precedes the therapeutic relationship, because the clinician's values and attitude toward the client are explicitly acknowledged as part of what creates the clinicians' capacity to facilitate and build it. From the therapeutic relationship, models and techniques can be layered on as a

part of the delivery of therapeutic services, but they are tertiarily important. This also is in line with how common factors research views the importance of the therapeutic relationship as compared to the models and techniques used in therapy (Martin, Garske, & Davis, 2000).

Just as critical whiteness theory expands on cultural competence, the construct of clinician way of being broadens the idea of what the white clinician's racial bias within the therapeutic relationship could mean (Fife, et al., 2014). Both common factors and the cultural competence framework stress the importance of the clinician as an instrument and the therapeutic relationship as key aspects of therapy (Chu et al., 2016; Martin, Garske, & Davis, 2000), but do not adequately understand how the white clinician's racial bias could be implicated. Because of its acknowledgment of the importance of clinician way of being to the relationship and technique, the TPM seemed important to conceptualizing the relationship between racial bias and the therapeutic relationship and technique (Fife, et al., 2014). According to this model, way of being is based on Buber's concept of an I-Thou relationship, where the clinician strives to "establish a living mutual relation" between clinician and client, centering humility and humanity (Buber, 1965; p. 19). Though the clinician is always in power and may be inclined to privilege their own perspective (Whiting, Oka, & Fife, 2012), in an I-Thou relationship, the clinician would choose to explore and value the client's perspective. Fife and colleagues state, "Therapists can choose to put the humanity of the client first, even when personal reactivity might influence otherwise. Accomplishing this takes a high degree of awareness of one's motives and thoughts" (p. 25) which include one's biases towards the client and the client's racial identity. This type of work expands on Person of the

Therapist (Aponte et al., 2009), and Self of the Therapist (DeMaria, Bogue, & Haggerty, 2019) as well, toward the endeavor of knowing oneself and one's biases better and using one's thoughts, emotions and experiences as tools in the therapeutic process. Again, while perhaps implied, this concept does not adequately address white clinicians' awareness or negotiations of racial bias.

Purpose of Current Research

In sum, the structural racism that Black clients face in the American mental health system are supported by and recreated within the clinician-patient relationship with white clinicians. Though research has explored racial matching and interracial clinician-patient relationships, there simply are not enough Black clinicians to address this need using matching alone. Therefore, the white clinician- Black patient dynamic must be further explored, in particular, how white clinicians cultivate therapeutic relationships where the Black client feels known and seen (Chu, et al., 2016). Clinician way of being offers a conceptual framework for this exploration because it is foundational to the therapeutic relationship and encompasses the clinician's conscious enactment of their attitudes and beliefs stemming from their own identity, social location, and experiences (Fife, et al., 2014). In combination with critical whiteness theory, which understands that white people hold racial bias as part of their participation in a white supremacist system (Olcon, Gilbert, & Pulliam, 2019), this study seeks to address the gap in understanding how white clinicians, who universally hold racial bias both implicitly and consciously, cultivate an open and nonjudgmental clinician way of being within their therapeutic relationships with their Black clients. Research has yet to explore how white clinicians navigate their racial bias as they attempt to develop their way of being and build strong therapeutic

relationships and technique with their Black clients. This dissertation study sought to

address that gap by exploring the lived experience of white clinicians as they negotiate

their conscious racial bias within their way of being with their Black clients.

Chapter 3: Methods

This study is a phenomenological examination of the lived experience of white clinicians' racial bias within their way of being with Black clients (Padgett, 2016; van Manen, 1990). This dissertation used key informant interviews (Padgett, 2016) to gather the lived experience of white clinicians who have experience treating Black clients (Creswell, 2017).

Epistemological Considerations

Because clinician way of being is understood as a conscious and explicit enactment of clinician attitudes and beliefs, but does not address either implicit or conscious racial bias, a phenomenological inquiry was designed to use in-depth interviews to ask participants to articulate their lived experiences with way of being when working with Black clients. Creswell (2017) defines phenomenology as the study of a phenomenon and even cites "the health idea of a 'caring relationship'" (p. 78) as a good example of what a phenomenological study might target. Phenomenology aims to grasp the essence of a conscious human experience, rather than an explanation or analysis of it (van Manen, 1990; Creswell, 2017). Because racial bias can be implicit, or unconscious and unacknowledged (Staats, 2013), and is an inherent part of white people's experience as a part of white supremacy even as they attempt to dismantle it (Abrams & Gibson, 2007; Olcon, Gilbert, & Pulliam, 2019), it may not be possible for participants to fully articulate or for researchers to accurately interpret. Similarly, though, Fife and colleagues' (2014) conceptualization of clinician way of being holds that it is the

conscious enactment of attitudes and beliefs but implies that unconscious "issues and reactivity" may be part of informing it. Due to the ambiguous nature of these phenomena, of both racial bias and clinician way of being, the epistemological choice to use phenomenology aims at understanding not the exact nature of the relationship between racial bias and clinician way of being, but the white clinicians' lived experience of navigating these inherently ambiguous phenomena in a way they can consciously articulate. This study did not attempt to identify implicit or unconscious racial bias. Instead, it looked for participants' articulated thoughts, feelings, and experiences with race, and examined how these consciously stated experiences were a part of the participants' negotiations of race within their way of being with their Black clients.

Recruitment and Sampling

This dissertation sampled from the population of white clinicians. All participants were licensed clinicians. I recruited using my professional networks including the agency where I worked at the time, my advanced training's alumni network, my social media connections, and societies such as the Eye Movement Desensitization and Reprocessing therapy (EMDR) and American Association of Marriage and Family Therapists (AAMFT) listservs.

To recruit participants, I solicited clinicians by email, flyers, and word of mouth through my personal and professional networks described above (Appendix B: email and flyer). In both of these materials, I included the purpose of the study, inclusion criteria, a description of the participation process, and a mention of the incentive (entrance into a raffle to win a $25 gift card to Starbucks). At the close of the data collection phase, I contacted the raffle-winning participant and they requested to donate the $25 to the

GoFundMe page for Walter Wallace, Jr., a Philadelphian who had recently been shot and killed by a Philadelphia police officers Sean Matarazzo and Thomas Munz during a mental health crisis call (https://www.gofundme.com/f/92wvm-funding-for-family; https://tinyurl.com/bz3nrcse). Though the IRB application specifically stated that the prize would be a Starbucks gift card, I decided that given the social context of the study, it would be appropriate to honor the raffle-winning participant's request and donated the $25 to the aforementioned cause.

I screened interested potential participants via a phone call, using the sampling criteria listed in the following section. Sampling continued until saturation—defined as the point when preliminary analysis revealed little to no new information or themes (Creswell, 2017)—was reached, which resulted in a total of 19 clinicians. Additional interested participants were contacted, thanked for their interest, and placed on a waitlist to participate if more data had been needed after deeper analysis. I did not interview anyone from the waitlist.

Inclusion Criteria. The definition of clinician for this study includes: licensed Psychologist (PhD or PsyD), Licensed Marriage and Family Therapist (LMFT), Licensed Social Worker (LSW), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Board-certified Art Therapist. Participating clinicians must be white-identified, practicing actively, and must be prepared to discuss their work with a Black identified client or clients in some detail. Potential participants were excluded upon screening if they are non-white identified, and if they had not treated at least one (1) Black client in their career. The interview asked clinicians to draw on experiences they

have had with treating Black clients, therefore the clinicians must have had at least some experience to reflect on.

Data Collection Instruments

Face Sheet. The following information was collected in the Face Sheet: age, gender, socioeconomic status, years working as a clinician, years working in their current setting, theoretical orientation, primary treatment unit (individual, couple, or family), and an estimate of how many Black clients they have worked with. While these factors may contribute to how these clinicians approach their Black clients, they are not cited in the literature as key factors in providing culturally competent care (Chu et al., 2016; Jones, Huey, & Rubenson, 2018), or building a therapeutic relationship (Martin, Garske, & Davis, 2000). They are also not seen as important for clinician way of being (Fife, et al., 2014).

Interview Guide. As discussed, this qualitative study used key informant interviews of white clinicians to understand their lived experience of their racial bias and how they navigate this in their way of being with Black clients. See Appendix A for the Interview Guide.

The interview guide was developed with the aim of giving participants numerous opportunities to articulate their lived experience with respect to racial bias and way of being, as informed by the constructs referenced in the literature review such as cultural competence (Chu et al., 2016), critical whiteness (Jeyasingham, 2012; McIntosh, 1990; Olcon, Gilbert, & Pulliam, 2019), the therapeutic relationship and common factors (Martin, Garske, & Davis, 2000) and clinician way of being (Fife, et al., 2014). Using Padgett (2016) and Josselson (2013) as a guide to interview guide construction, I

developed these questions by attempting to capture the "big question" (Josselson, 2013) which is "what is your awareness of your internal racial bias and lived experience of negotiating your internal bias within your way of being with your Black clients," by asking little questions surrounding that main question. Though the interview guide focused on direct articulations of way of being, it also targeted the therapeutic relationship, clinical techniques, and agency support with the topic of race as a way of understanding if and how racial bias is related to these extensions of clinician way of being. Because racial bias is a sensitive topic, may be both implicit and explicit and therefore difficult to articulate, this interview guide phrased the same question in multiple ways and provided probes to elaborate on initial answers that participants gave.

To pilot this interview guide, it was tested in 2 interviews drawn from the recruited participants within the population of interest. This created an opportunity for the interviewer to tweak questions and wording as needed to avoid confusion or awkwardness (Padgett, 2016). These interviews were transcribed immediately, and initial coding determined if the questions obtained data that was relevant to the intended research question. Changes in interview guide questions or additions of directions for probes reflected these determinations made from this preliminary analysis (Padgett, 2016). While the original interview guide contained some probes about how clinicians handled specific things with Black and white clients, such as gender, emotion, and other topics, the pilot interviews did not reflect that these questions were relevant, and therefore I eliminated them from the interviews moving forward. This was the only change.

Description of the Sample

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Participants in this study were all white-identifying. The sample was heterogeneous on all characteristics with the exception of gender. Of the 19 participants, there were 18 female participants and one male. Participants ranged in age from 26 years old, to 71 years old. Of the 19 participants, 8 identified as upper-middle class, and 11 identified as middle class. Participants were licensed clinicians, including 5 licensed Psychologists (PhD or PsyD), 6 Licensed Marriage and Family Therapists (LMFT), 2 Licensed Social Worker (LSW), one Licensed Clinical Social Worker (LCSW), 2 Board-certified Art Therapists, 3 Licensed Professional Counselors (LPC), and one PhD in Social Work and Social Research who was also an LMFT.

There was a vast range of clinical experience in this sample. Participants reported years of experience as a clinician ranging from 3 to 50 years. Three participants had worked in the same setting for their entire careers (5-8 years) while the rest reported multiple settings over their careers, with the shortest time in their current setting being 1 year and the longest being 39 years. Practice settings ranged from 11 participants working in non-profit agencies (such as those serving a combination of both full fee and low fee clients, and/or those serving a specific client population), 3 in private practice, 3 at the Veterans Association (VA), and 3 in community mental health settings (such as those seeing exclusively clients with Medicaid insurance). Within these settings, clients tended to have particular socioeconomic statuses. Though most clinicians reported having worked with clients in a range of socioeconomic positions, those who were lower middle class, working poor, or disabled tended to be in the VA or community mental health agencies, though some appeared in the non-profit agency setting as well. General presenting problems were mixed, including: trauma and/or PTSD (5 participants),

relationship issues (5), depression (2), anxiety (5), aging (2), and child welfare (1).

Primary theoretical orientations that participants reported identifying with were mixed, including: Emotion-Focused Therapy (2 participants), child welfare family therapy model (1), Cognitive Behavioral Therapy (4), Acceptance and Commitment Therapy (2), Affect Cognition Behavior orientation (2), Attachment theory (2), Eclectic (2), Psychodynamic (1), Somatic (1), and Systems (3).

Regarding participants' exposure to Black clients, all participants reported working with Black clients for all their years of experience, which again ranged from 3 to 50 years. They had caseloads ranging from 9 clients total to 50 clients total and treated between 9 and 30 clients per week on average. Participants reported working primarily with individuals, though one worked primarily with families, one with couples, and four had a caseload mixed with individuals, couples, and families. Participants struggled to quantify their number of Black clients and ratio of Black clients to other races. Some did not provide answers to this question or only answered one instead of both methods of quantification. For the ratio, some felt that they had as few as half a percent of their caseload being Black clients over the course of their career, while others felt as much as 70% of their caseloads were Black clients over the course of their career. Some participants could not quantify the number of Black clients they have worked with in total across their experience, but those who were able to quantify the number of Black clients they've worked with in total estimated a range between 10 clients to 500 clients in total. This seemed to depend partially on the number of years they had worked, though some participants at the high end of the range of years of experience had fewer Black clients than some at the low end of years of experience. There did not seem to be a relationship

between the practice setting and number of Black clients, though a trend emerged where people who worked in the VA or community mental health clinics saw more Black clients than those who worked in private practice or non-profits. This could also be explained by people having worked in multiple settings throughout their career (for example, starting off in community mental health then moving to private practice). In sum, with the exception of gender, the sample was heterogeneous in all aspects.

Research with Human Subjects

This dissertation research required human subjects and was submitted to Bryn Mawr College's Institutional Review Board (see Appendix C: IRB approval letter). Participants were white clinicians from a variety of treatment settings, who were being asked about their attitudes and approaches to negotiating their racial biases within their way of being with Black clients. Participants do not qualify as any of the vulnerable populations, and this proposal qualified for an expedited review. I informed all participants of risks, confidentiality, and obtained consent (see Appendix D: consent form). I also informed each participant of their entrance into the $25 Starbucks gift card raffle for participation, regardless of whether they stop the interview at any time due to discomfort. No participant elected to stop an interview for any reason. Finally, I provided my contact information for participants' potential post-interview concerns, though no one contacted me after the interview. After the interview, I contacted the raffle winner and they requested that the amount of their gift card to Starbucks be instead donated to the family of Walter Wallace, to which I agreed.

Data in the form of voice recorded interviews was de-identified and protected according to the NIH Security Best Practices for Controlled-Access Data (NIH, 2015).

All forms were de-identified using a code, stored in a separate Excel file. All data and associated files were named with the code. All materials were uploaded to Bryn Mawr OneDrive and deleted from all other devices (NIH, 2015). See the Face Sheet (Appendix A) for the non-identifying information that was collected; none of this can be used to identify the participants or tie them to their answers. All data will be saved indefinitely for future projects.

Data Collection Procedure

As discussed above in the Recruitment and Screening section, I sent out an email (Appendix B) to my professional networks including the agency where I work, my training's alumni network, my social media connections, and societies such as EMDR and AAMFT's listservs. In this email I asked for recipients to contact me to indicate their interest, and to forward the email to anyone they think may qualify. I then set up a five-minute screening call where I screened for the inclusion criteria listed above and set up the interview time. All interviews were conducted remotely using Zoom due to the COVID-19 pandemic. Interviews were recorded using a cell phone voice recording app and the built-in Mac computer recording app, in the event that one device had a technical malfunction (none did). Interviews lasted between 50 and 100 minutes (see Appendix A: Interview Guide for the questions that were asked of participants). After the interview, participants were debriefed by reminding them of the purpose of the study, thanking them for their participation, and asking them to express any questions or concerns. I also provided my contact information for any post-interview concerns, though none arose. See the consent form (Appendix D) which participants signed electronically and saved a copy of to their computers before sending to me. I developed a consent waiver, also shown in

Appendix D and approved by the IRB, in the event of technical issues with electronically signing the PDF consent due to the COVID-19 pandemic prohibiting an in-person exchange, but no issues arose, and the waiver was not used. Finally, each interview was transcribed and checked for accuracy by simultaneously listening to and reading the transcription.

Analysis Plan and Process

I completed the analysis using Dedoose, an online qualitative data analysis software package (https://www.dedoose.com/). I uploaded each interview transcript into the program and used the program's features to organize the data and help with coding. Specifically, I labelled codes with specific tags and colors, refined code definitions and rearranged the relationships between codes repeatedly using the coding tree feature, broke some codes out from one larger code and combined some smaller codes into a grand code, and used the quantitative features to see occurrences where codes overlapped with one another. Because qualitative analysis is cyclical, it requires multiple iterative cycles (Saldaña, 2015). As intended, I employed two cycles of coding and analytic memos as suggested by Saldaña (2015) and Padgett (2016). Analytic memos are a tool to assist with tracking code definitions and analytic decisions such as theme development (Saldaña, 2015).

