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The Black Therapist-White Client Counseling Dyad: The Relationship Between Black Racial Identity and Countertransference

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by

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ABSTRACT

The racial dynamics and sociopolitical history of the United States create a unique context for the Black therapist-White client counseling dyad. Each member within this dyad may have a number of transferences or countertransferences (i.e. responses) to one another based on their racial identity and socialization experiences; all of which may affect the therapeutic process. Utilizing a mixed-method design, two research questions guided the present study: (a) Does Black racial identity predict countertransference reactions experienced by Black therapists when working with White clients? (b) What are the benefits and challenges that Black therapists self-report when working with White clients? A multivariate multiple regression analysis was proposed to examine the first research question; however, this analysis was not conducted due to an insufficiently low sample size (*N*=28). Therefore, a descriptive analysis of mean comparisons based on primary themes in the qualitative data was performed. On the Black Racial Identity Attitudes Scale (Helms, 1990), mean comparisons did not appear to vary significantly based on themes; however, participants generally had high scores on the Internalization subscale. On the Therapist Response Questionnaire (Betan et al., 2005), means were generally low across themes, with the exception of Positive countertransference. These results may suggest that participants in this sample had positive, stable racial identity and that these therapists enjoyed their work with White clients regardless of challenges faced. To examine the second research question, the Discovery-Oriented Approach (Mahrer, 1988) was utilized with qualitative responses from 27 therapist participants. Qualitative results highlighted 29 themes regarding the impact of racial dynamics on the counseling process. Findings from the present study highlight the benefits and challenges Black therapists encounter when working in cross-racial dyads and provide implications for multicultural training.

Chapter I

Introduction

The number of Black Americans entering the field of psychology is increasing at a steady rate. In a report examining the racial composition of graduate students in psychology, Hart, Wicherski, and Kohout (2011a) found that during the 2010-2011 academic year, 9% of full-time, first-year students entering doctoral programs in psychology self-identified as African American or Black. Within master's programs in psychology, African American/Black students represented 6% of full-time, first-year students. For part-time students in psychology graduate programs, 17% self-identified as African American or Black. Likewise, there is a continuous increase in the number of Black faculty within the field of psychology (Daniel, 2009; Hart, Wicherski, & Kohout, 20llb). Approximately 14% of all faculty in psychology doctoral programs and 13% of faculty in psychology master's programs self-identify as a racial minority (Hart et al., 2011b). Hart et al. noted that the total number of students and faculty in psychology programs may actually be larger given that these percentages reflect graduate programs that elected to participate in the survey and "not the population at large" (Hart et al., 2011b, p. 1). Currently, no data could be found on the number of Black psychologists practicing in the field.

Research demonstrates that Black graduate trainees have distinct academic, social, and training experiences as they matriculate through their programs. Black graduate students have reported challenges related to socialization, marginality, connection with academic advisor, satisfaction with program, commitment to degree completion, and negative perceptions (Barker, 2011; Daniel, 2009; Ellis, 2001; Souto-Manning & Ray, 2007). Similarly, prior research indicates that Black faculty report a number of experiences affecting their retention within institutions of higher education. Difficulties related to perceived racism, marginalization, social

isolation, devaluation of research pursuits, challenges to authority, and negative feedback from students are among some of the barriers that Black faculty must overcome (Alexander & Moore, 2008; Fenelon, 2003; Stanley, 2006; Turner, 2003; Turner et al., 2008). Although this line of research encompasses the experiences of Black faculty and graduate students across a variety of academic programs, within the applied fields of psychology in particular (e.g. clinical, counseling, marriage and family therapy programs, etc.), relatively little is known about the experiences of Black trainees and Black psychologists/therapists, specifically with regard to their clinical experiences.

In order for clinicians to provide appropriate services, therapists must be able to effectively engage clients from a variety of backgrounds in order to help them overcome the challenges that they are facing. To accomplish this goal, clinicians must know how to work with clients from diverse racial, ethnic, and cultural backgrounds. For Black clinicians in particular, engaging clients may be particularly challenging given the distinct social and political history of this racial group. In a study of counseling dyads, Farsimadan, Draghi-Lorenz, and Ellis (2007) found statistically significant differences between ethnically matched and ethnically non-matched dyads in their ratings of the therapeutic bond, therapy outcomes, and perceived credibility of the therapist. Farsimadan et al. (2007) noted that it is important for future research to explore different types of ethnically matched and ethnically dissimilar counseling dyads, to examine the impact of social and political issues on the counseling dyad, and to understand client preferences for ethnically similar or dissimilar counselors (p. 573). However, to date, limited literature exists concerning the dynamics unique to the Black therapist-White client cross-racial counseling dyad.

Cross-cultural counseling is a fundamental tenet of training and clinical practice. Sue, Arredondo, and McDavis (1992) posited that it is essential for counselors to build competence in working with diverse populations and noted that if practitioners do not attain multicultural competence, it is unethical for them to provide services to culturally different groups. Sue et al. asserted that multicultural competence involves three essential tasks: "self-awareness of personal assumptions and biases, knowledge and exploration of the world view of culturally different clients (without negative judgment), and the utilization of appropriate and culturally relevant interventions that are consistent with the core values and experiences of clients" (p. 7). In 2003, the American Psychological Association expressed its commitment to multicultural practice through the release of the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003).

For Black clinicians in particular, multicultural counseling skills are especially important given that a number of their client interactions may constitute interracial and intercultural dyads. Agencies such as the United States Surgeon General's Office and the World Health Organization report that although racial minority groups are at risk for many mental health disorders, they are disproportionately less likely to access mental health care (DHHS, 2001). Limited availability, financial cost, access to mental health services, and negative stigma (due to historic mistreatment by educational and medical institutions) are factors that impact racial minorities' utilization of mental health services (DHHS, 2001). Research indicates that White Americans are not only more likely to have mental health services available to them, but that they are also more likely to use these services (DHHS, 2001).

Given the increasing number of Black clinicians and the possibility that they may work with more White clients than Black clients, it is important to consider the dynamics that are

present within the Black therapist-White client counseling dyad in order to prepare multiculturally competent practitioners. Black clinicians occupy a unique position in that there is inherent power owned by the clinician in the therapy room; however, the therapist identifies with a historically oppressed and negatively stigmatized racial group. Furthermore, the complexity of racial relations throughout the history of the United States as well as the individual events that the therapist may have experienced as a result of his or her race may impact the interactions that the therapist may have with his or her client (Chapman, 2006; Comas-Diaz, 1995).

Despite the unique dynamics of the Black therapist-White client counseling dyad, relatively few empirical studies exist that examine the therapeutic process of this particular dyad. Many of the studies exploring the Black therapist-White client dyad are either theoretical (i.e. Comas-Diaz & Jacobsen, 1995; Gelso & Mohr, 2001) or anecdotal in nature (i.e. Chapman, 2006; Kelly & Greene, 2010). However, in contrast, there is substantial empirical research investigating the clinical experiences of White therapists who work with clients from diverse racial groups (Burkard, Juarez-Huffaker, & Ajmere, 2003; Chao, Wei, Good, & Flores, 2011; Gushue & Constantine, 2007; Middleton et al., 2005; Utsey, Gernat, & Hammar, 2005; Vinson & Neimeyer, 2003). To this end, the current study examined the Black therapist-White client dyad with attention given to the racial identity of Black therapists and Black therapists' reactions to their White clients. In addition, the present study explored the benefits and challenges Black therapists identify when they work with White clients.

Cross-Racial Counseling Dyads

Bordin (1979) provided an early conceptualization of the therapeutic relationship, noting that the relationship is "contractual" and "collaborative" in nature. Bordin posited that mutual agreement on the goals of therapy, mutual agreement on the tasks of therapy, and an emotional

bond between the client and therapist comprise the therapeutic relationship. Within this context, Bordin highlighted that the levels of the emotional bond between the client and therapist can vary and that the strength of this bond influences the effectiveness of the therapeutic work. Characteristics of the therapist, characteristics of the client, and the interaction between the two may impact the emotional bond developed between the therapist and the client (Bordin, 1979). Research demonstrates that the working alliance is significantly related to multicultural counseling competency, client satisfaction with therapy, client termination of therapy, and successful therapy outcomes (Constantine, 2007; Fuertes, et al., 2006; Owen, Imel, Adelson, & Rodolfa, 2012; Owen, Tao, Leach, & Rodolfa, 2011; Taber, Leibert, & Agaskar, 2011; Wang & Kim, 2010).

Research on cross-racial counseling dyads, in particular, focuses on the dynamics between White clinicians and clients who identify with racial minority groups. These studies indicate that White racial identity is significantly related to counselors' perceptions of the therapeutic working alliance and their perceived ability to work with racially similar or dissimilar clients (e.g., Burkard, Juarez-Huffaker, &Ajmere, 2003; Burkard, Ponterotto, Reynolds, & Alfonso; 1999; Utsey & Gernat; 2002; Utsey, Gernat, & Hammar, 2005). However, only two empirical studies (Carter, 1990; Carter & Helms, 1992) could be found that examined the role of Black racial identity in cross-racial counseling dyads when the therapist identifies as African American/Black. In counseling dyads in which the therapist identifies as Black or African American, Comas-Diaz (1995) explained that unique challenges may arise within the therapy work given the social and political history of race relations within the United States. Comas-Diaz (1995) suggested that issues such as power reversal, transference, and countertransference may be specific concerns within the Black therapist-White client

relationship. For example, a Black therapist who has experienced racist events may have negative reactions to a client who expresses microaggressions within the therapy session, and these reactions may interfere with the therapist's use of power in session and/or the therapist's ability to provide empathy to his or her client. Furthermore, Kelly and Greene (2010) discussed their personal experiences as African American female therapists and the reactions elicited from clients due to the stereotypes their clients held about African Americans and women. Given the distinct position Black therapists may be in (i.e. a position of power as a therapist and identification with a historically oppressed racial group) and the variety of reactions that White clients may elicit from them, the current study explored the dynamics that occur within the Black therapist-White client counseling dyad, with particular attention given to the benefits, challenges, and reactions of the therapists engaging in these clinical interactions.

Transferential Processes in the Counseling Dyad

Within the therapy dyad, both the client and the therapist bring life experiences, worldviews, values, and judgments into the session. Although therapists are often aware of the experiences and biases they may bring into the therapy room (as a result of supervision and training), clients may not necessarily be aware of or have insight into the influence of their past experiences. Therefore, clients may unconsciously recreate or "transfer" their past experiences and/or perspectives onto their therapists. Broadly defined, transference refers to "the client's unconscious shifting to the therapist feelings and fantasies that are reactions to significant others in the client's past" (Corey, 2009, p. 73). Transference may include positive or negative reactions to the therapist and may influence the ways in which a client may interact with his or her therapist. Transference is generally viewed as a naturally occurring process and an important

area of exploration for the therapist and client in order to achieve successful therapy outcomes (Chapman, 2006; Corey, 2009; Gelso & Mohr, 2001; Kelly & Greene, 2010).