The first cycle of coding explored the data using a method called holistic coding, which Saldaña (2015) describes as a "grand tour of the data" (p. 73), and in vivo coding, which lends itself to familiarity with the "participant perspectives and actions" (Saldaña, 2015, p. 73). These are both in line with my exploratory stance with this research question and the phenomenological approach to capturing lived experience of participants

and essence of the phenomena of clinicians articulating their way of being with Black

clients (Creswell, 2017; van Manen, 1990). I looked for aspects of the participants'

experience including thoughts, emotions, and behaviors they articulated. Because I coded

by reading through each narrative from start to finish, the initial codes included specific

small quotations or ideas such as "shame" and "being myself with clients." Many of these

became part of larger codes in the second cycle of coding.

The second cycle of coding aimed to develop categorical, conceptual or thematic

organization from the initial set of codes (Saldaña, 2015). In this cycle, I employed

pattern coding to organize the data and attribute a theme to multiple codes, and axial

coding which described the deeper meaning of each category and explored how

categories or code groups were related to one another (Saldaña, 2015). During second

cycle coding, I pondered what the smaller codes meant about the essence of navigating

conscious thoughts, feelings, and experiences with race, in relation to clinician way of

being, and how codes fit together categorically to form meaning units, which are

important for phenomenological research (Creswell, 2017). I also used the feature of

Dedoose which shows how much each code overlaps with another code, to either collapse

two codes into one if applicable, or to join overlapping codes into a category of meaning.

Because phenomenological research looks for the essence of an experience, the numbers

of occurrences of the codes are not relevant, but the way they relate to each other is, as it

pertains to finding the meaning of the lived experience of white clinicians navigating

racial bias as they enact their way of being with Black clients.

To establish interrater reliability, I trained another researcher on the coding

scheme and provided them with 3 randomly selected interviews to code using this

scheme. We then discussed their results to ensure that we agreed on the execution of the coding scheme. We had a high degree of agreement immediately and were able to agree upon all initially divergent coding decisions with discussion. This procedure is supported by Padgett's (2016) approaches to increased rigor and trustworthiness in qualitative research.

Regarding data security, Dedoose is the chosen analysis platform because it is web-based, intuitive to operate, and affordable. Dedoose has a 7-lock security system, which keeps the de-identified data safe (see Human Subjects section of this Chapter for more information about de-identification) through mechanisms such as encryption, encryption of the backup data, login requirements, and inability to login from a non-private VPN (https://www.dedoose.com/about/terms). Dedoose also does not share data of any kind unless the researcher consents, and/or it is legally required by subpoena (https://www.dedoose.com/about/terms). These measures ensure the safety of the data for the period of analysis as well as the post-analysis period where data will be kept for future projects in accordance with the IRB submission and informed consent documents.

Potential Measurement Issues

There is some potential for measurement issues in this study. Discussed in more detail in the limitations section of Chapter 6, social desirability bias occurs in participants answering interview questions differently due to the desire to impress the interviewer or to not give wrong or socially unacceptable answers (Padgett, 2016). This may be the case when a white person is aware of their privilege and feels shame about being seen as racist (DiAngelo, 2011; 2018). This is also to be anticipated when white people talk about race, especially with other white people and particularly when they are aware of their various

levels of privilege but unsure of how to acknowledge it or communicate about it (DiAngelo, 2011; 2018). While this was not an issue with the measurement itself, it emerged as part of the findings related to how white clinicians navigate their conscious racial bias within their way of being with Black clients.

Reflexivity Statement

As the researcher taking a phenomenological approach, my identities and experiences play into how I am able to collect and analyze data related to racial bias and clinical work; they must be bracketed through explicit articulation and acknowledgement (Creswell, 2017). Most basically, I am a practicing clinician as well as a researcher, and have my own biases about how to be an effective clinician. I have attempted to hold my clinical skills and biases aside and approach this study as a researcher as one would do in bracketing (Creswell, 2017). For example, I consulted with my Chair while developing the interview guide to remove clinical wording from questions. Additionally, I avoided clinical interpretations while analyzing the data, instead using only the participants' direct statements about their thoughts, emotions, and behaviors to draw conclusions. Throughout this study, I have used memos and consultation with multiple colleagues including my Chair and an independent coder who coded 3 of my interviews, as well as other people who do their own research on different topics (Padgett, 2016).

Further, I am a white clinician who works often with Black and other non-white clients. I feel ashamed that I did not develop my own critical awareness of my privilege and complicitness with the system until I started witnessing the struggles of my clients. When I first became aware, I felt ill-equipped to deal with my own guilt about my privilege and inherent safety in the situations my clients faced, such as community

violence and racism within social service systems. So, I began a journey starting with Ta Nehisi-Coates' *Between the World and Me* (2015) and Robin DiAngelo's *White Fragility* (2018) which opened my eyes to the necessity not just of learning skills to work with racism, but of breaking open my notions of race and interrogating what my own whiteness means to me. Despite its good intentions, I do not feel that my clinical education or supervision prepared me for this unending journey of self-discovery and community action. Thus, I wanted to understand what other white clinicians feel and how they work with their Black clients.

During the course of developing and conducting this study, the social climate in this country changed drastically with the COVID-19 pandemic disproportionately impacting Black communities and a social uprising across the country due to widespread awareness of the police brutality impacting primarily Black men and boys. These major shifts moved many white people and organizations, including numerous agencies where study participants worked, to learn about racism and examine their racial bias and strive toward anti-racism. I believe that this shift increased my motivation and inspiration to complete this study and may have also inspired people to volunteer to participate who normally would not have done so. This may have helped the study to engage participants at all stages of their racial bias awareness journey as opposed to just those who were far enough along to be less afraid of guilt and shame associated with social desirability in talking about race. The social climate may also have encouraged people to be more open and honest about their discomfort and struggles within their navigation of racial bias within their way of being during their interview, because of all the public discourse which may have normalized their experience.

One personal experience of mine that literature cites as a potential nuance in this research is the shame and discomfort that white people feel when they are called out for being racially insensitive (DiAngelo, 2011; 2018). Another similar phenomenon is simply the fear of other white people thinking they are racist (DiAngelo, 2011; 2018). Social desirability bias, when participants answer questions in the way they think the interviewer wants them to, or in order to escape negative judgment by the interviewer, was likely present to some degree (Padgett, 2016). However, participants did share their negative emotions and insecurities, a sign that they were being honest about their perspective. In a similar vein, participants may have answered questions in language they would use with another white person, and it may not reflect how they would answer the questions if they were in a racially diverse presence (DiAngelo, 2018). However, judging by the data, being interviewed by a white researcher seems to have enabled participants to be more vulnerable about their challenging emotions and mistakes they'd made with Black clients without needing to worry about offending a person of color or appearing racist in a diverse group. Finally, when analyzing the data, I took steps to ensure that my own perspective did not impact or distort the analysis, a process called reactivity by Padgett (2016). This is important for bracketing as part of phenomenological research (Creswell, 2017). I addressed this by keeping analytic memos (Saldaña, 2015) and by having another coder code 3 of my interviews, as previously mentioned (Padgett, 2016).

Strategies for Rigor & Trustworthiness

This section outlines strategies I used for attending to rigor and trustworthiness, which is the notion that the study was done ethically, and the findings represent the perspectives of the participants (Padgett, 2016). My main strategies were an audit trail,

peer debriefing, and having another researcher code interviews as well. Concerning the audit trail, I made a document in OneDrive where I recorded my thoughts and impressions after each interview. I also began a new Research Journal, also housed in OneDrive, where I recorded my preliminary ideas about the analysis as I read through the transcripts, coded, discussed coding with my second coder, and read or listened to anything that pertained to this research (Saldaña, 2015). In addition, I kept analytic memos in the Research Journal, which contained details on all of my decisions about coding including code choices, abstractions about the codes, and developing themes from the data. These memos were used to generate codes and categories, and informed the second-round coding as I developed higher levels of abstraction (Saldaña, 2015). Finally, the Research Journal included drafts of coding charts or other visual depictions created during analysis. All of this should function as an audit trail, a record of the process of analysis unfolding in the interest of replication by another researcher. Additionally, peer debriefing served to manage my own biases and reactions as well as gain alternative perspectives on the data (Padgett, 2016). Finally, as mentioned earlier, another researcher used my coding scheme to code 3 of my interviews and discussed the minimal discrepancies with me to come to a consensus (Padgett, 2016). This was a method used to establish inter-rater reliability and support rigor and trustworthiness more generally.

Chapter 4: Results

Several themes emerged from analysis of participant interviews in this study. First, white clinicians interviewed robustly describe their way of being by referring to their values and identity as clinicians with a particular emphasis on use-of-self, reflection on their own social locations and identity formation, and on openness and authenticity. Next, participants described the client race in interaction with their way of being, particularly by explaining their thoughts and feelings about race, their Black clients, their work with their Black clients, and how they interpreted that their Black clients perceive them. The emotional and cognitive categories were not discrete, and emotions and thoughts are assumed to reciprocally influence one another within one person's awareness. On the emotional level, participants spoke about their emotional reactions regarding their Black clients and how these reactions are rooted in participants' own personal experiences from their social locations. On the cognitive level, participants discussed thought-based assumptions they make about Black clients, their work with Black clients, and their interpretations of Black clients' experiences in therapy with them. These layers of emotional and cognitive narratives showed that participants' thoughts and feelings about their Black clients influenced their way of being with these clients. Further, the cognitive and emotional impact of client race on way of being maps onto the therapeutic relationship and technique levels as well.

Third, regarding the therapeutic relationship, participants described a rupture and repair process focused on retaining their Black clients after committing a

microaggression. Some also mentioned the referral source as exacerbating or ameliorating the likelihood of a rupture or lack of trust in the therapeutic relationship. Next, on the level of technique, client race impacts way of being by influencing how clinicians bring race explicitly into the therapy by addressing it or not. Further, in a few cases, participants stated that they did not feel that their way of being was different with Black clients but also shared contradictory accounts within their descriptions of their way of being and its extension through their therapeutic relationships and techniques. Finally, results regarding the impact of agency support around racial bias and way of being showed how participants navigated their experiences with race and Black clients within the agencies where they worked.

In discussing these results, pseudonyms were assigned to each participant to allow for quotes and paraphrased narratives to be shared anonymously without revealing the identities of the participants. Context will be provided where possible, with the ultimate goal of maintaining participant anonymity.

Way of Being, Social Identity of the White Clinician, and Use-of-Self

Participants in this study were asked a variety of questions about their way of being to examine their awareness and articulation of it through their lived experience. The theme emerged that clinician way of being is generally framed as highly related to use-of-self, which is conceptualized as the clinician incorporating their identity, emotions, and thoughts into their approach to therapy through the process of honest self-reflection (Aponte, et al., 2009). This included openness and genuineness, enacting one's values, and employing a humanistic approach. In support of this theme, almost all participants used the words "open" and/or "genuine" in describing their way of being.

Other participants used words including "authenticity", "realness", "transparency", and "being myself." The theme of being themselves and enacting their values arose frequently, like this participant who described themselves as humanistic and maternal: "Supportive. Warm. Accepting. All of those Rogerian values. Probably a little bit maternal… Sometimes I play the role of coach, I think." (Ella). Another participant shared how she sees herself and hopes to be perceived: "Easy, good humored, a bit challenging as in I challenge [clients]… fun to work with, enjoyable. I always feel like myself with the client, with rare exceptions. I don't take stances [laughter]." (Holly). This level of genuineness was reflected universally in the data when clinician way of being was explored in general terms. As one participant put it, they are "professional but relaxed, like 'Hi, I'm a human' [laughter]" (Jen). These participants all used language that centered their selves, to define how they see their way of being generally with their clients. Thus, the lived experience of clinician way of being for participants in this study was one where they feel like themselves, they feel open and genuine, and they feel connected to their values and uniqueness as people.

As mentioned above, self-of-the-therapist and use-of-self were prevalent in participant descriptions of their way of being. The theme of self-of-the-therapist or use-of-self emerged many times surrounding clinician way of being, across the vast majority of the participants in this study. For instance, multiple participants referenced how some part of their identity (gender, religious affiliation, able-bodiedness, etc.) came up in their way of being and how they dealt with that (i.e., Brynn, Dee, Ginette, Sam). Specifically, one participant talked about how her disability makes some clients want to take care of her, and within her way of being with clients she must navigate letting them help her in

some ways while also letting them know she can still occupy the caregiving role of therapist (Sam). Another participant shared that their own experience of historical trauma and cultural revolution helped them to empathize with and be curious about the experience of Black clients as people (Brynn). In general, participants seemed to share parts of their identities and social locations that they also valued and brought into their way of being in a conscious way, hoping that clients perceived these parts of them as well.

An additional piece of use-of-self is how clinicians incorporate their own thoughts and feelings into their therapeutic approach and relationship with clients. In the next section, participant narratives about their emotions with regards to client race shaped their use-of-self as an aspect of their way of being.

Race of the Client in Interaction with Way of Being

Another theme that emerged was that the race of the client interacted with clinician way of being on multiple levels, including the emotional, cognitive, and behavioral levels. The emotional level encompassed participants' articulations about their emotions regarding race and way of being, including emotional reactions which come from their personal experiences and social locations which shaped the participants' attitudes and beliefs about client race. The cognitive level contained thoughts including assumptions about Black clients and perceptions of Black clients' behavior and motives.

Emotional Narratives About Client Race Influencing Way of Being

As mentioned above, the theme of use-of-self which appeared in general descriptions of clinician way of being also appeared as participants referenced their own personal feelings about the client's race through their own experiences within their social

location and whiteness, and talked about how they navigated those personal feelings with respect to their way of being with Black clients.

Participants' interviews were rich with emotion about Black clients. Some examples include the following: nervousness or anxiety about offending them (Alex, Brynn, Ella, Linda, Rachel), or pride about being able to help them (Olivia, Rachel), or anger and sadness about what Black people have been through in this country (Fae). The majority of those who discussed emotions discussed feeling numerous complex emotional experiences, such as feeling both anxiety about offending someone and empathy for their minority experience (Ella). One participant only shared the emotion of pride, which is actually a cognitive appraisal − namely feeling proud of themselves for doing good work with Black clients and being appreciated by them (Quinn). About a third of the participants discussed only the challenging emotional responses that they had, such as frustration (Alex, Linda), white guilt or shame about being white and having privilege (Alex, Rachel), anxiety (Linda, Meg, Penelope), emotional discomfort (Alex, Nelly), sadness about what Black clients have been through and that they are overrepresented in the participant's mental health setting (Nelly), and some helplessness and hopelessness at times (Penelope). Interestingly, three participants had a hard time connecting to their emotions or coming up with examples of their emotional responses to clients (Ingrid, Linda, Quinn) and two clients struggled to conjure any memories of emotional reactions that they tended to have when working with Black clients across the whole of their career experience (Brynn and Holly).

Importantly, participants' narratives about their emotions about client race gave insight into how they formed and maintained their attitudes and beliefs towards race

which underlie their way of being with their Black clients. In this way, participants'

emotional experiences with race in their personal lives and with clients seem to have

influenced their way of being with their Black clients. For example, one participant

shared that they grew up in a place outside the US where they were the racial minority.

They talked about how this has made them feel confused about racism and how

understanding of racism doesn't come naturally to them. Additionally, they talked about

feeling eager to be in relationships with Black people, but also concerned that they would

appear overzealous and deter new clients from becoming comfortable (Dee). A different

participant discussed how their own personal experience of a historical cultural trauma

helped them to approach Black clients, who have a different type of trauma but can relate

because they have their own historical trauma (Brynn).

More explicitly, some participants noticed how their emotions towards their

clients stemmed from their social position and identities and shared about how this

impacted their way of being with their Black clients. Four participants discussed

navigating their own identity and positionality so as to properly join with Black clients

and facilitate client agency without making assumptions or taking up too much space in

the therapy (Ingrid, Meg, Olivia, Sam). In particular, one participant stated their mission

to do this very clearly:

> "I try to show up in the world in a way that's as kind of loving and compassionate
> as I can. Um, I really buy into this perspective that all I have is the present… how
> do I make space for what's here, not overly cling to anything that's here, but
> really notice my opportunity to live in accordance with my values. And so for me,
> those values tend to be things like kindness, compassion, love, safety,
> vulnerability… I try to be as humble as I can be… it is very important for me to
> show up in a way that is willing to take responsibility when I'm wrong, and own
> that, not deflect it, and work on it." (Ingrid).

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This quote shows the clinician embracing the work of continuously developing an authentic, humble and genuine relationship with clients through their way of being, including taking accountability for hurt they may have caused. Yet another participant mentioned how they use racially aware joining with their Black clients such as refraining from referring to certain music or fashion trends to try to bond with the clients, because they felt like, as a white person, that is not their culture to speak about (Meg). More complicatedly, one participant expressed anger and sadness about Black people's experience of racial trauma but reported feeling comfortable, curious, grateful and joyful about working with Black clients and doing social justice work external to the clinical sphere as well (Fae). In their position as a clinical teacher and supervisor, they use these emotions and values to educate students on dealing with race with their Black and non-white clients (Fae).

Numerous participants also shared how they navigated challenging emotions in experiences with Black clients. In contrast to feeling eager, competent, and excited, these participants shared that they felt some apprehension or anxiety around race, not necessarily acknowledging the impact of this on their way of being in any particular way but just noting its presence (Alex, Ella, Nelly). Another participant shared feeling shame and embarrassment over committing a microaggression which required a repairing conversation (Olivia); this will be discussed in greater detail in a future section, but indicates a difficult emotional experience of navigating race within way of being and the therapeutic relationship.

In summation, these narratives show how participants incorporate their emotional responses to race in pivotal past personal moments, as well as more recent experiences

with clients, into their attitudes and beliefs about client race and how this also impacts their way of being.

The Named Impact of Whiteness on Way of Being with Black Clients. No one stated that whiteness does not impact their way of being. Many participants explained how they saw their white identity impacting their way of being with Black clients (Brynn, Dee, Ingrid, Kelsey, Linda, Meg, Nelly, Olivia). To start, without acknowledging whiteness specifically, numerous participants said that they felt that white clinicians should approach Black clients with caution, hesitancy, and less of a challenging stance (Ella, Linda, Rachel). Other participants did acknowledge the impact of whiteness more explicitly. For example, Fae reported feeling curious and joyful as a white clinician getting to create space and work together with Black clients, by addressing their whiteness and inviting honest and direct feedback from clients. Another participant, Dee, expressed feeling confused by whiteness because, growing up abroad, whiteness did not have the same implications as it does in the US. On a different note, a question was raised by a few participants in acknowledging the impact of whiteness: can the white clinician define success (Linda, Meg, Nelly) and take credit for it (Meg, Olivia) when working with Black clients? One of these participants, Linda, stated that she wondered if Black clients should work with white therapists at all due to the impact of white supremacy on Black people, saying that she understood that she, as a white clinician, represented oppression and may therefore have been harmful to the client in her presence alone. Another of these participants, Meg, shared that they did not have the bodily experience of racial oppression and were careful not to assume that they understand what the Black client experiences and feels. They also reported feeling upset when clients attempted to

bond with them by putting down or devaluing other Black people or aspects of Black culture, which they interpreted as their Black clients responding to their whiteness. In sum, these narratives represent varying emotional responses to how participants felt that whiteness showed up in session and influenced how they navigate whiteness in their way of being with Black clients.

Assumptions about Black Clients and Perceptions of their Experience

Participants also shared thoughts they had as they explained their way of being with Black clients. Taking into account the fact that articulating emotions in words is actually using thoughts to label emotions, the thoughts discussed here in this section encompass the following: assumptions that participants made about race in general and their Black clients, thoughts about how participants interpreted their Black clients' experience of treatment, and participant thoughts about their interpretations of their Black clients' perceptions of them as clinicians. Generally, on the cognitive level, client race impacted way of being via the thoughts that participants had about Black clients themselves, their treatment experience, and their Black clients' perceptions of them as clinicians.

One category was assumptions about Black people in general and Black clients' experience of mental health treatment broadly and also with them as clinicians. For instance, some participants mentioned Black people's resistance to, distrust of, and stigma about mental health treatment within their community (Candace, Jen, Rachel). One participant assumed that their Black clients may feel inferior to them (Candace), and another participant mentioned Black clients seeing therapists as "the white therapist in the big office" (Fae). Another participant shared that their Black clients would not be in the

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mental health system if they were white and behaving similarly to the behaviors that got them referred to treatment (Rachel). In contrast, one participant spoke about challenging her assumptions about Black people as part of her way of being (Ginette). This participant talked about a learning experience where she worked with a woman who appeared to be white but was actually multi-racial, and how she worked to be open, research the clients' culture, and ask questions. Importantly, many participants discussed Black clients as non-monolithic in their acknowledgement of race having an impact on way of being (i.e., Brynn, Jen, Penelope, Meg). Some, like Brynn, stressed the importance of getting to know each client as an individual regardless of race and probing their multitude of unique human experiences including and apart from race.

In addition, clinician way of being was also impacted by thoughts about how the client perceived the therapist, most of which were concentrated within the context of the therapeutic relationship. For example, one participant said,

> "I think I'm very, pretty transparent as a person… I think I work best, like I can go be challenging but I can only do that if they also feel that my commitment to them, my affection for them, my caring for them. I think I use a lot of humor in my sessions…" (Kelsey).

This participant described being themselves, how they felt they portrayed themselves to the client, and their use of particular approaches like challenging and humor which fit with their personality. They also imagined that the client perceived them as committed to the client. Another participant described her openness to receiving people as they are, and recognized the potential for her own projections or assumptions to take over. She said, "I'm present and open and validating of clients, I hear them for who they are, not some projection I would have of them." (Brynn). Other participants also mentioned this phenomenon of "hearing them for who they are" using the term "meeting

them where they are" (for ex., Ginette). Though this type of statement could be distilled to openness, curiosity, patience, and respect, these participants added the dimension of considering the client's perceptions of them as clinicians, hoping that the clients see them in the ways that they are trying to be.

In interpreting the client's perceptions of them as clinicians, participants focused on whether they perceived that their Black clients trusted them. Some participants talked about their involvement with the civil rights movement and how that translates to them feeling camaraderie and empathy with Black clients, though they did not speculate if clients feel that as well (Brynn and Fae). Another participant shared their feelings of closeness towards Black people in general but added that they did not know if Black clients returned that warmth and applied a tempered approach due to this lack of perceived trust (Dee). Interestingly, one participant described the idea of "borrowed trust," talking about their experience growing up in a segregated area, in comparison with their partner who grew up in a Black community (Kelsey). Though Kelsey and their partner are both white people, Kelsey reported noticing that they each have a different visceral experience and comfort level around Black people. Further, Kelsey described their partner as having "a total at-ease-ness" which they did not have. Because Kelsey's entire caseload is comprised of direct referrals, they reported that this lack of "total at-ease-ness" translated into their way of being with Black clients as a sense of respectful slower pacing built on what they called "borrowed trust" due to being directly referred but still wanting to build authentic trust slowly. Adding to the importance of trust, of the participants who stated that race impacts how they view their success with their Black clients, the main theme was the presence of trust and respect in the therapeutic

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relationship, specifically the white clinician perceiving that the Black client felt trusting of and respected by the white clinician (Fae, Linda, Penelope, Quinn). One participant exemplified this, saying, "a marker of success is when minority folks of any kind, that could be gender or sexual orientation included, feel comfortable talking about their minority status with me" (Fae), thus encompassing the importance of white clinicians perceiving that their Black clients trust them and behaving in order to gain that trust.

In summation, participants described their thoughts and emotions about their Black clients and their work with them as impactful on their way of being. Participants addressed their emotional reactions to Black clients and explained how these influenced their way of being, and similarly shared how their cognitions about their clients and their perceptions of how their clients perceive them also influenced their way of being with those clients.

Way of Being Impacts the Therapeutic Relationship

The interaction of client race on white clinicians' way of being with Black clients extended to the therapeutic relationships that white clinicians built and maintained with Black clients. In particular, how white clinicians negotiated whiteness and race within their way of being influenced the trajectory of the therapeutic relationship, specifically how they went about building trust (as discussed above), and how they navigated the rupture and repair process. The referral source also arose as another important aspect that participants considered as they navigated race with Black clients, namely whether those clients were mandated or voluntary, or if they were placed, directly referred, or chose this clinician.

Participants evidenced their navigation of race in their way of being with their Black clients as they discussed the process of rupture and repair with these clients. Most notably, some participants articulated how they displayed ignorance or racial bias, which prevented them from enacting their ideal way of being and created a rupture with the client. They then spoke to the repair process that they engaged with to heal the wound with the client (Ingrid, Sam, Olivia). For instance, Sam shared about how she went from unaware to being able to address her ignorance with her client, and how she adjusted her way of being which helped the therapeutic relationship to develop. More specifically, Sam talked about how she was open and genuine in her way of being but was also ignorant to the spiritual language a Black client was using and how important this was to understand the client as a person. Sam realized that she had a deficit, and asked about the meaning of this language, taking an intentionally humble position and giving the client the opportunity to inform her. Sam shared that the client teaching her was a very powerful experience for her as a person and clinician and that this was an opportunity for Sam to adjust her way of being to include a stance of not knowing, and in turn build up the therapeutic relationship by creating space for humility towards and appreciation of the client. In future interactions they were able to build more trust and worked together for many years.

Other participants shared more serious ruptures, including Olivia who was mentioned earlier for this vignette. Olivia shared that she said something inherently racially biased, visibly hurting her Black clients' feelings and creating a rupture in the therapeutic relationship. Despite feeling ashamed, Olivia shared this experience in supervision and received feedback which she then implemented, to apologize to the client

and invite the client's opinions about what could be done to repair the rupture. Addressing it with the client ultimately furthered the therapeutic relationship due to the client's appreciation of the apology and openness to forgiving Olivia. In negative cases, participants wondered if their difficulties bonding with and maintaining therapeutic relationships with Black clients was due to something they were not aware of, suggesting that it could be their own racial bias or a mishandling of race (Alex, Quinn). For instance, Alex talked about how they felt "resistance" from one client early in treatment (Alex's term) and then the client dropped out of therapy unexpectedly. Alex stated that they were unsure if they could have handled racial differences better in the few sessions they had with this client before they stopped attending therapy. Another participant (Quinn) also shared that they had difficulty retaining clients of color specifically, even though they shared using practices they felt were culturally competent. Overall, participants reflected on how they handled what they felt may be racially charged ruptures in the therapeutic relationship, as part of their commentary on their enactment of way of being, showing how their way of being influences their therapeutic relationship maintenance.

Participants also seemed to perceive that the referral source could exacerbate or ameliorate the likelihood of a rupture in the therapeutic relationship with Black clients. For those who worked with voluntary clients, which tended to be in non-profit or private practice treatment settings, participants tended to feel that choosing the clinician or receiving a direct referral aided in building trust, maintaining the therapeutic relationship, and repairing ruptures. To start the process of building the therapeutic relationship, some of these participants felt that receiving direct referrals facilitated the client's openness, investment, and willingness to trust the therapist because these clients are referred by

people they trust (Dee, Kelsey). Kelsey was mentioned above with her idea about how a direct referral facilitated "borrowed trust" which she could then earn. Numerous of these participants such as Brynn, Dee, Ella and Holly commented that they felt that they did not receive many direct referrals of Black clients and wondered if this was because their whiteness may deter Black clients, or because their referral systems were generally not composed of Black people, or some other reason. By contrast, participants who work in community mental health settings and the VA, where treatment was involuntary (mandated) and/or clients were typically randomly placed with clinicians without a choice, mentioned having a harder time with joining (Candace, Meg, Quinn, Rachel). These participants cited the lack of choice and autonomy that clients had over the process and how they sometimes felt that this led them to starting the therapy in a deficit of trust. However, some of these participants, such as Candace, shared that in these settings they still feel capable of joining with and providing good therapy to their Black clients. Others, such as Quinn, noted that they sometimes struggle with retaining their Black clients for the full recommended course of treatment but did not explicitly name a therapeutic relationship rupture or the referral source as a reason for this attrition.

Technique: How Clinicians Address Client Race Explicitly with Black Clients

Finally, the impact of client race on clinician way of being was shown through participant accounts of adjustments in behavioral approaches that they make when working with Black clients, particularly addressing race with Black clients. Interestingly, participants often answered interview questions about their way of being by instead talking about the technique of addressing race with Black clients to demonstrate something about their way of being. Furthermore, participants spoke about how they

intentionally used their thoughts and feelings (discussed earlier) to think about the therapeutic relationship and trust (discussed earlier) *and* to frame how they addressed race with their Black clients. More specifically regarding addressing race, participants shared about whether and how they do this, with or without considering the therapeutic relationship. They also shared how they created space for particular client emotions, were aware of their own guilt and varying levels of confrontational approaches, how they guarded against the client being the race expert, and how they balanced their own anxiety with their desire to be respectful to Black clients.

Generally, most participants stated that they address race first rather than waiting for their clients to bring it up (Fae, Ingrid, Jen, Kelsey, Linda, Meg, Penelope, Quinn, and Sam). Yet, multiple participants said that they sometimes address it first and sometimes wait for their clients to address it (Holly, Jen, Nelly, Olivia, Quinn, Rachel, Sam). Other participants stated that their clients hadn't brought anything about race up to them and so they hadn't either (Alex, Brynn, Candace). As in other sections of the data, some participants made contradictory statements, saying for example that they always bring it up first but also talking about times when they waited for a client to do so (Jen and Quinn). All the participants whose tactic on addressing race was to do so vaguely if at all, also stated that they commonly felt a degree of anxiety or discomfort with their Black clients (Alex, Brynn, Dee, Ella, and Ginette). A few participants said that they wait for clients to bring up race, knowing that race could be a factor for Black clients but not wanting to push their own agenda as white clinicians or offend their client (Alex, Candace, Linda, and Olivia). In their considerations about whether and when to bring up race, some participants talked about addressing race with clients and leaning on the

trusting and strong therapeutic relationship to do so once it has been established (Fae),
while others appraised the relationship as part of their decision about whether and when
to address race (Kelsey).

One way that participants' way of being extended to their technique of addressing
race was how they stated that they wanted to create space for client emotions in how they
addressed race. Participants who stated that they addressed race first said that they did so
to create safety and space so the client knew they could talk about race with them (Fae,
Ingrid, Jen). Some did this specifically by asking if the client had concerns with having a
white therapist (Penelope). One participant shared that they typically brought up race to
let Black clients know that they did not have the experiences of oppression that the
clients did as a way to invite them to share their experiences of oppression with the
clinician (Quinn). One participant acknowledged that if they didn't bring up race, the
clients may or may not bring it up, but it could still be impacting them even if they didn't
feel safe to address it; by putting it out there, this participant was attempting to "attune"
and "invite them in" (Fae). With making space for a particular client emotion or
presentation, another participant shared how their values about a racial stereotype led
them to address race by creating space for their female Black clients' anger in therapy.
They said, "I'm really passionately anti- the angry Black woman stereotype, so I want to
make a lot of space for my Black female clients to be angry in the room" (Ingrid). This
clinician actively rejected the "angry Black woman" stereotype and intentionally
attempted to create more emotional space for Black female clients to be angry as a result.

In addition to creating space, some participants grappled with their feelings
around directness or confrontation with their Black clients, some of which were related to

guilt. For example, Rachel discussed how their guilt about being white and having privilege influenced their difficulty being as confrontational with Black clients as they would with white clients. Another participant noted that she uses caution when bringing up race, but also said that she is very direct with clients and especially clients of color. When I asked her for clarification, she stated that the trust in the relationship with the Black client is what allows her to move from a cautious way of being to a more directive one (Penelope). Another participant (Candace) shared that they feel nervous to push their Black clients and may need to "dumb myself down… to make myself more approachable" to combat their clients' hesitancy to engage within the mental health system. Here, the emotion and thought are accompanied by an active use of those thoughts and feelings by dumbing themselves down to attain the desired outcome of the client feeling more comfortable.