For the Black therapist working with a White client, there may be a range of reactions that the client may have towards his or her therapist. In a discussion of their personal experiences as Black therapists working with both Black and White clients, Kelly and Greene (2010) highlighted that gender, skin complexion, hair texture, and sexual orientation were all important contributors to how clients reacted to them within therapy. With their work with White clients specifically, the authors noted the importance of attending to power dynamics within the therapy relationship, explaining that clients may unconsciously (or consciously) exert power in the therapy session in similar ways that power might be exerted in the larger society. Chapman (2006) explored her experience as a Black therapist working with a White client and shared both positive (e.g. perceptions of her as nurturer and empathic) and negative reactions (e.g. devaluation of therapist and perceptions of Blacks as angry/violent) elicited by the client. Chapman (2006) further explained that the reactions expressed by her client sparked emotional reactions within her (e.g. feelings of victimization, decreased self-efficacy, and pity) and shared the influence that her reactions had on her work with the client.

Although therapists may be aware of the experiences and worldviews that they bring into the therapy work, they too have a number of reactions that may be elicited as a function of the characteristics, behaviors, or experiences of their clients. "Countertransference" refers to "exaggerated interfering or facilitating thoughts, feelings, or behaviors that a therapist experiences toward a client … [that can be] conscious or unconscious and a beneficial therapeutic tool" (Ladany, Walker, Pate-Carolan, & Gray Evans, 2008, pp. 36-37). Schwartz and Wendling (2003) noted that based on the extent to which clinicians are aware of their reactions

and are able to utilize those reactions to understand their work with clients, countertransference can either enhance or negatively impact the therapeutic process. In a content analysis of empirical studies of countertransference from 1990-2001, Schwartz and Wendling found that countertransference studies focused on three primary areas: clients diagnosed with personality disorders, clients with past trauma, and children and adolescents with mental health concerns (p. 652). The authors called for a more broad study of countertransference, noting the importance of examining this phenomenon when therapists work with diverse client populations.

In addition, Gelso and Mohr (2001) proposed a conceptualization of countertransference that acknowledges the influence of racial identity and sexual orientation on the clinician. The authors introduced the notion of "culture-related countertransference" which refers to "therapists' culture-related distortions of the patient and rigid interpersonal behaviors rooted in his or her vicarious experiences with members of the patient's racial group" (p. 59). Gelso and Mohr (2001) described potential reactions that might occur when the therapist identifies as a member of a minority group and the client identifies as a member of the majority group. The reactions experienced may include: "fear, disdain, superiority, or comfort" (Gelso & Mohr, 2001, p. 60). Although limited empirical studies exist about the varying types of countertransferential reactions experienced by clinicians, Betan et al. (2005) proposed an eight factor model of countertransference in which therapists may experience any of the following feelings toward clients: overwhelmed/disorganized, helpless/inadequate, special/overinvolved, positive, sexualized, disengaged, parental/protective, and criticized/mistreated. To date, no studies could be found that examine the relationships between the racial identity attitudes of minority therapists and the type of feelings they experience when working with White clients. Therefore,

the present study sought to explore the relationship between Black racial identity and countertransference within the Black therapist-White client counseling dyad.

Research Questions

Research suggests that African American/Black counselors may experience a number of reactions when working with White clients (Chapman, 2006; Comas-Diaz & Jacobsen, 1995; Kelly & Greene, 2010); however, limited empirical research examines the unique dynamic present within the Black therapist-White client counseling dyad. The purpose of the current study was to examine the relationship between Black racial identity and countertransference experienced by Black therapists when working with White clients. To this extent, the dissertation addressed the following research questions:

RQ_1: Does Black racial identity (i.e. Pre-Encounter, Post-Encounter, Immersion, Emersion, and Internalization) predict countertransference reactions (i.e. overwhelmed/ disorganized, helpless/inadequate, special/over-involved, positive, sexualized, disengaged, parental/protective, and criticized/mistreated) experienced by Black therapists when working with White clients?

RQ_2: What are the benefits and challenges that Black therapists self-report when working with White clients?

Based on the exploratory nature of the current study, preliminary hypotheses for the first research question (RQ_1) were:

H_1: Pre-Encounter attitudes will account for a significant amount of variance in positive and special/over-involved countertransference reactions.

H_2: Post-Encounter attitudes will account for a significant amount of variance in overwhelmed/disorganized and helpless/inadequate countertransference reactions.

H_3: Immersion-Emersion attitudes will account for a significant amount of variance in disengaged and criticized/mistreated countertransference reactions.

H_4: Internalization attitudes will account for a significant amount of variance in positive countertransference reactions.

Given the exploratory nature of the current study, these preliminary hypotheses were developed based on Black racial identity theory and research on Black racial identity statuses, specifically potential emotional states individuals may experience with each identity status. Due to the qualitative, exploratory nature of the second research question, there were no specific hypotheses. However, by examining the range of experiences shared, consistent themes and response patterns were identified. The findings of the present study provide insight into the multicultural training needs of clinicians who identify as African American/Black.

Chapter II

Literature Review

Method for Literature Search

Empirical articles used for the literature review were drawn from three online databases: PsycInfo, PsycArticles, and Ebscohost. For each database, keywords for the search included: race, racial identity, Black Americans, Black therapists, Black racial identity, therapy, working alliance, counseling dyads, supervision dyads, cross-cultural counseling, cross-racial counseling, transference, countertransference, multicultural competence, multicultural counseling, multicultural training, microaggressions, Westen Countertransference Scale, and Black Racial Identity Attitudes Scale. Abstracts of journal articles were reviewed and those relevant to the research questions were included. In addition, relevant book chapters identified in the search results were included. Articles and book chapters dating earlier than 1980 were only included if they provided seminal information and context for the variables of the current study. The literature review comprises three key topic areas that are presented accordingly: (a) Black Racial Identity Development, (b) Racial Identity and Implications for Counseling, and (c) Transferential Processes in Therapy.

Black Racial Identity Development

Although often used interchangeably, race and racial identity are distinct constructs. Prior to the discussion of racial identity, it is important to outline the differences that exist between race and racial identity. According to Helms and Talleyrand (1997), race refers to an "ascribed social category based on phenotypic features that has no biological basis" (p. 1246). As a result of race, individuals may experience certain privileges or disadvantages within a society. In contrast, racial identity is "a sense of group or collective identity based on one's perception that

he or she shares a common racial heritage with a particular racial group" (Helms, 1990, p. 3). Within this context, racial identity involves a process of identifying attitudes towards one's racial group as well as recognizing attitudes towards other racial groups, and thus, has a number of social and psychological implications for the individual. Furthermore, it is also important to distinguish racial identity as being a separate construct from ethnicity. Helms and Talleyrand (1997) explained that although ethnicity refers to a collective or shared identity, it does not necessarily involve identification with phenotypic traits of a specific race, nor the differential treatment one may experience as a result of having the phenotypic traits of a particular race.

Early studies of racial identity emerged in the 1930s with the work of Eugene and Ruth Horowitz (Horowitz, 1939; Horowitz & Horowitz, 1938). Throughout their careers, the Horowitzes explored the extent to which racial prejudice was a learned behavior and how racial attitudes shaped personal and group identity for White and Black children. Drawing on the work of the Horowitzes, Kenneth and Mammie Clark further explored the racial preferences of Black children specifically and the influence of these preferences on self-concept (Clark & Clark, 1939). The findings of the studies completed by Clark and Clark influenced racial identity theory as well as public policy concerning segregation within the American educational system (Jackson, 2001). Formal models of Black racial identity were later developed within the context of the Civil Rights Movement in the 1950s and 1960s. These initial models fell into one of two categories: "Client-As-Problem Models (CAP) and Nigrescence Racial Identity Models (NRID)" (Helms, 1990, p. 9).

The CAP perspective of Black racial identity focused on the personality development of Black Americans. Within these models, attention was given to how Black Americans responded to various social issues and dynamics in society, particularly when interacting with other racial

groups (Helms, 1990). For example, in the counseling literature, research examined how Black Americans would express anger in therapy when interacting with a White therapist (Helms, 1990, p. 10). A number of the CAP models sought to define types of Black Americans and to predict and explain the behaviors of each type (e.g. Vontress, 1971). In contrast, NRID models examined the process of "becoming Black" in which the attitudes towards and identification with one's racial group were the primary foci (Helms, 1990, p. 17). NRID models sought to understand the process by which individuals could "develop a healthy Black racial identity and argued that over-identification with Whiteness and White culture was psychologically unhealthy" (Helms, 1990, p. 17). Contemporary models of racial identity, most notably the Nigrescence Model (Cross, 1971) draw from the early NRID models. The Nigrescence perspective influenced the development of a number of Black racial identity models (e.g., Banks, 1981; Gay, 1984; Jackson, 1975; Milliones, 1980; Sellers, et al., 1997), including the model proposed by Helms (1984), which is the framework used for the current study.

In the original conceptualization of the Nigresence model, Cross (1971) described the process of Black racial identity development as the "Negro-to-Black conversion experience." Cross (1971) posited that Black Americans experienced a five stage developmental process to attain a healthy Black identity. Cross (1991) later referred to this process as Nigrescence, "the process of becoming Black" (Cross, 1991, p. 147). Cross (1991) explained that his model described "a resocializing experience that seeks to transform a preexisting identity (a non-Afrocentric identity) into one that is Afrocentric" (Cross, 1991, p. 190). Cross (1971) proposed five stages of achieving an integrated Black racial identity: Pre-Encounter, Encounter, Immersion-Emersion, Internalization, and Internalization-Commitment. Since 1971, Cross published two further revisions of the model in 1991 and 2001 in which he explained and refined

each stage in the model and developed an inventory to measure the stages of the model, the Cross Racial Identity Scales (CRIS) (Cross, 2001). Due to the clarification of the original model and elaboration provided for each stage in Cross (1991), this revision will be the focus within the current literature review; however, I note key distinctions/modifications from the 1971 model. In addition, attention will also be given to the revisions highlighted in Cross (2001).

Cross (1971) originally described individuals within the Pre-Encounter stage as having a preference for Whiteness and Eurocentric culture. Cross noted that individuals held attitudes that idealized Whiteness and devalued Black culture, which led them to abandon their Black identity. However, Cross (1991) explained that within the Pre-Encounter stage, individuals may hold a wide range of attitudes some of which comprise: attributing minimal importance to the influences of race, viewing race primarily as a burden (in which identification is only with negative stigmas of being Black), or idealization of White culture and a devaluation of Black culture and values. Cross (1991) posited that Pre-Encounter attitudes may originate from five areas: "miseducation, a Eurocentric cultural perspective, race image, assimilation, value structure, or value orientation" (p. 196). Miseducation and Eurocentric cultural perspective each refer to the formal education system in which Black history and culture are abandoned by school systems and Eurocentric culture and history are the foci of learning. Race image refers to the sensitivity one may experience to negative stereotypes of Blacks and a fear of representing anything that is associated with Black identity (Cross, 1991, p. 196). Assimilation is a focus in which Blacks must strive to be accepted by Whites and conform to their culture and values. The assimilation perspective views social mobility as the process for accomplishing this task. Value structure and orientation described the range of differences in values that Blacks have (i.e.

individualism vs. communalism; low salience vs. high salience of Black identity) (Cross, 1991, p. 196).