Another subtheme was how participants enacted their way of being by attempting to guard against the client being the race expert, by incorporating cultural humility or acknowledging their own positionality. For instance, one participant talked about how they took care not to center themselves in conversations about race, so that their clients did not have the burden of helping the participant with their feelings about race, which the participant believed was not the client's job (Rachel). Other participants talked about their personal therapy, learning, and/or introspection around race and cultural humility as they acknowledged the impact of race on their way of being (Brynn, Ginette, Jen, Meg, Penelope). One participant put it simply:

> "For me, right now, it's very much about, um… being aware and asking myself the tough questions, and knowing, just recognizing what processes are going on within myself, and then being open to the experiences of others…

continuing to be open about wanting to talk about um, issues specific to race"
(Penelope).

This quote shows a participant actively thinking through how they wanted to work with their own thoughts and feelings by asking "tough questions" to continuously remain open to talking about race. This is a connection between participants' use-of-self in their way of being and its translation into how they address race with their Black clients.

As a final aspect of how client race and way of being were implicated in the technique of addressing race, participants shared about anxiety and the desire to respect Black clients. For example, some participants mentioned waiting for the client to bring race up because they thought it would be respectful to not assume that it is relevant for the client (Alex, Candace, Linda, Olivia). Another piece of respect and anxiety, one of these participants observed that they felt very upset when they heard Black clients making comments that showed internalized racism, because this meant that they could not have up-front and direct conversations about race with these clients (Linda). This participant felt stuck because they did not want to, in their words, "start lecturing them about Blackness" because they knew they only experienced racism intellectually and not in their embodied awareness. Similarly, another participant said that race impacted how they joined with Black clients on cultural factors. They specifically mentioned not wanting to refer to things that are specific to Black culture because they were aware of cultural appropriation and did not want to be complicit in that appropriation (Meg).

Contradictions within Interviews Regarding the Impact of Race on Way of Being, the Therapeutic Relationship and Technique

For the most part, participants stated that race impacted their way of being, and there were many excerpts to that effect. All but Alex, Brynn, and Quinn said that race impacted their way of being. Only Quinn did not directly acknowledge the impact of race on their way of being, though they did discuss things that they would think about or say to a Black client that would not be relevant with a white client, such as not having the experience of being racially profiled like them. Some participants stated that their way of being is the same with clients of all races (Brynn, Candace, Holly, Olivia). Upon further analysis, there were no true negative cases due to the fact that all participants who said that race did not impact their way of being also said at another time that it did in some way. This contradiction did not coincide with any demographic factors such as age, experience, or treatment setting.

For example, one participant stated that, while race is a factor in how they relate to their clients because they acknowledge historical racial trauma, race is not a factor for them because they work with people as they are, in all their unique attributes and experiences including but not limited to racial identity (Brynn). This participant noted that race is not weighted more heavily as one of the intersectional aspects of the client that they consider when developing and maintaining the therapeutic relationship.

A different participant stated all of the following things: it would be naive to think that race does not impact anything; they did not feel race was a barrier; they did not think clients felt inferior to them; and they did not think it actively played a role but if it did then the client had not ever given them that feedback (Candace). In this example, the participant stated that racial difference existed but did not acknowledge the probable impact of this difference on the client's experience and therefore did not think they

should adjust their way of being. They made some suggestions as to what the client might think and feel about race but did not fully acknowledge that there could have been an impact on the client. At another point in the interview, though, this participant spoke to specific things that they did to accommodate their Black clients' potential feelings, thereby acknowledging a difference.

Some participants were not quite contradictory but did struggle to articulate if and how they felt race impacted their way of being. For instance, one participant stated that they did not notice a difference in their case conceptualization or way of being with a non-white client, but then said that they want to think more about how cultural norms impact their client's presentation and how this should change their way of being with this client (Linda). A few participants talked about having a similar way of being with white and Black clients yet having different feelings like anxiety or pre-session nerves (Meg, Linda) or hesitancy (Alex) or caution (Ella), with some also saying that they approached these moments differently by being more careful or building up trust before using challenging interventions (Penelope). Overall, all participants acknowledged some differences in their way of being, therapeutic relationship, or techniques they use with Black clients, even if they also said that they did not see a difference in their way of being with Black clients at the beginning of the interview.

Agency Support with Racial Aspects of *Way of Being*

A final theme that emerged was that clinician way of being is impacted by the level of support that a white clinician perceives from their place of work to explore and address their racial bias. This study asked if participants felt they had support from their agencies/practices, what that support was, and if they felt they needed anything else from

their agency. Some participants reported that they felt like they had support and others felt like they did not have support. Of those that have support, some reported that they did not use the support they had, but they knew it would be there if they needed it in the form of a supervisor or someone to answer their questions if they had any (Alex, Candace, Ginette). Others stated that they had support and used what they had (Ingrid, Jen, Nelly, Olivia, Penelope, Rachel, Sam). Their support came in the form of reading groups, supervision groups, and task forces. Having support seemed to help these participants to feel more confident in their work with Black clients, or at least to have somewhere to turn when they felt they needed advice. A few of these participants, and a few of those who reported that they do not have support, stated that they knew what additional forms of support they needed (Fae, Jen, Linda, Meg, Quinn). Of these participants, some have not sought support, while some have sought support and been denied by authority figures within the organization (Fae, Quinn). Finally, there were some participants who stated that they did not have support from their agency to deal with anything regarding race (Fae, Holly, Linda, Penelope, Quinn).

Additionally, participants named emotional and other consequences of having or not having agency support. For instance, participants stated that they felt frustrated and upset at times (Fae, Linda, Quinn). Multiple participants shared that they were not transparent with their agency about what they are doing in sessions because they have had to privately modify the oppressive organizational requirements such as the therapeutic model, interventions, and documentation content to address the needs of their Black clients (pseudonyms withheld). These participants commented on how the reimbursement structure in mental health systems is focused on behavior-based

interventions, and how as a clinician they were complicit in this system which forces compliance to treatment standards rather than true healing. This was directly at odds with how they each described their personal way of being of openness, flexibility, and non-objectification, and they reported that this discrepancy caused them significant distress. Another participant wondered out loud about whether it was their agency that was not "doing the right thing" and not providing enough support, or if they personally were not "asking the right questions" or reaching out in the right ways to get support (Meg). This seemed to further reinforce the confusion they had been expressing earlier in the interview about how to manage their acknowledged racial bias within their way of being and subsequent practice of therapy.

Overall, participants who knew that they needed agency support stated that they needed a few main things, including some form of assistance to help them identify and work through biases, as well as an organizational structure that recognizes and combats white supremacy on the institutional level. Participants who did not feel they had that support expressed distress because of it, while those who felt they did have support seemed generally content.

Chapter 5: Discussion

Race-based social inequality justifies the need for quality, just mental healthcare for Black Americans. Due in part to the dearth of Black clinicians available (APA, 2017) it is important to understand how interracial therapist-client dyads function. Though common factors and cultural competence frameworks highlight the importance of the therapeutic relationship in all models of therapeutic services (Martin, Garske, & Davis, 2000; Chu, et al., 2016), they do not acknowledge the inherent bias towards white supremacy that all white people, and therefore white clinicians, hold according to critical whiteness theory (Olcon, Gilbert, & Pulliam, 2019). This study invoked the construct of clinician way of being, which is the clinicians' conscious attitudes and beliefs towards the client and the root of the therapeutic relationship (Fife, et al., 2014) to explore how white clinicians grapple with and negotiate their racial bias consciously within their way of being with their Black clients.

Although this study was conceptualized in 2019, as this dissertation study was being conducted, the US was experiencing social unrest and a reckoning with white supremacy due to widespread police brutality and health disparities related to the COVID-19 pandemic (Lund, 2020). This social movement highlighted the need to address the existing research gap on the impact of white supremacy and racial bias on white clinicians' delivery of mental health services to Black clients. Further support for looking specifically at how white clinicians consciously navigate their racial bias in the therapeutic relationship with Black clients comes from the piece of the cultural

competence framework which states that cultural competence works because it allows the

client to feel known and empowered (Chu et al., 2016). To the contrary, Fife and

colleagues (2014) propose that clients can tell when clinicians hold judgment toward

them, stating that judgement is a form of objectification and hinders the therapeutic

relationship. Research on interracial therapist-client dyads supports this notion that

clients are negatively impacted by clinicians' unacknowledged biases, as well as

inflexible use of cultural competency frameworks (Chang & Berk, 2009). Therefore,

again, understanding the link between white clinicians' inherent racial bias associated

with their complicitness with white supremacy (Olcon, Gilbert, & Pulliam, 2019), and

how they consciously negotiate this in their way of being and forging therapeutic

relationships with Black clients, is paramount to understanding how interracial therapist-

client dyads function at this time of social reckoning.

To address this gap, the current study examined how white clinicians articulate

the impact of client race on their way of being in the context of treating Black clients.

Using semi-structured interviews, this phenomenological approach explored the lived

experience of key informants who were licensed clinicians working in community-based

treatment settings, community mental health, child welfare, the VA, non-profits, and

private practices (N=19). Content analysis of verbatim transcripts suggests that clinicians

understand and define their way of being in humanistic terms. It revealed the importance

of "use-of-self" defined as incorporating one's own feelings and life experiences within

one's intersectional identities and social locations (Aponte, et al., 2009), and the

importance of participants' emotional narratives of their prior experiences with race, as

two ways that race influences their way of being with Black clients. Another initial

finding was that clinician way of being is foundational to the therapeutic relationship, which then extends to the models and techniques utilized. Deepening this finding, the white clinicians interviewed reflected that client race impacts their way of being, therapeutic relationship, and techniques with Black clients, on a continuum oriented from ignoring race in the relationship altogether, to directly referencing the impact of race on the treatment relationship and techniques. Taken together, findings of this study highlight the need for further research on the implications of client race and whiteness on white clinicians' way of being and therapeutic relationships with Black and other non-white clients. The study offers insights into the necessity for white clinicians to develop personal awareness of their racial bias and skills for navigating it clinically within their way of being with Black clients.

In this chapter, two main findings address the gap of understanding how whiteness and conscious racial bias are negotiated within clinicians' way of being with Black clients. First, although way of being as written (Fife, et al., 2014) does not specifically include race, analysis revealed that whiteness is implicated within way of being through white clinicians' expressed emotions, behaviors, and thoughts, which white clinicians use to navigate their way of being with Black clients. I propose that, to address the conceptual gap in how racial bias impacts way of being, whiteness must be acknowledged as an influential factor in the conscious enactment of way of being, expanding its existing emphasis on "use-of-self" to include examination of the power and privilege of whiteness and its inherent racial bias, and the conscious excavation of and reckoning with that bias by the white clinician. Second, a continuum of clinician way of being emerged from the data where two distinct typologies, Hollow and Integrated, exist

at each end. Many participants did not fit into one typology but instead exhibited

emotions and thoughts which indicated partial acknowledgement and grappling with how

their conscious racial bias influenced their way of being. This suggested a continuum of

developing adaptation to racial bias and its impact on way of being, ranging from an

expressed dismissal of the impact of whiteness and the need to adapt to working with

Black clients on the Hollow end, to fully aware of potential impacts of whiteness within

the treatment and actively navigating it within way of being with Black clients on the

Integrated end.

Whiteness Within White Clinician Way of Being: Use-of-Self & Emotions

In this exploratory study, participants shared how they navigated race with their

Black clients on the level of thoughts and emotions. Thoughts and emotions are

conscious, but could indicate unconscious or implicit bias (Staats, 2013). As discussed in

the epistemological discussion within Chapter 3 (Methods), this study did not attempt to

discover implicit bias, but instead analyzed participant explanations of their thoughts and

feelings about their biases towards their clients and navigations of their own race and the

clients' race as they enacted their way of being. Operating from the critical whiteness

understanding that all white people carry implicit racial bias as a part of their existence

within a white supremacist system (Olcon, Gilbert, & Pulliam, 2019), this study did not

seek to problematize the existence of any racial bias. Instead, this study sought to

delineate how white clinicians acknowledge their own biases through narratives about

their experience, and work with them as they enact their conscious way of being with

their Black clients.

With that understanding, the thoughts and feelings that participants described provided insight into how white clinicians experience themselves cultivating their way of being and navigating race as a part of that conscious process. This study found that whiteness did influence way of being with Black clients, through the white clinicians' thoughts and feelings ranging from dismissal of race altogether, to discomfort and confusion around race, to curiosity and invitations to work directly with race within their way of being. This extended to how white clinicians navigated race within the therapeutic relationship and techniques as well, as proposed by the TPM and depicted visually in Figure 1 below.
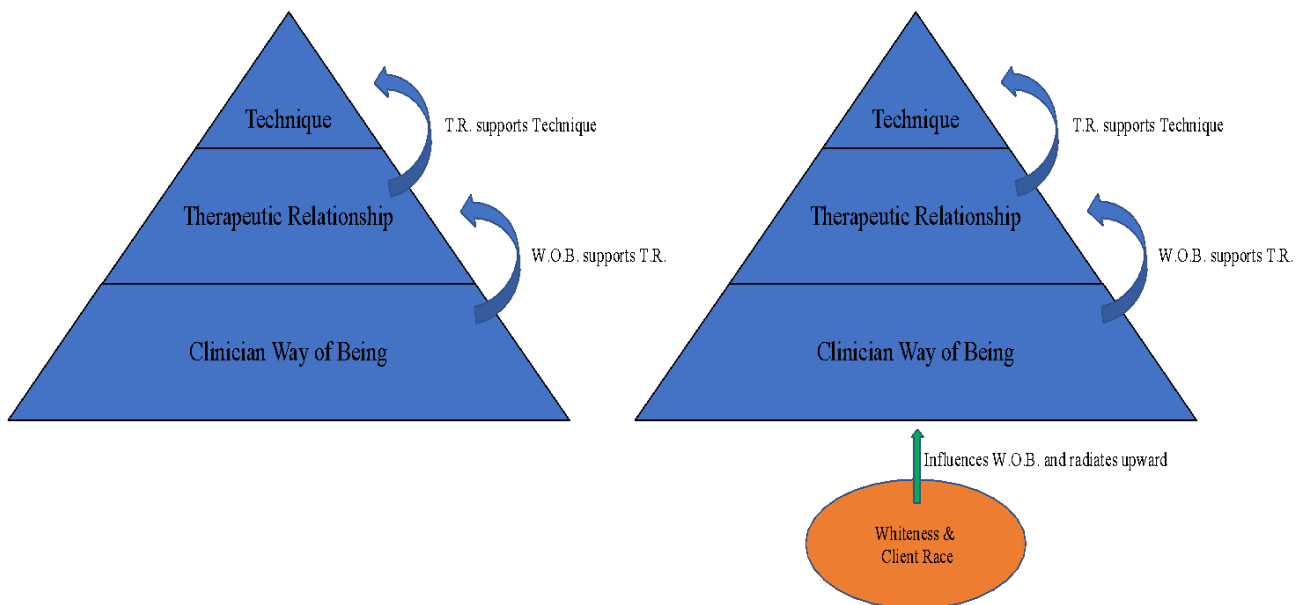
Figure 1. The Two Therapeutic Pyramids

In Figure 1, the pyramid on the left depicts Fife and colleagues' (2014) conceptualization of clinician way of being and its relationship to the therapeutic relationship and the models and techniques a clinician employs. The pyramid on the right shows the influence of whiteness and client race as a foundational influence on clinician way of being, which then radiates through the therapeutic relationship and techniques by

extension. This acknowledgement of the impact of the interaction between clinicians'

navigations of whiteness with their reactions to the client race and their way of being, is a

new contribution to the construct of clinician way of being and the TPM more broadly.

Use-of-Self & Emotions as Part of Clinician Way of Being

Clinician way of being is understood as the conscious attitudes and behaviors that

a clinician has and expresses towards their client, with the aim of being nonjudgmental,

open, genuine, and non-objectifying (Fife, et al., 2014). More specifically, Fife and

colleagues define way of being as follows:

> "Way of being refers to the in-the-moment attitude that therapists have toward
> clients and provides a foundation for the therapeutic alliance. This attitude can be
> genuine and open to the humanity of the client, or it can be a stance that is
> impersonal and objectifying. Our way of being will influence how clients
> experience us." (Fife, et al., 2014, p. 24).