Events or experiences that challenge the individual to examine how he or she thinks about his or her race comprise the Encounter stage (Cross, 1971). The individual is no longer able to deny his or her race because the event or experience illuminates the distinction of the individual as a Black person within a racist society. Furthermore, the individual struggles with the abandonment of the identity he or she held in Pre-Encounter, but has not yet formed a new identity. Cross (1991) noted that within this stage, previous beliefs and values become a focus of exploration due to the dissonance that surfaces as a result of having events or experiences that do not conform to these beliefs or values (p. 199). Cross provided the example of police brutality as an event that might occur within the Encounter stage (Cross, 1991, p. 199). Cross noted that it is not a single event or experience that causes an individual to examine their racial identity, but multiple events that contrast with their notions of what it means to be Black or to identify with the Black community (p. 199).

Immersion-Emersion refers to process in which individuals begin to reconceptualize their racial identity and to form a new orientation that values their Black identity. Cross (1971) describes this stage as a two-part process in which the individual "immerses" him or herself into Black culture and adopts an identity based on what he or she believes is the way to be Black. In Emersion, the individual moves from an idealization of what it means to be Black, and learns about the complexities of Black history and culture. Within this stage, Cross (1991) explained that individuals may begin to read Black literature, join organizations dedicated to Black issues, focus on politics that impact the Black community, engage in new social activities, and focus on things that promote Afrocentricity. Although there is a positive orientation to Black culture,

Cross (1971, 1991) highlighted that as individuals immerse themselves within Black culture, they may experience negative feelings towards White individuals and may devalue the culture of White individuals. However, within the Emersion phase of this stage, individuals begin to reflect on and gain control of their emotions. Individuals begin to move from an idealization of Black culture to a more complex understanding of the culture and challenges faced by those within the culture (Cross, 1991).

The Internalization stage refers to the development of an integrated, positive Black identity (Cross, 1971). Cross (1991) described individuals as having a "humanist" perspective in which individuals recognize the significance of their Black identity and are able to appreciate the identities of others (p. 211). Individuals are also able to recognize the importance of other components of their identity (i.e. gender, religion, sexual identity, etc.). Within this stage, individuals embrace their Black identity and are able to utilize their identity to frame how they view and interact in the world. Unlike the varying emotional states in the Immersion-Emersion stage, individuals are comfortable with who they are and experience a reduction in cognitive dissonance between their personal identity and group identity (Cross, 1991, p. 211). In addition, Cross (1991) explained that the individual begins to develop a multicultural perspective. Cross (1991) highlighted three functions of an integrated Black identity: "to defend against negative psychological stress in a society that can be racist; to provide a sense of purpose, meaning, and affiliation; and to provide psychological mechanisms to facilitate social intercourse with people, cultures, and situations outside the boundaries of Blackness" (p. 215).

Closely related to the Internalization stage, Cross (1971) stated that the fifth stage, Internalization-Commitment, is the continuous maintenance of an internalized Black identity. Within this stage, individuals frequently reflect on their Black identity and explore social

activism within their community. Individuals make a personal commitment and seek opportunities to incorporate their racial identity into all areas of their lives. Cross (1991) further explained that the distinction between this stage and Internalization is the purposeful commitment that the individual makes (rather than a fluctuation of interest) in sustaining their racial identity. However, Cross (1991) noted that Internalization-Commitment may be viewed as a second phase of the Internalization stage given that there are no empirical distinctions between these two phases. Cross (2001) did not recognize Internalization-Commitment as a distinct stage, however expanded Internalization to include four identities: Black Nationalist, Biculturalist, Multiculturalist Racial, and Multiculturalist Inclusive. However, Cross (2001) noted that further research is necessary to clearly define each of these identities (p. 207).

Drawing on the work of Cross (1971), Parham and Helms (1981) further explored and expanded the Black racial identity model. Parham and Helms contended that the stages of Cross' model are continuous and that individuals could potentially be in more than one stage simultaneously. In addition, the authors noted that considerable intragroup differences may exist within each stage. Helms (1990) described each status of Black racial identity as a "worldview" and explained that each status serves as a "cognitive template to organize information about themselves, other people, and institutions" (p. 19). In contrast to the descriptions provided by Cross (1971, 1991), the stage of an individual is thought to be a reflection of experiences and interactions with society at a particular time. Furthermore, stages continue to change as the individual encounters new experiences. The stages do not necessarily reflect a linear progression, and therefore an individual may cycle (or recycle) through each of the stages (Parham & Helms, 1985; Helms, 1990). In addition, Helms (1990) concluded that there are four (rather than five) stages: Pre-Encounter, Encounter, Immersion-Emersion, and Internalization. However, the

experiences of an individual at each stage reflect the descriptions provided by Cross (1971, 1991).

In sum, Helms (1990) explained that during the Pre-Encounter stage, individuals identify with and idealize White culture, and as a result, they may reject their Black identities as well as any experiences that they may have as a result of their racial minority identity. The Encounter stage involves events or learning experiences in which the individual recognizes that she or he may not have the same opportunities or privileges as a White person, but has not yet formed a Black racial identity. The Immersion stage occurs when the individual engages in a variety of activities that enhance their connection to their Black identity. Within this stage, individuals may experience negative feelings towards individuals who identify as White. In the Emersion stage, individuals begin to develop a positive Black identity and negative feelings begin to dissipate. During the Internalization stage the individual identifies with Black culture and has an identity that does not devalue the racial identity of others (Helms, 1990). Since the development of Black racial identity developmental models, research on racial identity has expanded to include: White racial identity models, People of Color racial identity models, and color-blind racial attitude models (Carter, Helms, & Juby, 2004; Chao et al., 2011; Gushue & Constantine, 2007; Helms, 1990, 1995; Neville, Spanierman, & Doan, 2006).

Racial Identity and Implications for Counseling

Within a theoretical article examining the effects of racial identity attitudes on the counseling process, Helms (1984) proposed the Black-White Interaction model. Helms contended that racial identity influenced the attitudes and behaviors of each individual within the counseling dyad and that the interaction of the two determined the nature of the counseling relationship as well as the outcomes of counseling. Helms (1984) described four types of

counseling relationships: parallel, crossed, progressive, and regressive (p. 2). In cross-racial counseling dyads, the parallel relationship is one in which the counselor and the client share similar attitudes about Blacks and similar attitudes about Whites. The crossed relationship occurs when the counselor has different and opposing views towards Blacks and Whites than the client holds. Within the progressive relationship, the counselor holds racial attitudes that are at a higher stage of identity development than the client; and therefore, the counselor is able to move the client toward a healthier stage of racial identity. The regressive relationship comprises a counselor who is at a lower level of racial identity development than the client and is therefore unable to understand the client's worldview (Helms, 1984, pp. 2-4). Helms (1984) noted that regressive relationships are most likely to result in termination by the client.

Carter and Helms (1992) examined the association between the counseling relationship types proposed by the Black-White Interaction model and the affective state, cognitive reactions, and global perception of the therapeutic working alliance. Utilizing a sample of 33 simulated counseling dyads (10 Black and 23 White clients and 6 Black and 27 White counselors), there were 17 parallel relationships, 7 progressive relationships, 9 regressive relationships, and no crossed relationships. Relationship types were determined using participants' raw scores on the Black Racial Identity Attitudes scale and White Racial Identity Attitude scale and transforming those scores into percentiles based on preliminary norms for each of the scales. In addition to completing the racial identity attitudes scales, participants also completed the Therapist's Intentions Scale, Client Reaction Inventory, Session Evaluation Questionnaire, State-Trait Anxiety Inventory, and the Hostility Dimension of the Symptom 90 Revised Checklist.

Within the parallel relationships, results revealed 15 significant correlations between affective cognitive reactions and counselor intentions. In progressive relationships, there were 14

significant correlations between affective cognitive reactions and counselor intentions. Analyses of regressive relationships showed 17 significant correlations between affective cognitive reactions and counselor intentions. Within each relationship type, different affective states and cognitive reactions emerged, suggesting that racial identity attitudes influence the process and outcome of counseling as well as perceptions of the counseling relationship.

Similarly, Carter (1990) explored the relationship between racial identity attitudes and counseling process (specifically counselor intentions) and examined differences in counseling process between same-race and cross-race counseling dyads. Within a sample of 31 simulated counseling dyads, 19 comprised of White counselors/White clients, 8 included White counselors/Black clients, and 4 consisted of Black counselors/White clients. All participants completed the Black or White Racial Identity Attitudes Scale, Therapist's Intention Scale, Client Reaction Scale, and a demographic questionnaire. In Black counselor/White client dyads, Pre-Encounter attitudes were significantly and negatively related to the counselor intention of Hope; and Encounter attitudes were significantly and positively related to Feelings (p. 150). Disintegration attitudes of White clients (i.e. "conscious but conflicted acknowledgement of one's Whiteness," Helms, 1990, p. 58) were significantly and positively related to client reactions of Lack Direction and Ineffectiveness.

In addition, significant, positive relationships were found between Reintegration attitudes (i.e. "acceptance of the belief of White racial superiority and Black inferiority," Helms, 1990, p. 60) and the client reaction of "Lack Direction" and "Ineffective." The client reaction, "Better Understanding," was significantly related to Encounter attitudes of the counselor. Internalization attitudes of the counselor were significantly related to client reaction of "No Reaction" (p.150). Within the Black counselor/White client dyads, counselor intention of Relationship (i.e.

"counselor's desire to improve the quality of the relationship") was used significantly more than in any of the other dyads. Also, the client reaction of "Hopeful" was found to occur significantly more within the Black counselor/White client dyad than in any other dyad. These findings suggest that Black counselors holding Pre-Encounter attitudes may not have high expectations for the progress that their clients can make in therapy. In contrast, Black counselors holding Encounter attitudes may be more likely to process feelings (of their own and the client) concerning racial issues that occur within session. Additionally, results of the study indicate that White clients reactions may relate more to their own racial identity attitudes rather than to the intentions of the Black counselor.

Recently, the Black-White Interaction Model (also referred to as the Racial Identity Social Interaction Model) was used to investigate the racial dynamics within same-race and cross-racial supervisory dyads. Utilizing racial identity theory and the Racial Identity Social Interactional Model as the theoretical framework, Jernigan, Green, Helms, Perez-Gualdron, and Henze (2010) conducted a qualitative study examining racial issues in supervision from the perspective of supervisees of color. Results indicated that supervisees of color were more likely than their supervisors to initiate conversations about race and that racial issues were important to discuss in both same-race and cross-racial dyads. Analyses also revealed that many of the supervisory relationships were either regressive or progressive in nature, in which supervisors and supervisees reflected varying levels of racial identity development and comfort in addressing racial issues. This study highlighted how racial identity status influenced how racial dynamics were attended to and the impact of these dynamics on the supervisory relationship.

In addition to the study of the Racial Identity Social Interactional Model, studies have been published by Black therapists that explore their clinical experiences with White clients.

Although these clinicians do not detail their racial identity statuses formally, the experiences they share suggest that Black racial identity attitudes may influence the counseling process. Kelly and Greene (2010) examined how their identities as African American therapists affected client perceptions. Kelly and Greene (2010) highlighted that there is considerable intra-group variability among African American therapists and that this variability will impact how clients perceive the therapist. The authors emphasized the importance of attending to issues concerning race, noting that power dynamics that occur (between Black and White Americans) in society may surface within the therapy relationship. Kelly and Greene (2010) noted the significance of attending to power dynamics and the reactions (i.e. defensiveness, discomfort, etc.) that the therapist may experience. In addition, the authors shared that African American therapists should be aware that factors such as skin complexion, hair texture, and hair style may confirm stereotypes held by clients and these should be areas of exploration within the discussions of racial issues.