The term was first used by Anderson (2006) as a description of how a therapist "conveys

to the other that they are valued as a unique human and not as a category of people; that

they have something worthy of saying and hearing that you meet them without prior

judgement" (p. 44). Fife and colleagues argue that this is conveyed through "attitude,

tone, body language, word choice, and timing" (p. 25). In direct contradiction to this,

implicit bias is bias that is "expressed automatically, without conscious awareness" which

impacts "individuals' attitudes and actions" (Staats, 2013). Though way of being is held

and delivered ideally without judgement, critical whiteness theory's statement that white

people are inherently biased toward maintaining white supremacy and are complicit in

maintaining white supremacy through their implicit investment in judgements and biases

of inferiority against non-white people, renders this impossible without thoughtful

excavation and examination of power, privilege, and bias (Abrams, 2007; Nayak, 2007;

Olcon, Gilbert, & Pullinam, 2019). Thus, this contradiction between needing to apply a nonjudgmental way of being and being a white clinician within a white supremacist system necessitates incorporating the clinician's intentional reckoning with that contradiction directly into the construct of conscious way of being. This would acknowledge the presence of whiteness and bias as a part of the process of cultivating the most effective way of being with clients of color.

As discussed, white clinicians interviewed robustly describe their way of being in humanistic terms, referring to their values and identity as clinicians with a particular emphasis on use-of-self, reflection on their own social locations and identity formation and on openness and authenticity. Participants supported this by referencing their personal experiences, therapy, and self-development as they talked about their way of being. Personal participant narratives about experiences they have had with race showed how they developed the thoughts and feelings they currently hold about client race.

The therapist's reflections on who the therapist is as a person, sometimes called use-of-self but also referred to as person-of-the-therapist (Aponte, et al., 2009), or self of the therapist (Rogers, 1957), is part of both the therapeutic relationship and clinician way of being. This kind of orientation to authenticity and use-of-self is grounded in a post-modern humanistic approach to therapy (Corey, 2005). The person-of-the-therapist encompasses the qualities of the therapist as a person, such as empathy, warmth, genuineness, and congruence (Greenberg, Elliot, & Lietaer, 1994; Rogers, 1957); flexibility, trustworthiness, confidence, interest, affirmation, openness, relaxation (Ackerman & Hilsenroth, 2003); openness, humility, kindness, mutuality, mindfulness, and lack of contrivance (Safran & Muran, 2002). These personal qualities also influence

the therapist's navigation of the relationship because the therapist strives to incorporate these qualities and enact them consciously through their way of being with clients (Fife, et al., 2014). Participant descriptions of themselves and their efforts to cultivate therapeutic relationships with these qualities illustrate participants' desire to not only reflect on their own personal traits, but how they hope to be perceived by their clients. Taken together, this data and the literature support the connection between way of being and the therapeutic relationship, through the participants' use-of-self. Interestingly, in this study, none of these qualities were associated with any variable such as the participants' educational degree, years of experience, type of therapy they practice (i.e., Cognitive Behavioral, Emotion Focused, etc.) or the treatment setting they practice in (i.e., VA, private practice, non-profit, etc.). This was a finding that was universally present within the sample.

Conceptually, use-of-self incorporates the clinician's identity, emotions, and thoughts into their approach to therapy through the process of honest self-reflection. Multiple areas of scholarship about therapy, such as self-of-the-therapist scholarship (Aponte, et al., 2009) or literature on psychodynamic countertransference (VandenBos, 2013), suggest that when clinicians experience something within them that impacts the way they feel and behave toward clients, or notice themselves projecting feelings about someone/something else onto the patient, they must explore this in their own therapy and/or supervision (Aponte, et al., 2009). The goal is to learn the signs of something unconscious and work to make it conscious so that it can be used intentionally by the therapist as part of their craft, rather than letting it blindly impact the client (Aponte, et al., 2009; VandenBos, 2013). Fife and colleagues (2014) refer to this as working on

"issues and areas of reactivity" but do not explicitly mention race or power as a part of this exploration.

Stemming from critical whiteness theory's call to excavate racial bias, and the honest self-reflection component of use-of-self, reflection on whiteness and clinician and client race is important. In this study, numerous participants shared personal narratives about experiences they had with race earlier in life that shaped the way they feel about and approach race within their way of being with their Black clients. Some of these narratives included reflection on the impact of whiteness in relationship with Black clients, while others did not. Overall, the presence of these personal narratives was remarkable because it indicated that participants had personal experiences about race and whiteness, which then impacted how they view client race. Careful, honest reflection on these experiences and how they influence clinician way of being and the therapeutic relationship is the epitome of use-of-self and was not always present in participant interviews. The missing awareness of power and privilege as an aspect of those formative racial experiences is stark in a participant population which holds power and privilege as licensed professionals who are white, among other potential intersectional identities (Whiting, Oka, & Fife, 2012). To combat the possibility of clients feeling objectified and judged, Fife and colleagues state that therapists need "a high degree of awareness of one's motives and thoughts. This type of self-responsibility is at the heart of engaging in an I-Thou manner." (2014; p. 25). From the lens of critical whiteness, with the understanding that racial bias will be present, it may be helpful to incorporate intentionally developing an awareness of racial bias into the self-of-the-therapist piece of clinician way of being explicitly (Foster, 2003). In this way, white clinicians would strive

to make unconscious bias conscious and work with it through the process they would otherwise use with the thoughts and feelings that they deem to be relevant within use-of-self, to be able to deliver a non-judgmental, non-objectifying way of being within their work with Black clients.

Just as critical whiteness theory attempts to decenter whiteness as a cultural norm (Foster, 2003), critical race theory acknowledges that non-white people have been oppressed through economic, legal, and religious systems which prevented them from engaging with the same human rights and lifestyle practices as white people, inherently stifling their authenticity (Crenshaw, Gotanda, Peller, & Thomas, 1996). Both disciplines would agree that it is a privilege to be authentic and to value authenticity in a society that is built on white supremacy; they would see white clinicians' value on authenticity as blind to the barriers that non-white clients experience which make it dangerous and/or impossible for them to be authentic in the same ways (Crenshaw, Gotanda, Peller, & Thomas, 1996). As Crenshaw and colleagues (1996) report, it has been dangerous for non-white people to break from the racist rules of society, so clinicians must be aware of this and consider that their authenticity may be causing undue stress for Black clients who are trying to determine their level of safety in therapy with this clinician. Thus, instead of presenting with an authentic and non-judgmental way of being, as Fife and colleagues (2014) suggest, critical whiteness theory would support white clinicians actively challenging their own biases, acknowledging how they enact and benefit from privileges they hold, and creating space for Black clients to be authentic in ways that are not safe outside of the therapeutic holding space due to the racist systems that exist outside of therapy; or at least acknowledge that they as the clinician have not only the

power of being the professional in the space, but also the power that they are afforded by white privilege which undergirds the approach they experience as authentic.

Though most participants did not describe their general, racially neutral way of being in a manner that could be characterized as impersonal and objectifying, when they described their way of being specifically with Black clients, there were some descriptions that included objectification due to pre-judgements about Black people or emotions resulting from their assumptions about Black people. This included responses where participants shared feeling or thinking differently about Black clients than white clients without acknowledging that this thought or emotion was related to the racial difference between the two clients. This also lends support for the conclusion that participant motivations for addressing race as part of their way of being are informed by the emotions and thoughts participants have in response to client race with their Black clients.

Contradictions

Because clinician way of being is a conscious process which is influenced by the self, including unconscious aspects like biases, some contradictions within interviews were expected. Consistent with this prediction, the main contradictory finding was that many participants stated that they did not incorporate race into their way of being with Black clients in a different way than they would for white clients, then shared ways that they did just that in other sections of the interview. Again, according to critical whiteness theory, this is a common point of internal tension for white people, which holds that white people are inherently biased toward maintaining white supremacy and must actively acknowledge and challenge that bias (Foster, 2003; Nayak, 2007). Interestingly,

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the interview question about the impact of *whiteness* on way of being, as opposed to the impact of *race* on way of being, seemed to elicit a more consistent response across participants that whiteness does impact way of being. The participants' discussions of how race impacts way of being contained more contradiction. No one stated that whiteness does not impact their way of being. Thus, when explicitly named, *whiteness* seemed to garner a more direct acknowledgement from participants than the general term of *race* did.

Further, some participants contradicted themselves by stating that race both does and does not impact their way of being. This appeared mostly in the form of colorblindness in addition to the direct contradictions mentioned earlier. Colorblindness is defined as "ignoring race, or skin color" (Jones, 1997). In contrast to critical race theory, colorblindness ignores institutional and systemic marginalization as well as personal history, and the power inherent in intersectional identities and positions people inhabit (Crenshaw, Gotanda, Peller, & Thomas, 1996). Colorblindness is antithetical to the approach suggested by critical whiteness theory, which necessitates an examination of power and privilege with respect to how each individual white person is personally responsible for maintaining racist and oppressive systems (Foster, 2003; Olcon, Gilbert, & Pulliam, 2019). Within this framing, the cultural competence lens which stresses knowledge and technique related to non-white races is insufficient and needs to instead be grounded in a critical examination of identity, position and privilege (Chu, et al., 2016; Sue, et al., 2009). Those who made contradictory statements seemed to exemplify this tension between acknowledging race in a general way, and the greater struggle to reckon with one's own identity and inherent complicity within this oppressive system.

Racial Bias Within the Therapeutic Relationship

This study found that clinician way of being also impacts the developmental trajectory of the therapeutic relationship as it is formed and maintained throughout the course of therapy, through participant descriptions of the therapeutic relationship, trust, ruptures and repairs as part of their explanations of their way of being. Just as participants referred to their thoughts and feelings about their work with Black clients when asked about their way of being, they also used the therapeutic relationship to describe their way of being with both their white and Black clients, suggesting that way of being impacts the therapeutic relationship regardless of client race.

Furthermore, participants' articulations of navigating their thoughts and feelings about race as part of their way of being with Black clients also impacted their descriptions of their therapeutic relationships with these clients. First, some participants had difficulties joining and building therapeutic relationships with Black clients because of their trepidation around race and whiteness. Second, some participants struggled to navigate their challenging feelings when receiving feedback from Black clients, though others had the opposite experience and were able to deal with these experiences successfully without internalizing painful emotions. Third, participants used the therapeutic relationship with their Black clients not only as a descriptor of their way of being, but also as an indicator of treatment success, suggesting that the therapeutic relationship is highly connected to how white clinicians think and feel about their work with their Black clients. Taken together, these results support the finding that whiteness and race influence how clinicians navigate way of being and also greatly impacts the development and maintenance of the therapeutic relationship with Black clients.

Overall, participant narratives about their therapeutic relationships suggest that participants who were willing to confront emotional discomfort and expand their thinking tend to strive to negotiate race and whiteness more intentionally and make space for the client's experience within the therapeutic relationship, even if it is uncomfortable for the clinician. This is directly congruent with how critical whiteness scholars suggest that white people engage with critical whiteness, by "critical interrogation" of their complicity within and perpetuation of white supremacy (Frankenberg, 1993; Knoetze, 2016). Incorporating the work of Fife and colleagues (2014), the I-Thou stance is one where the clinician is open to the humanity and experience of the client, their complexities, and their independence from the clinician and the clinician's perceptions of them. Fife and colleagues (2014) state that clients will perceive if clinicians are relating to them from an I-It stance and note that this could significantly damage the therapeutic relationship. The results chapter showed examples of how participants' thoughts and emotions towards Black clients sometimes detracted from their delivery of a way of being that facilitated a strong and durable therapeutic relationship. Participants shared a variety of experiences, ranging from shame and nervousness around Black clients, to embracing the diversity of experiences that their Black clients may have from their own, to feeling honored to attempt to create relationships with Black clients and taking specific care to do so in a way that makes space for the client's emotional reality rather than their own. This spectrum of emotional experiences capture how clinicians navigate their thoughts and feelings about race as they cultivate their way of being with Black clients and nurture therapeutic relationships with them.

In addition, participants shared about a range of experiences with rupture and repair with their Black clients, where the impact of race on clinician way of being could be observed expanding to influence the trajectory and durability of the therapeutic relationship. Participant data illustrates the different approaches to building and maintaining therapeutic relationships, specifically around repairing ruptures. As stated above, the critical interrogation (Knoetze, 2016) of privilege through the rupture and repair process involved participants confronting challenging feelings to address the clients' experience over their own. While some participants mentioned early terminations without addressing the health of the therapeutic relationship, others shared about repairing microaggressions that they recognized could have jeopardized the therapeutic relationship if they had not been repaired. One participant in particular shared a powerful story about overcoming shame and confronting the client directly to make the repair (Olivia). The difference here is that some participants took ownership of racially biased actions and intentionally confronted shame and emotional discomfort, a process which is supported by critical whiteness scholars (Frankenberg, 1993; Knoetze, 2016) and microaggression literature (Sue, Alsaidi, Awad, Glaeser, Calle, Mendez, 2019). The literature about rupture and repair supports the therapist actively confronting and repairing a rupture in the therapeutic alliance (Safran & Muran, 2000). Yet, instead of looking at ruptures in this context simply as alliance ruptures, the dynamics of power and race within the rupture is what makes some of these ruptures also microaggressions. Sue and colleagues define microaggressions as hurtful verbal or non-verbal interactions that non-white people have with unintentional white perpetrators (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). Sue and colleagues (2019) developed a model

for how to address microaggressions actively as opposed to letting them go without intervening. Though this article talked specifically about witnesses instead of perpetrators, these actions were employed by the participant, Olivia, who shared her story about repairing a microaggressive rupture. They include naming the invisible microaggression as such, disarming the microaggression, educating the clinician who was the perpetrator (which Olivia did via supervision), and seeking external support (Sue, Alsaidi, Awad, Glaeser, Calle, Mendez, 2019). Olivia did exactly this and was successful at regaining the client's trust, per their report, because she was able to overcome her shame in order to act in the client's best interest. In sum, the endeavor of building and maintaining durable therapeutic relationships via the rupture and repair process with Black clients was one element which differentiated white clinicians who actively incorporated race into their way of being from those who did not.

Implicit Bias Within the Technique and Models

The fact that all participants were able to discuss their way of being, regardless of their theoretical orientation or model of therapy they practice, supports Fife's (2014) notion that way of being is a foundational and universally applicable construct for clinicians practicing from any theoretical framework. In the TPM, Fife and colleagues (2014) illustrate this point by saying,

> "A cognitive therapist may approach a client with an attitude of elitism, believing that their expertise will help fix the distorted beliefs and automatic thoughts in the client. Or, they could approach their client in an open and respectful way of being, recognizing the fullness of the client and maintaining a humble, respectful approach." (p. 26).

Almost universally in this study, when asked about way of being, participants talked about their personality, values, and intentions within the therapy, rather than the specific techniques they use or the model that they most identify with, as if to confirm that the

intention and approach are more important than and foundational to how they are executed technically. This is supported by Chu and colleagues (2016) who indicate that the client feeling known and seen is paramount to the use of cultural competency frameworks or interventions.

Like the therapeutic relationship findings above, participant narratives exemplified the extension of their negotiations of race on way of being, through the therapeutic relationship, and to the technique they use to address race. Employing their thoughts and emotions about their Black clients and their clients' perceptions of them as a part of their way of being, and the additional layer of their appraisals of the therapeutic relationship, participants demonstrated that the approach to technique is multi-layered and complex. Data supported the notion that white clinicians enact techniques based on culturally competent knowledge and skills, in addition to navigating their personal emotions and thoughts about race with Black clients, especially when they address race. Revisiting the data, addressing race seemed to provoke the full spectrum of emotional reactions from participants on the topic of addressing race. In taking the interviews holistically, the participants who were more experienced at confronting difficult emotions and working through their own anxiety seemed to feel more at ease with addressing race and navigating client feedback. This data supports the undergirding of the technique of addressing race with an intentional, self-reflective way of being and durable therapeutic relationship.

The White Clinician Continuum

This chapter has so far discussed how white clinicians negotiate their race and whiteness within their way of being with Black clients. It established that clinician way

of being is foundational to the therapeutic relationship and extends to the techniques used by clinicians. Specific to race, white clinicians grapple with thoughts and emotions about whiteness and race from their own personal and professional experiences, as a part of their use-of-self and conscious enactment of their way of being with Black clients. They also negotiate whiteness with respect to the therapeutic relationship, specifically in rupture and repair, and the techniques they use. Taken together, participant interviews revealed a pattern where grappling with and negotiating race within the therapeutic relationship and techniques could be placed on a continuum. To lay out this continuum in the most respectful way possible to the participants in this study, who are still on their journey toward an anti-racist way of being, I will describe common themes within each area on the continuum rather than describe specific participants who fit into each category.

Taken as whole interviews, a continuum emerged as pictured below (Figure 2).

Figure 2. The White Clinician Continuum

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Figure 2 shows the white clinician continuum, where white clinicians on the left side are classified in the Hollow type, and white clinicians on the right side are classified in the Integrated type. The continuum is oriented toward participants' level of "critical interrogation" (Frankenberg, 1993; Knoetze, 2016) of their whiteness and its impact on

their way of being with Black clients, as evidenced by their narratives about the therapeutic relationships they have built and their descriptions of how they employ the technique of addressing race. The two ends describe a specific type of white clinician experience, and the middle describes the continuous process of grappling which does not fit into either category. White clinicians can exist at any point on this continuum and move locations at any time, consistent with anti-racist literature which states that being anti-racist is a process, not a single action or status to attain (Kendi, 2019). To that end, arrow shapes of each section of the continuum indicate the aim of working towards the direction of anti-racism. This is also in line with how critical whiteness theory discusses the constant process of reckoning with and confronting white supremacy internally and systemically that white people should go through (Foster, 2003; Nayak, 2007). Generally, as participants moved closer to the Integrated type, they seemed to have a more complex emotional experience of building therapeutic relationships with and addressing race with Black clients as they reckoned with their whiteness and the privilege it affords them, systemically and personally, and its potential impact on their clients. In some instances, participants seemed to have developed a continuous way of grappling with uncomfortable emotions and thoughts about race in a way that exemplifies an anti-racist approach to way of being, the therapeutic relationship, and technique. This also lends support to the notion that race and whiteness, and specifically the dynamics of racial bias, power and privilege, are foundational to way of being, the therapeutic relationship and techniques for white clinicians working with Black clients.

Participant Demographic Trends Within the Continuum

Surprisingly, there did not appear to be many commonalities within or between any categories with respect to sample characteristics. Participants in each age group, type of license, treatment setting, and theoretical orientation were scattered across the continuum. The socioeconomic status and primary presenting problem of the clients whom participants regularly work with also did not impact their place on the continuum. One potential trend started to emerge, which was the level of experience that participants had working with Black clients. Those who are closer to the Integrated type, on the right side of the continuum, reported working with a higher ratio or number of Black clients in their career, which implies that they have had more experiences with Black clients than those who are on the left side in the Hollow type. However, this was not the case across the board, as some participants who had many experiences with Black clients were in the Hollow type at the left end of the continuum. More targeted research related to this continuum could help clarify this.

In addition, another potential trend was that almost all participants who were closer to the Integrated end of the continuum or were in the Integrated type referenced a pivotal experience with race in their personal life or professional career, which helped them work through thoughts and feelings about race and apply this learning to their way of being, therapeutic relationships, or technique. With more research and a larger sample, this trend could mean that white clinicians may learn through practice working with Black clients. As the discussion unfolds, let it be acknowledged that no participants in this study espoused blatant racism and all participants make statements indicating their desire to acknowledge and work on their biases and provide better care for their Black clients. This speaks not only to the voluntary sampling method which allowed people

who care about this topic to opt into the study, but also perhaps to the social moment of late spring 2020 after the murder of George Floyd.

The Hollow Type

At the left end of the continuum is the Hollow type. The TPM depiction of a Hollow-typed white clinician is pictured below (Figure 3) to visually explain what it means to be at this end of the continuum. Figure 3 depicts the Hollow type, where white clinician way of being is undermined by the clinician's insufficient navigation of their uncomfortable emotions and prior judgements about race. This in turn creates a hollow foundation on which the culturally competent techniques are inadequately supported.

Technique

Culturally competent techniques espoused and/or employed (sometimes too rigidly)
Not adequately supported by a durable therapeutic relationship

Therapeutic Relationship

White clinician has difficulties maintaining therapeutic relationships due to unacknowledged power, microaggressions, and/or shame avoidance about race
Not supported by anti-racist way of being

Clinician Way of Being

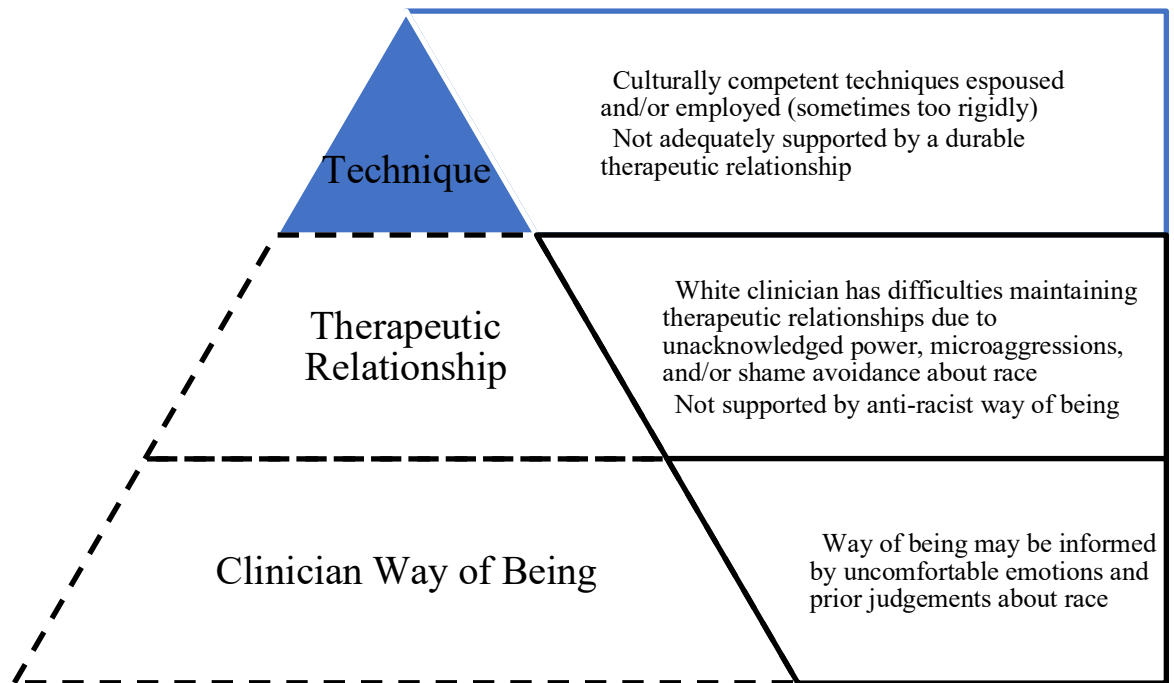Way of being may be informed by uncomfortable emotions and prior judgements about race

Figure 3. The Hollow Pyramid

In the Hollow type, the techniques a white clinician uses may be culturally competent, but they fall short because they are not undergirded by an intentionally self-

reflective way of being or durable therapeutic relationship. This could be due to either the clinician's confidence in their work despite making racially problematic statements, or the clinician's stated discomfort, anxiety, or other such emotions and prior judgements about Black clients which inhibit it. Further, participants in this category tended to report that they felt confident in working with their Black clients despite also reporting negative indicators such as weak therapeutic relationships as evidenced by unrepaired ruptures and frequent or unexplained treatment dropouts (Quinn, Alex, Candace). However, they also stated that they had cultural competence training and felt that they used culturally competent techniques, hence the hollow and unsupported pyramid depicted above (Figure 3) and the use of the word "hollow" to exemplify this type.

Research cited earlier in this dissertation has acknowledged how culturally competent methods are insufficient for truly anti-racist therapy practices because they do not adequately acknowledge the role of the white clinician as benefiting from the power and privilege of whiteness within the interracial dyad (Chu, et al., 2016; Jones, Huey, & Rubenson, 2018). Within the Hollow type, white clinicians do not employ the foundational understanding of how whiteness and race may be present in the interracial therapist dyad within their techniques such as addressing race with clients and dealing with client feedback. They typically also struggle to confront uncomfortable emotions and challenge prior judgements they have about race within their role as the clinician. Thus, the culturally competent techniques that they employ are inadequate because they are built upon a hollow pyramid, as opposed to a durable therapeutic relationship and intentional, honest, self-reflective way of being.

In support of this finding, scholars Chang & Berk (2009) found in their research that some non-white clients respond negatively to experiencing clinicians that they perceive as using cultural competence in ways that were "too textbook," dismissing the clients' experiences of oppression, or being unaware of biases they had that impacted the client (Chang & Berk, 2009). This directly supports the notion that white clinicians must examine and challenge bias in order to mitigate its impact on non-white clients. If left unnamed and unexamined, this bias inherently applies to their Black clients, and obstructs the nonjudgmental way of being that is needed for safe and effective therapy (Chang & Berk, 2009; Jones, Huey & Rubenson, 2018). Again, this dissertation did not attempt to identify unconscious bias, but rather explored how clinicians navigate the emotions and judgements they hold about race and power as white people within a white supremacist system, working with Black clients. Within the aspect of technique, participants in the Hollow category either felt confident but made statements indicating potentially harmful judgements about race or could not grapple with their uncomfortable emotions about race.

One aspect of how the Hollow type was exemplified in participant narratives occurred when participants stated that they felt very confident in their culturally competent work with clients of color, despite also reporting that they struggled to retain these clients for the entire course of the treatment plan. For example, Quinn reported feeling very confident in addressing race right away with all Black clients but used methods which were very othering, such as assumptively naming the oppressive experiences that clients may have had as a way to invite them to share about their experiences as a Black person. Despite cultural competence techniques instructing white

clinicians to acknowledge difference, doing so in this manner may actually be harmful to the client by highlighting and exacerbating the power differential without taking ownership of whiteness and working to help the client feel safe and seen. Literature supports this notion that taking a culturally competent approach without properly navigating the clinician's own whiteness and its impact on the Black client in the present, specifically the inherent power differential, is insufficient because it does not allow the white clinician to understand and accommodate the Black clients' needs in the therapy (Chang & Berk, 2009; Jones, Huey & Rubenson, 2018; Menakem, 2021). This may lead to alienation of the client due to the microaggressions creating unresolved ruptures in the therapeutic relationship (Chang & Berk, 2009; Jones, Huey & Rubenson, 2018).

In sum, within the Hollow type, participants struggled to employ techniques for addressing race which adequately encompassed their successful navigation of race. An added difficulty was the lack of a supportive way of being and durable therapeutic relationship as foundational aspects to undergird the technique. The finding that white clinicians may feel confident in their culturally competent technique while also describing problematic methods is important because it highlights the inadequacy of cultural competence as an approach (Chu, et al., 2016; Jones, Huey, & Rubenson, 2018) and lends support to the critical whiteness theory approach to continuously working towards challenging one's own feelings and judgements about non-white people as a white person (Nayak, 2007).

Grappling: Developing Awareness of Racial Bias

Within the middle of the continuum, the grey area of grappling with race and whiteness is housed. The foundation of anti-racism is acknowledging power and privilege

by dismantling bias and its accompanying behavior (Kendi, 2019) rather than shying away from this work to avoid shame and protect oneself from emotional discomfort (DiAngelo, 2011; 2018). Working towards acknowledging and navigating dynamics of racial power and privilege, there seemed to be two main points on the continuum in the middle section. To the left, towards the Hollow end of the continuum, participants tended to share mostly uncomfortable and challenging feelings about race as well as confusion or lack of understanding of how to work with these in their encounters with Black clients. These participants were able to articulate their stuck feelings on how to work with race with their Black clients, and some even shared that it was because of their inability to confront and fully grapple with their emotional discomfort (Brynn, Dee, Ella, Jen). These participants shared feelings like anxiety, apprehension, confusion, and also curiosity. For instance, one participant acknowledged their existing racial bias and grappled with their emotional discomfort within their *way of being*, but also indicated that they still attempt to create a safe space for Black clients, saying:

> "I feel like the academic and the self-worth confidence, that there's something that can be offered and guided to white clients, whereas I imagine with Black clients, I'm more worried about like, I will never totally get your experience, and I don't want to say something wrong that's… but I also want to make it an open space…" (Jen).

This participant was grappling with their whiteness and working through how to create an open space for Black clients within the context of therapy with a white clinician. They acknowledged that they did not have an implicit understanding of Black people's experiences but had not explicitly named whiteness or racial trauma as part of what they were working with. They knew they had to change something but were unsure of what to change and felt worried about it rather than empowered to explore further.

To the right, towards the Integrated end of the continuum, participants tended to name their whiteness more explicitly as something that might impact their Black clients, though they still sometimes struggled with their feelings and what to do next. They may have had some negative experiences in their work with Black clients, and may have overcome some of them (Linda, Meg, Rachel). Participants in this category sometimes specifically addressed the work they were doing outside of the clinical arena and whether that helped them feel like they were challenging white supremacy where possible. For example, Holly shared that they are not very emotionally reactive in their clinical role, but experience deeper emotions related to race in other aspects of their work and life. A few participants, namely Linda and Meg, were aware of their whiteness as a potential issue but reported being paralyzed by fear of hurting their Black clients and unsure of how to proceed safely as white clinicians. Generally, participants in this category tended to be in the process of noticing systemic inequality and questioning their role but seemed generally unsure of how to navigate this within their way of being with their Black clients.

Integrated Type

The right-side endpoint on the continuum is the Integrated type. The term "integrate" speaks to the process of integration where white clinicians became aware of, reckoned with, and incorporated their emotions and thoughts about race and whiteness holistically into their approach to their way of being, therapeutic relationships, and techniques, especially in addressing race with their Black clients. This integration is depicted in Figure 4 below by a solid TPM where each component employs anti-racist best practice and supports the components above it. Here, the white clinician excavates

emotions and thoughts to navigate whiteness and race within their way of being with their Black clients. This then helps them to create and maintain durable therapeutic relationships and employ anti-racist techniques.
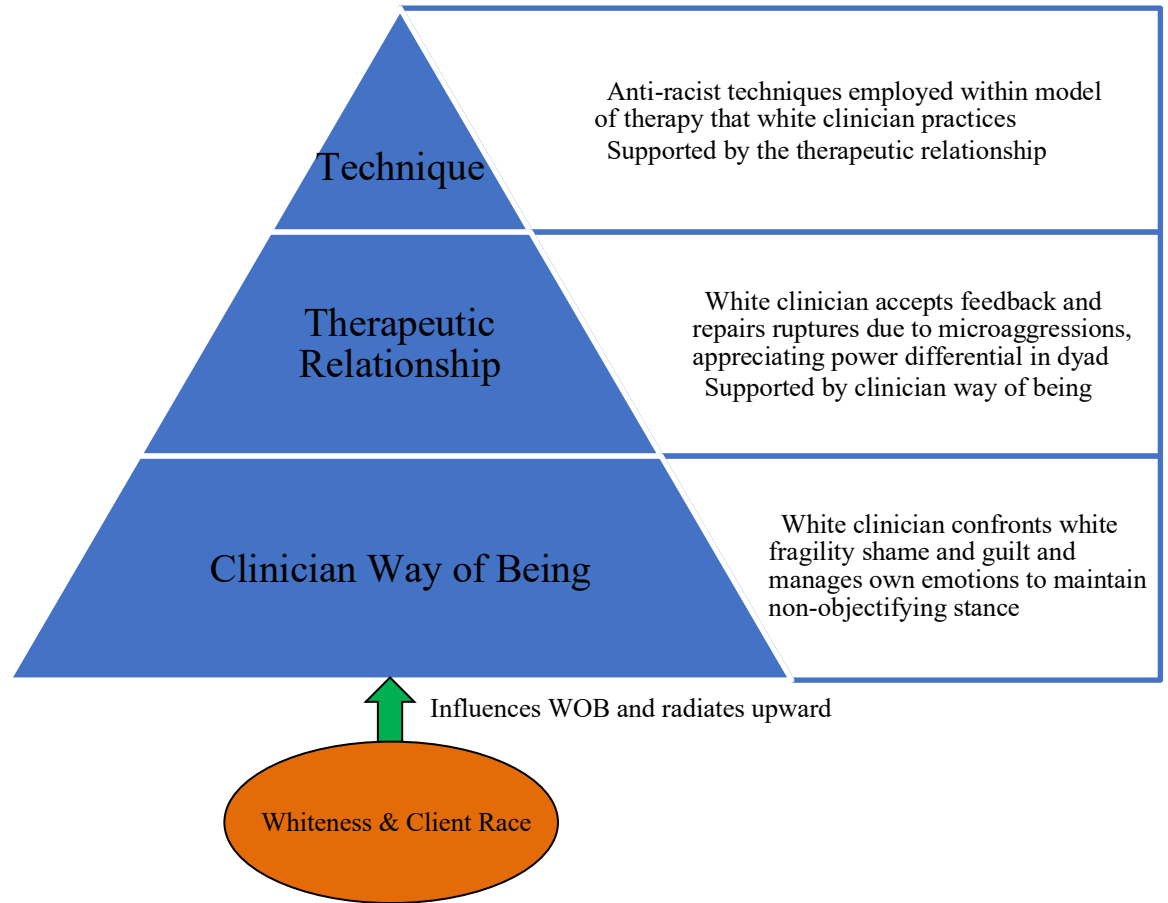
Figure 4. The Integrated Pyramid

The integration of the white clinician's critical interrogation of whiteness and racial bias impacts not only way of being, but the entire pyramid, leading toward anti-racist clinical practice (Nayak, 2007; Kendi, 2019). This type of clinician continuously acknowledged emotional discomfort and prior judgements related to race, confronted it, overcame shame, and learned from mistakes and feedback from Black clients.