Similarly, Chapman (2006) explored her experience as a heterosexual, African American female therapist working with a homosexual, White male client. Chapman described her racial identity as an integral part of her identity and highlighted conflicts within her identity. Chapman shared her internal experiences of shame about being African American, despite verbal expressions of racial pride (p. 221). Chapman also detailed early experiences of ostracism when attending a predominantly White school and shared how these early feelings contributed to the shame she experienced as an adult. Chapman highlighted the ways in which supervision allowed her to recognize the extent to which she experienced internalized racism and how this impacted her interactions with her client. During therapy sessions, Chapman recalled the ways she processed racial differences with her client, noting a variety of feelings she experienced which

included: “rejection, shame, devaluation, anger, and helplessness” (pp. 224-226). Although Chapman was aware of the influence of racial identity on her interactions with clients, she did not provide a theoretical examination of her racial identity. The descriptions provided by Chapman suggest that she held attitudes similar to those within the Encounter status and through her interactions with her client (along with supervision) she was able to hold attitudes consistent with those in the Immersion-Emersion status.

Within recent research on Black racial identity attitudes, there is evidence to suggest that Black clinicians may experience a number of affective concerns when working with White clients. For example, Carter, Pieterse, and Smith (2008) examined the relationship between racial identity status and expression of anger among Black Americans. Participants in the sample completed the Black Racial Identity Attitude Scale and Anger Expression Scale. The two predominant statuses that emerged were Undifferentiated (i.e. no dominant identity status) and Immersion-Emersion. Analyses revealed that Undifferentiated profiles had significantly lower Anger-Out scores and higher Anger-Control scores in comparison with the Immersion-Emersion group. Immersion-Emersion profiles were associated with significantly lower Anger-Control scores and significantly higher Anger-Out Scores. Consistent with Black racial identity theory, Immersion-Emersion attitudes were significantly related to negative affective states.

Carter and Reynolds (2011) examined the relationship between race-related stress, racial identity status attitudes, and emotional states. A sample of 229 Black adults completed the Index of Race-Related Stress, People of Color Racial Identity Attitude Scale, Profile of Mood States, and a personal data sheet. Canonical correlation analysis revealed that racial identity was significantly related to depression, anger, confusion, tension, and fatigue. In addition, within this sample, Black women reported that they were more likely to experience institutional and cultural

racism than Black men. Likewise, in an examination of the identity development process of Black adolescent girls and young women, Thomas, Hacker, and Hoxha (2011) discussed the concept of "gendered racial identity." Gendered racial identity referred to the intersection of participants' oppressed racial and gender identities rather than the oppression of one component of their identities. Each of the studies presented suggests complex psychological and affective processes involved as Black individuals interact in the world. By understanding how these experiences influence racial identity attitudes, and how racial identity attitudes impact the counseling process, there are a number of implications to consider in the training and supervision of Black clinicians.

Research within the counseling literature, however, has primarily focused on the role of White racial identity within cross-racial counseling dyads. Burkard, Ponterotto, Reynolds, and Alfonso (1999) examined the relationship between White racial identity attitudes and counselor and observer ratings of the therapeutic working alliance. The study included a sample of 124 White graduate trainees enrolled in counseling classes. Participants completed the White Racial Identity Attitudes Scale, Working Alliance Inventory, and the observer form of the Working Alliance Inventory. Utilizing an analogue research design, participants were assigned to one of two conditions: a therapy condition with an African American client or a therapy condition with a White client. Participants listened to a 12-minute section of an initial interview and completed two ratings: (1) participants placed themselves in the role of the counselor and (2) participants rated their observations of the relationship between the counselor and client. Hierarchal regression analyses revealed that White racial identity attitudes significantly accounted for variance in counselor ratings of the working alliance in same-race and cross-racial dyads. The variance in counselor ratings of the working alliance varied by racial identity status:

Disintegration attitudes accounted for 22%, Reintegration accounted for 11 %, Pseudo independence accounted for 14%, and Autonomy accounted for 8%. No significant relationship was found between White racial identity attitudes and observer ratings.

Vinson and Neimeyer (2003) conducted a longitudinal study exploring the relationship between racial identity status and multicultural counseling competency among White and non-White trainees. The sample included 87 counseling psychology trainees (of which 13 participants identified as non-White) from 26 different training programs that were recruited in 1997. In 1997 and 1999 (2-year follow-up), participants completed the White Racial Identity Attitudes Scale, People of Color Racial Identity Attitude Scale, Multicultural Counseling Awareness Scale-B, Motivation to Control Prejudice Scale, and a demographic questionnaire. Test-Retest correlations demonstrated stability in multicultural competence, but variability in racial identity. Paired t-tests analyses revealed a significant increase in multicultural awareness knowledge and skills for White and non-White trainees. However, when comparing White and non-White trainees, White trainees reported a significantly higher increase in knowledge and skills. Racial identity development did not change significantly over the two-year period. The relationship between racial identity and multicultural competence remained consistent for White trainees, with higher levels of racial identity being significantly associated with higher levels of multicultural competence. For non-White trainees, there were no significant relationships between racial identity and multicultural competence. Vinson and Neimeyer (2003) suggested that future research should explore differences in the racial identity development process for White and non-White trainees as well as the processes that influence their multicultural competence. In addition, the authors note that attention to racial identity development may be an important component to address throughout training.