This category contains aspects of multiple participants who embodied the Integrated type of clinician (Fae, Ingrid, Kelsey, Olivia, Sam). Again, these clinicians were not entirely unbiased, but they did have specific characteristics that put them in this category. Specific markers of participants within the Integrated type include: the ability to acknowledge their biases and uncomfortable emotions, some prior therapy or other introspective work with their racially biased thoughts and feelings, stories about repairing ruptures related to microaggressions they committed with Black clients, and culturally responsive and anti-racist techniques that were supported by this other work they had done.

Acknowledging Bias and Uncomfortable Emotions. From participant interviews, the Integrated type seemed to be characterized by a more direct, hopeful, and active integration of uncomfortable thoughts and feelings within way of being. The main difference is not only that these participants were able to name their whiteness as potentially problematic and own how they are part of a white supremacist system, but also that they used hopeful language when discussing their experience with attempting to disrupt white supremacy while working with their Black clients. While they also experienced discomfort, shame, and uncomfortable emotions, these participants reported feeling empowered to work through them, with feedback from their clients where applicable, and with or without support from their agency.

Therapy or Introspection as Part of Their Way of Being. As mentioned above, self-of-the-therapist self-reflection (Aponte, et al., 2009) was an underlying piece of way of being which helped clinicians deal with their own "issues and areas of reactivity" (Fife, et al., 2014). While not all participants in the Integrated type referred to their

personal therapy directly, they all mentioned a level of introspection about their privilege

and/or intersectional identities which seemed to lend itself to unpacking biases they

previously held. For example, Ingrid referred to her extensive training and training of

others in a form of therapy which requires the therapist to be aware of their own emotions

while conducting the therapy. Ingrid shared about an experience with a Black client

where Ingrid became tearful in session due to a personal experience that was triggered by

the client's statement in therapy, and how Ingrid handled this by acknowledging her

power and position and reassuring the client that this emotion was not about them and

should not preclude them from taking up emotional space in the session. While this is a

challenging experience that most clinicians hope to avoid, by explicitly naming and

intentionally navigating power, Ingrid diffused a potentially harmful experience for the

Black client. This type of maneuver could not have been done in a state of heightened

emotion without Ingrid's significant prior exploration of her intersectional identities,

specifically how "white woman tears" may impact Black clients. This is written

extensively about in anti-racism literature, instructing white women to decenter

themselves whenever possible as Ingrid did (DiAngelo, 2018, Kendi, 2019; Saad, 2020).

Rupture and Repair for a Durable Therapeutic Relationship. A marker of the

Integrated type is when white clinicians can acknowledge and repair ruptures due to

microaggressions. As discussed earlier, microaggression scholars assert that

microaggressions should be named and dealt with directly (Sue, et al., 2007; Sue, et al.,

2009). According to participants in this category, this required them to confront their

shame, and seek supervision at times (Olivia, Sam). This is consistent with scholarship on

white fragility (DiAngelo, 2018; Saad, 2020) which urges white people to challenge their

tolerance of shame and emotional discomfort around race as part of their accountability within racial justice work. It also builds on critical whiteness theory's similar assertions (Foster, 2003; Olcon, Gilbert, & Pulliam, 2019).

As a partial aside, the mention of supervision is interesting because it contrasted some of the Hollow type and Grey Area testimonies where participants either reported that they did not need supervision about race or felt that they did not have access to what they needed. However, this is not a true finding, as almost everyone in the Integrated type expressed frustration with the agencies that they worked in for the lack of supervision they felt they had with addressing racial issues in therapy apart from Olivia who mentioned using supervision to deal with her feelings about her microaggression and figure out how to repair the rupture. Nonetheless, it may be interesting to track the role of supervision and agency support in future studies.

Being able to admit wrongdoing, especially around the shameful topic of racism, requires a certain amount of acceptance by white clinicians that they will make mistakes, be called out, and need to be humble in the face of negative feedback from Black clients (DiAngelo, 2018; Kendi, 2019). Chang & Berk's (2009) research indicated that non-white clients felt more satisfied when working with clinicians who could receive such feedback. This is contrary to the shame-based avoidance described by DiAngelo (2018) and embodied by some of the participants in the Hollow type. Participants in the Integrated type spoke of welcoming feedback from Black clients about how they were doing and especially if they made a mistake or committed a microaggression. These participants also noted receiving positive feedback from their Black clients not only about managing microaggressions and repairing ruptures, but also their general approachability

despite being white. This seemed to speak to a general air of comfort dealing with race-based discomfort if it did arise, which some participants named specifically while others seemed to imply when sharing how they navigated receiving this type of feedback.

Anti-racist Techniques. At the top level of the pyramid is technique. As discussed earlier, culturally competent technique is insufficient when it is not supported by an anti-racist way of being and durable therapeutic relationship. Participants in the Integrated type exemplified using techniques that were anti-racist and could articulate the reasons for these techniques. For example, Fae shared about making room for conversations about race early and often and judged their success as a white clinician by their clients' ability to bring up, share, and joke with them about race in therapy, importantly including the client being able to use joking as one of many ways to call Fae out if needed. Another participant, Ingrid, talked about making room for Black female anger as a counter to the "angry Black woman" stereotype. These methods of explicitly addressing race acknowledge how Black clients may have been impacted by racism elsewhere, but also in this specific therapeutic setting; this is emblematic of the white clinician taking responsibility for power and whiteness in this space and working to co-create safety with the client by allowing them to be themselves and take up space with the clinician. The underlying durable therapeutic relationship, where microaggressions will be named and ruptures will be repaired, undergirds this type of approach as already discussed, thus providing a sturdy foundation.

In sum, the Integrated type is characterized by a pyramid that looks solid and whole, because anti-racist personal work undergirds how whiteness and race are navigated within the white clinician's way of being with their Black clients. This then

supports these white clinicians building and maintaining durable therapeutic relationships and enacting anti-racist techniques as well. Integrated type white clinicians are characterized by acknowledging and working with uncomfortable emotions with a hopeful attitude, introspecting on their whiteness in relation to client race, repairing ruptures (especially those that occur as microaggressions), and using anti-racist techniques supported by the other aspects mentioned here. Again, while the Integrated type of white clinician enacts an anti-racist way of being much of the time, they will also experience setbacks and make mistakes because anti-racism is not a static state or status but rather a continuous process of reckoning with white supremacy (Kendi, 2019; Olcon, Gilbert, & Pulliam, 2019).

Chapter 6: Implications and Areas for Future Research

Implications for Clinician Education and Supervision

So far, this discussion has established that implicit racial bias is an integral part of the experience of white people in a white supremacist society (Nayak, 2007; Olcon, Gilbert, & Pulliam, 2019). This study explored the experience of white clinicians negotiating conscious racial bias via thoughts and feelings within their way of being with Black clients, and how this extended to their therapeutic relationships and techniques. A continuum of white clinicians emerged from the data, aiming towards a holistic and integrated approach to navigating conscious racial bias within way of being in a way that radiates through the therapeutic relationship and technique. Throughout the past year, following the murder of George Floyd, large numbers of white people began to do the work of understanding white supremacy and their complicities within the system (Lund, 2020; Saad, 2020). As some participants mentioned in their interviews, they were newly engaging with literature and popular media to uncover their racial biases. This study has shown how important this work is within the therapeutic relationship and process, stemming from clinician way of being. Taken together, these findings and the current social context necessitate an approach to clinical training and supervision that addresses implicit racial bias on a deep and personal level and facilitates white clinicians' active grappling with it as a part of their way of being with non-white clients. This exploratory study could be the beginning of research to lay groundwork for the development of a clinician assessment and training program based on this continuum. Components could

include an assessment or survey to determine where on the continuum someone falls, then a series of educational, introspective, group discussion, and clinical practice opportunities to uncover, challenge, and integrate grappling with whiteness and race with respect to clinician way of being.

Survey

With more research including a larger sample, a survey could be developed and tested to further develop the continuum. Eventually, a survey could be created to potentially determine where any given clinician is on the continuum. Survey questions could include invitations to talk about racial biases that a person holds or used to hold, as well as attempts to assess implicit bias without having the person name it explicitly. It could ask for past and current experiences working with clients of color to ascertain how clinicians navigate their emotions and judgements about race within their way of being, much like this study did. The results of the survey could place individual white clinicians on the continuum and could serve as a starting point from which to tailor the educational and reflective components of the training and development process.

Clinical Education and Training

New clinician education programs could offer opportunities for budding clinicians to incorporate skills to navigate whiteness as it impacts their way of being with their non-white clients. It is common for clinicians to do self-exploration while training, including therapy, in service of learning their clinical style, understanding transference, and creating therapeutic relationships (Aponte, et al., 2009). However, because the extensively taught framework of cultural competence does not encourage critical interrogation of whiteness as a part of white clinician development, there is no guarantee

that white clinicians will ever have an impetus or forum to reckon with their own emotions and experiences about race. This study has shown that these emotions and experiences influence how white clinicians navigate way of being with Black clients, and prior literature supports the notion that white clinicians at any stage should be afforded the opportunity to begin this process of critical excavation (Chang & Berk, 2009; Chu, et al., 2016; Jones, Huey, & Rubenson, 2018).

In addition, instead of using cultural competence frameworks to teach about navigating race and culture, new clinician training programs could incorporate education, reflection, group discussion, and clinical practice opportunities to work on excavating racial bias at the beginning of the training program and continuously striving towards anti-racist practices like the ones articulated by Menakem (2021), Saad (2020), and Kendi (2019) to name a few. One reason for placing this at the beginning of training is that it is harmful to Black clients to let white clinicians learn racial bias awareness by working through it with the clients because the clients must endure microaggressions and hold the impetus to name and correct the clinicians' behavior, which further exacerbates the power imbalance already in existence (Chang & Berk, 2009; Sue, et al., 2009).

In the training, new clinician training programs could start by providing education about critical race theory (Crenshaw, Gotanda, Peller, & Thomas, 1996), critical whiteness theory (Olcon, Gilbert, & Pullinam, 2019), and historical and present racial trauma (Menakem, 2021; Sue, et al., 2009). They could explore the systemic effects of institutionalized white supremacy including within the mental healthcare system where they will one day practice (Jones, Huey, & Rubenson, 2018). They could also be educated about implicit bias (Staats, 2013). With all of this, they could be given

opportunities to think about the impact of race and power dynamics on the therapeutic

relationship, and techniques such as those discussed by participants in this study. As

modeled by authors of color like Saad (2020), with each piece of education, clinicians

could be asked to reflect individually and then process their thoughts and feelings as a

group. This intentional and multi-modal unpacking could facilitate personal growth

regarding race, laying the groundwork for a clinical practice component.

From there, the clinical practice component could consist of role play and

discussion of potential scenarios where race-based challenges could arise such as the

clinician committing a microaggression or receiving negative feedback from a client of

color. Exercises like these are already included in the works of Menakem (2021) who

addresses racial trauma being stored in white and Black bodies, and Saad (2020) who

instructs white people on methods for unpacking their personal relationship with white

supremacy; they could be expanded on and adapted for clinical practice scenarios.

Working through these individually and as a group could challenge white fragility via

group calling in and witnessing (DiAngelo, 2018). Though this entire process may

require certain components like a series of long workshops in a fixed group of people to

establish safety and continuity in the group process, there may also be opportunities to

create smaller working groups or Continuing Education workshops for clinicians who are

already licensed to participate in this work as well. On a more systemic level, agencies

could one day adopt this type of training similar to how the Sanctuary Model (of trauma

treatment for organizations who treat traumatized clients) is adopted through a

certification process (Bloom , 2013). This could signal to clients of color that they are

receiving services from an agency that strives to cultivate anti-racism organizationally and with each of its white clinicians.

Enhanced Supervision

Similar to the clinician education program described above, peer-supervision or agency-wide supervision could provide an opportunity for clinicians of any experience level to engage with one another around this material. Educational materials could be pulled from the clinical training program if desired. Even without this, though, supervision presents the unique opportunity for clinicians to share their experience of grappling with race and whiteness with one another. White clinicians can then hold one another accountable and challenge their white fragility in the context of supervision by sharing vulnerably about their mistakes and learning from one another's growth (DiAngelo, 2018). If an agency-wide model were to be adopted, this could create a culture of support within agencies, which could even mitigate systemic issues like high turnover that occur when clinicians feel ill-equipped and unsupported in the face of challenges (Bloom, 2013). Given how this study evolved during the time of political and social reckoning about race, and in keeping with the systemic nature of critical whiteness theory (Foster, 2003; Nayak, 2007) it would also be useful to incorporate opportunities for self-exploration to turn into action in clinicians' local communities as well as the greater mental healthcare system in which they work.

Areas for Future Research

This exploratory study explored the lived experience of white clinicians navigating their racial bias within their way of being in their work with Black clients using key informant interviews. Though the results lent themselves to understanding the

essence of white clinicians' lived experience of grappling with race and whiteness in multiple aspects of the therapeutic process, there are still questions to be answered within this area of study. Areas for future research are numerous. Most obviously, this same study could be replicated to explore how white clinicians navigate their racial bias within their way of being with clients of other races and intersectional identities such as sexual orientation or socioeconomic status.

In addition, future studies could be structured as comparisons to elucidate more information as to whether specific demographic variables influence how white clinicians navigate whiteness and race within way of being and/or their placement on the white clinician continuum. In this study, there were no demographic commonalities, but future studies could incorporate larger sample sizes, and even different epistemological framings, to address this question. For example, one study could compare clinicians from various disciplines, like Social Workers in comparison to Licensed Professional Counselors. This comparison study could ask specifically about education and training in addition to clinical experiences to shed light on how different disciplines prepare clinicians to work with their intersectional identities and the privilege they encompass as part of approaching their way of being, and the effectiveness of various approaches. Similarly, studies could compare treatment settings, sampling white clinicians within community mental health in comparison to white clinicians in private practices, for example. Multiple potential factors to compare linearly, as well as intersectionally, include age, theoretical orientation, and political orientation of clinicians, and each would lend a specific lens to understanding the lived experience of white clinicians navigating race within their way of being with Black clients.

As mentioned in the white clinician bias continuum discussion, another study could incorporate a larger sample and ask specifically about not only what clinicians have learned across their experience, but also how their own way of being differed in each treatment setting if they worked in more than one across their career. This was not a specific factor that the current study considered, but comparing one white clinician's experiences in different settings to one another might provide some insight into how they navigate intersectional factors like poverty, how they functioned with differing levels of agency support, and if years of experience is more influential than some of the other factors on how they negotiate race in their way of being. In other words, is it more experience, multiple different experiences, or specific experiences, that help facilitate white clinicians' development of their awareness and navigation of their conscious racial bias within their way of being?

As mentioned above in the implications section, the exploratory study for this dissertation could be the preliminary piece of a much larger undertaking where a survey and training program are developed to help white clinicians excavate racial bias and navigate their whiteness within their way of being. Further studies would include a qualitative study with a much larger sample size to develop areas for questioning, development of a survey tool, pilot testing that survey tool, then doing a larger study to assess the survey's reliability and validity. This survey could then aid white clinicians in knowing where they are on the continuum and where to start. It could also be used to gather data more broadly about the state of the field and the level of anti-racist practice happening broadly across the mental healthcare system.

Limitations

Despite the fact that this entire dissertation study was performed during the COVID-19 pandemic and during social unrest, there were very few technological difficulties and virtually everyone who volunteered and was approved was able to participate. However, a few limitations did arise. One limitation was that the sample only contained one man, and no other men volunteered even after the number of interviews had been reached and a waitlist formed. Though there is a gender imbalance in certain sectors of mental healthcare, it would have been ideal to have more than one male perspective on this subject. Because there were so many volunteers, and due to the stress of the COVID-19 pandemic and social rest on me as a mental healthcare provider and those that I was interviewing who were also providing mental healthcare in this context, I decided to proceed with the interviews rather than sample specifically for more male participants.

Because of the study topic dealing with race, this study had the potential for social desirability bias, which means that participants could have answered questions how they thought the researcher wanted them to, or in order to save face with the researcher, rather than truthfully (Padgett, 2016). This could have played out in a few ways. First, people could have volunteered because they wanted to be seen as good, responsible white people. Second, when answering questions, white fragility could have driven people to respond as good white people, causing them to understate or deny their internal thoughts, feelings, biases, and experiences with racism with their clients (DiAngelo, 2018; Padgett, 2016). To combat social desirability, I attempted to ask questions in numerous ways and probe further when uncomfortable emotions seemed to arise; however, there is no way to know if people were holding back their truth out of fear of judgement. Though I was

attempting to bracket my experience as a clinician, it may have helped me to navigate the emotional discomfort inherent in this topic and encourage participants to be vulnerable and honest in their answers.

In the same vein, another potential limitation is my subjectivity as a white clinician and researcher, evaluating other white clinician's experiences negotiating race within their way of being with Black clients. To combat my own potential for blind spots due to my own racial bias, I memoed in my Research Journal, talked to peer clinicians and peer researchers (as well as one person who does both like me), and employed another coder for inter-rater reliability. In our sessions to discuss the coding schemes, the second coder and I agreed on most of the codes at the outset and were able to come to consensus on the divergences very easily. I also engaged actively in my own racial bias awareness exploration, including reading *Me and White Supremacy* (Saad, 2020)*, My Grandmother's Hands* (Menakem, 2021), *How to Be An Anti-Racist* (Kendi, 2019), listening to podcasts like NPR's *Code Switch* (Meraji, 2013-present) and re-watching documentaries like *13th* (Duvernay & Moran, 2016). I also got involved in racial equity efforts in my community in various ways, most notably starting an Anti-Racism Task Force at the agency where I worked and running a book group for clinicians in my organization to read and discuss *My Grandmother's Hands* together (Menakem, 2021). These resources and actions helped me to think critically about my own racial bias and to continuously question how I was interpreting and analyzing my data, but most importantly provided multiple forums for me to be called out or challenged in the process.

Conclusion

In sum, this dissertation used a phenomenological approach to explore the lived experiences of key informants who were practicing clinicians working with at least one Black client (N=19), using semi-structured interviews to learn about how they negotiate conscious racial bias within their way of being with their Black clients. This study found that white clinicians' expressed emotions and thoughts about whiteness and race, and personal narratives about racial experiences they have had in the past, influenced how they navigated their way of being with Black clients. Findings supported the notion that way of being is foundational to the therapeutic relationship and techniques, generally and with regards to race with Black clients. More specifically, white clinicians used the therapeutic relationship and techniques to explain how they experience and approach their way of being with their Black clients. Finally, a continuum emerged from the data analysis, from Hollow on one end to Integrated on the other, with two semi-distinct areas within the in-between space. This continuum exemplified how white clinicians grapple with whiteness and how their grappling is evident within their therapeutic relationship and techniques they use with Black clients.

There are myriad implications for this work. First, education, professional development training, and supervision across mental health disciplines can help advance white clinicians to the Integrated end of the continuum. It can do this by focusing on racial bias inquiry, emotional processing, and skill building around how to acknowledge and work through bias as articulated by authors such as Saad (2020), with expansions for the clinical setting aimed at incorporating it into way of being, the therapeutic relationship, and techniques. Additionally, research could develop an instrument to help white clinicians identify where they are on the continuum and a program to assist them

toward reaching the Integrated type with resources for each stage. Further, a systemic and community-based approach oriented toward action within and outside of the clinical sphere may be beneficial to combat the isolation that the white guilt and shame may produce (DiAngelo, 2018) and to create lasting change in the mental healthcare field in keeping with the instruction of critical whiteness theory which supports systemic action (Olcon, Gilbert, & Pullinam, 2019). Establishing a culture of white clinicians striving toward anti-racist clinical practice truly is the end goal of providing more than culturally competent, but anti-racist mental healthcare of Black and other non-white people who need and deserve the highest standard of care.

Dissertation Interview Guide
Updated 6/14/2020

Face Sheet Questions
Date of interview:
Age:
Self-identify gender:
Self-identify SES:
Years working as a clinician:
Years working in your current treatment setting:
Years of experience working with black clients:
Estimated total number of black clients worked with:
License/credentials:
Theoretical orientation of practice:
Primary treatment unit (circle):   Individual   Couple   Family
How many clients in your overall caseload?
How many clients do you see weekly?
General SES of your clients
General presenting problems of your clients

Priming – Story of Working with ALL Clients
- Tell me about an experience with treatment of a client of any race that sticks out to you/made an impression on you.
  - What was the outcome of treatment and what does this mean to you? Would you call this a "success" and either way what does that mean to you?
  - Generally, how would you describe your way of being with this client?
  - How would you say your race impacts your way of being with this client?

Way of Being with Black Clients
- With black clients, generally how would you describe your way of being?
- How does race impact how you know you're being successful with a black client?
- How does your own race/whiteness impact your way of being with black clients?
- What are some common reactions you have in working with black clients?
- How do you use these reactions to frame your work with that client?
- How have your black clients addressed your whiteness?
- How do you address your whiteness with black clients?
- Do you have any support from your agency and/or supervisor in working on these aspects of your practice with black clients? Tell me about how this impacts your work.

Appendix B
Recruitment Materials

Recruitment Email

Dear __,

My name is Briana Bogue, and I'm an LMFT and PhD Student in Bryn Mawr College's Graduate School of Social Work. I specialize in trauma work, and have a passion for understanding how therapy can work better with marginalized populations. Though I wear many hats professionally, I am writing to you in my capacity as a PhD Candidate at Bryn Mawr, working on my dissertation. I'm writing today to ask if you have any interest in being part of my dissertation study or know anyone who might be qualified and interested. To qualify, you need to be a white, practicing clinician (LMFT, LPC, LSW, LCSW, PhD) who has had some experience treating clients who identify as black. It does not matter where you work, and I will not collect that information. Your interview will be anonymous and your answers will not be tied to your identity. Participation includes a quick screening call to see if you qualify, and then an hour- to 90 minute- long interview. [COVID-19 addition: To adhere to social distancing requirements, we will conduct the interview via a phone call or a Zoom call where your video will be disabled to protect your confidentiality.] [Post-COVID-19: The interview will be in the location of your choosing.] I am interviewing white identified clinicians on how you work with your black clients. I'm also looking at the successes and challenges white clinicians perceive in this endeavor. If you have any time and are interested, please respond to this email. I'll set up a time to give you a quick call (approximately 5 minutes) to ask you a few screening questions. [COVID-19 addition: Then, we can set up the time for the interview and, if applicable, make sure that you have the required technology and space to use Zoom.] [Post-COVID-19: Then, we can set up the time and location of the interview when and where it is convenient for you.] Your participation will enter you into a raffle for a $25 Starbucks gift card to thank you for your time and perspective. Lastly, again, it would be helpful to me if you could send this email on to anyone you know who is a white clinician working with clients who identify as black. Where they work or how long they've been practicing is not of concern. I will be collecting interview data for several months, so if anyone comes to your mind at any time, please send them this email or refer them to me so that I may reach out to them.

Recruitment Flyer/Email Attachment

PARTICIPANTS NEEDED

DISSERTATION RESEARCH STUDY

For Briana Bogue, PhD Candidate at Bryn Mawr GSSWSR

Who?
Clinicians who have worked with black identified clients
Currently practicing in any treatment setting in Greater Philadelphia

What?
Research study asking about how you work with your black clients
5 minute qualification screening call
CONFIDENTIAL & ANONYMOUS
60-90 minute interview
       with Briana Bogue, LMFT
       [during COVID: via voice-only Zoom or phone]
       [post-COVID: in the location of your choosing]

Why?
To understand what white clinicians are aware of and do to work with black clients

IF INTERESTED PLEASE CALL 203-815-3273
OR EMAIL BBOGUE@BRYNMAWR.EDU

Leslie Alexander, Acting Chair
Institutional Review Board
Bryn Mawr College
101 North Merion Avenue
Bryn Mawr, PA 19010-2899
610 520-2635

                                                      B R Y N   M A W R

Briana Bogue
Graduate School of Social Work & Social Research
Bryn Mawr College

May 11, 2020

R20- 0037 – Clinicians' negotiation of internal bias in their way of being with Black Clients

Dear Briana

        The Bryn Mawr College IRB provided an expedited review of the above research. Minor changes were requested and made. Your proposal is approved according to the expedited review category found at: 46 CRF 46.110 (b 7(interviews & b 6(audio recordings).
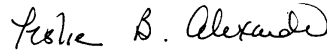
        We do have an annual check-in to determine if the research is continuing or has been terminated. Your annual check-in will occur in the May 2021 IRB meeting, You will be notified by the Grants office that the annual check-in is due.

         If you want to make any changes in the protocol, you must be in touch with the Bryn Mawr College IRB to obtain approval for the changes BEFORE they are implemented. Data collection cannot continue under a changed protocol until all changes have been approved by the IRB.

         If any participant experiences complications or adverse effects or lodges a complaint with regard to participation in the study, you must also be in touch with the Bryn Mawr College IRB immediately. All such events need to be reported to the Bryn Mawr College IRB as soon as they occur.

         Best of luck with this research.

                                                      Sincerely,

                                                      Leslie B. Alexander

                                                      Leslie B. Alexander, Ph.D.
                                                      Professor and Acting Chair
                                                      Bryn Mawr College IRB

Cc: Professor Sara Bressi

Appendix D
Consent Form
Bryn Mawr College

1) Title of Study: White Clinicians' Negotiation of Internal Bias in their Way of Being with Black Clients

2) Purpose and General Description of the Study

In this study, I am going to ask about your way of being with your clients, and what you think is successful for you, in particular with your black clients. I am interested in this because of the disparity in psychotherapy usage among black Americans (Jones, Huey, & Rubenson, 2018). I am interested in outlining how therapists think about their way of being with clients, and also their way of being with black clients specifically.

The interview will last an estimated 60-90 minutes and contain approximately 7 questions about the participant as a clinician, how they describe their work with black clients, and their feelings about their work with black clients. All data will be de-identified, confidential, and protected. Names will not be collected except to assign a code to the interview, which will then be used for the remainder of the data collection and analysis.

3) What does participation involve?

You have already participated in a short (approx. 5 minute) screening call to determine your eligibility for this study.
This interview is to be conducted in a private, quiet location of your choice, for an uninterrupted 60-90 minutes. The interview will consist of approximately 10 questions about you as a clinician, how you describe your work with black clients, how you feel about it. The answers that you give will be disassociated from your name, and your interview will not have your name or identifying information anywhere on it at any time in the data analysis or reporting.
The interview will be recorded via iPad and iPhone voice recording apps. The data will be collected solely in this interview.

4) Confidentiality

Data in the form of voice recorded interviews will be de-identified and protected according to the NIH Security Best Practices for Controlled-Access Data (NIH, 2015). All forms will be de-identified using a code, stored in a separate Excel file. All data and associated files will be named with the code. All materials will be stored on my encrypted Macbook Air, backed up to password protected Google Drive, and stored in hard copy in a locked cabinet in my home office (NIH, 2015). See the Face Sheet (Appendix A) for the non-identifying information that will be collected; none of this can be used to identify the participants or tie them to their answers. All data will be saved indefinitely for future projects.

5) Risks of participating in the study
You may experience some temporary discomfort during the interview (anxiety, sadness, etc.); if it persists, please be in touch with me and I will provide some suggestions about who to talk to.

6) Benefits to participants or others

There are no direct benefits to you for participating in this research. However, you may find it interesting to talk about the issues addressed in the research and it may be beneficial to the field and to future clinicians and clients who have experienced similar concerns.

7) Compensation

You will be entered into a raffle to win a $25 Starbucks gift card for your participation in this interview. I will draw one winner after all interviews have been conducted, and notify that winner using the contact information you specified during our screening call for this interview. If you need to stop the interview at any time for any reason, you will still be entered into the raffle as a compensation for your inconvenience up to this point. There is no additional compensation for any follow-up contacts.

8) Deception

There is no deception used in this study.

9) Voluntary participation

Your participation is completely voluntary. You can withdraw from the study at any time. You do not have to answer any questions that you don't want to answer. If you choose not to participate, there will be no penalty or loss of any benefits for not participating. You will still be entered into the gift card raffle even if you end the interview or do not answer all questions.

10) Questions about the research and rights of research participants

If you should have any questions about the research, please feel free to call or email the Principal Investigator, Briana Bogue, at 215-382-6680 x4420, bbogue@brynmawr.edu. If you have questions about your rights as a research participant, please be in touch with Leslie Alexander, Professor and Chair, Bryn Mawr College IRB (lalexand@brynmawr.edu; 610-520-2635).

    I am 18 or older: Yes _____   No_____

    I have read this consent form or it has been read to me.   Yes_____   No_____

    I have had all of my questions about the study answered to my satisfaction.

Yes___ No _____

I have been given a copy of this consent form.   Yes_____   No_____

I agree to participate in this research. Yes_____ No_____

I give permission to audiotape my interview. Yes___ No___

I give permission for the PI to contact me with further questions. Yes ___ No ___

   If Yes, contact email or phone #: _____

   Name (please print): _____

Signature: _____Date: _____

Interviewer Name (please print) _____

Signature_____ Date:_____

Waiver of Written Informed Consent

Script:

Hello: My name is Briana Bogue and I am a PhD student researcher doing research for my dissertation. Thank you so much for taking the time to meet with me.

I am interested in knowing about your way of being with your clients, and what you think is successful for you, in particular with your black clients. We will be talking about you as a clinician, how you describe work with black clients, and your feelings about your work with black clients. I am interested in this because of the disparity in psychotherapy usage among black Americans (Jones, Huey, & Rubenson, 2018). I am interested in outlining how therapists think about their way of being with clients, and also their way of being with black clients specifically.

The interview should take about 60-90 minutes. You can stop the interview at any time, and not answer any questions you don't want to answer. You may also speak off the record and ask me not to record certain areas in the interview. No one will be able to link your answers with your identity, including anyone you work with, receive services from, etc. I will keep the data from your interview in a secure location on my BMC OneDrive indefinitely for future projects.

There are no direct benefits to you for participating, though you may find it interesting to share your experiences about how you work with black clients with someone else. There are no foreseeable risks to you in participating in the interview; the risks are no greater than what is experienced in everyday life. You may experience some temporary discomfort during the interview (anxiety, sadness, etc.); if it persists, please be in touch with me and I will provide some suggestions about who to talk to. And if you do feel uncomfortable, you may stop the interview at any time.

If you have questions about my research, you can contact me at bbogue@brynmawr.edu or 203-815-3273, or Dr. Sara Bressi at sbressi@brynmawr.edu, who is supervising my work. If you have questions about your rights as a research participant, you can contact Leslie B. Alexander at lalexand@brynmawr.edu or 610-520-2635. She is Chair of the IRB (the committee at Bryn Mawr College which reviews all research involving research participants).

With your permission, I would like to audio record your interview. This will help me remember everything that you said. This audio file will be stored on my BMC OneDrive using a code. I will also transcribe your interview and edit out any identifying information like names you mention. I will also store this on my BMC OneDrive and store a backup hard copy in a locked cabinet in my home office in case of technological failure (NIH, 2015). Would this be okay with you?

Would you like to receive a copy of this script for obtaining your waiver of written informed consent?

Are you ready to begin?

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