Similarly, Middleton et al. (2005) examined differences in White racial identity statuses among counselors, counseling psychologists, and clinical psychologists and examined the relationship between racial identity statuses and self-reported multicultural competence. The sample included 412 participants identified through membership in either the American Counseling Association or the American Psychological Association. Participants completed the White Racial Identity Attitudes Scale, Multicultural Counseling Inventory, and Survey of Demographic Training Data. Multivariate analyses revealed no significant differences in racial identity statuses based on professional identity (i.e. counselors, counseling psychologists, and clinical psychologists). However, significant differences were found in multicultural competence; participants who reported higher statuses of White racial identity (i.e. Pseudo-Independence and Autonomy) also reported higher levels of multicultural counseling competency (p. 450). The authors concluded that racial identity development should be an important component within clinical training because higher levels of racial identity impact multicultural competence.

In addition, Utsey, Gernat, and Hammar (2005) conducted a qualitative study examining the interaction of White racial identity, White privilege, and color-blind racial attitudes within counseling and supervision. Utsey et al. (2005) explored how the interaction of these variables impacted the responses of counselor trainees when racial material was presented within a therapy or supervision session. Participants included 8 White counselor trainees who participated in a focus group. Qualitative analysis revealed 19 themes within six categories: White racial consciousness, White racial awareness, minimizing race, discomfort with racial issues, reducing the threat of race, and finding a comfort level. Utsey et al. (2005) concluded that discussing racial issues remains a difficult and "taboo" topic and that the racial identity attitudes held by

participants influenced their ability and comfort level with addressing racial issues. In addition, Utsey et al. (2005) recommended that professors and supervisors attend to the anxiety experienced by counselor trainees concerning racial issues and that racial identity development be a focus within clinical training.

Chae et al. (2010) further explored the relationship between White racial identity, cultural competence, and self-esteem within a sample of rehabilitation counseling students. Participants included 134 master's level students in their first year of training who identified as White. Participants completed the White Racial Identity Attitudes Scale, Multicultural Counseling and Awareness Scale, Rosenberg Self-Esteem Scale, and a Demographics Sheet. Multiple regression analyses revealed that White racial identity was predictive of multicultural competence such that lower levels of racial identity development predict lower levels of cultural competence and higher levels of racial identity development predict higher levels of cultural competence. Chae et al. noted that trainees at lower levels of racial identity development may be more likely to minimize the importance of cultural issues within therapy work. In addition, participants who reported lower levels of racial identity development reported significantly lower self-esteem than participants with higher levels of racial identity development. The authors suggested that future studies should examine the relationships that exist between racial identity, psychological functioning, and multicultural competence. In addition, Chae et al. also noted that attention to racial identity development should be incorporated into diversity training in counseling programs to prepare students to work with clients from diverse racial and cultural backgrounds.

In sum, findings from studies of White racial identity (of therapists) demonstrate significant relationships between racial identity attitudes, the working alliance, and multicultural counseling competency. Research reveals that racial identity development is an important

component of multicultural training and that racial identity attitudes may influence the affect, behaviors, and cognitions of the therapist when working with racially different clients. However, no recent studies could be identified that examines how Black racial identity attitudes impact the dynamics of cross-racial counseling dyads when Black clinicians work with White clients. Therefore, the current study sought to address these limitations within the racial identity literature. In addition, the present study sought to expand the work of Cross (1971, 1991) and Helms (1990) through the examination of the relationship between Black racial identity statuses and countertransference reactions in cross-racial counseling dyads.

Transferential Processes in Therapy

Goldstein and Goldberg (2004) provided an overview of the evolution of transference and countertransference and their meanings within psychotherapy. Goldstein and Goldberg suggested that there are two models of transference: "the old model of transference" developed within the context of psychoanalysis and "the new model of transference" focused on relational dynamics between the therapist and client. Grounded in Freudian psychoanalysis, the old model of transference, "views transference as a displacement of feelings and thoughts from important people of childhood to a relatively neutral, anonymous, and abstinent therapist…[and] is based both on the actual and fantasized past as experienced by the patient" (Goldstein & Goldberg, 2004, p. vii). From this perspective, Freud posited that clients would have "intense feelings of affection or antagonism" towards the therapist regardless of the behavior of the therapist (p. 4). Within psychotherapy, exploration of transference brought unconscious thoughts and feelings into consciousness and united childhood experiences with present functioning. Initially, Freud viewed transference feelings as a barrier within therapy; however, he (and future psychoanalysts) later acknowledged that addressing transference was the crux of therapy and that without

exploration of this phenomenon, the client would not be able to recover from the distress he or she experienced (pp. 4-5).

The introduction of the "new model of transference" occurred in the late 1970s when Merton Gill, a psychoanalyst, described transference as "a phenomenon emerging between two people (the therapist and the client) rather than one person (the client) as originally suggested by Freud" (Goldstein & Goldberg, 2004). Goldstein and Goldberg noted that Gill believed that "transference included the patient's natural, spontaneous responses to the present situation in which the therapist was a new, present, real object, whom the patient to some extent (consciously or unconsciously) perceived realistically" (p. 13). The new model focused on the present experiences of the client as well as his or her childhood experiences as the template for understanding the unconscious thoughts and feelings of the client. Within this context, exploration of transference emerged from the current relationship between the therapist and client. The shift from the old model to the new model recognized that the therapist was not a "neutral, objective figure" (as suggested by Freud), but one with a complex past who brings his or her own personal experiences into the therapy room (p. 15). In addition, the new model provided a novel framework for examining the dynamics between the therapist and client for therapists external to the field of psychoanalysis. Contemporary psychoanalysts continue to use the "intersubjective" or "joint" perspective of transference; however, Goldstein and Goldberg (2004) explained that the use of the old or new model of transference may vary based on the individual client and the orientation of the therapist.

Countertransference, as originally conceptualized by Freud in the early 1900s, was a distinct phenomenon from transference and was thought to occur sporadically throughout treatment, be indicative of unresolved conflicts of the therapist, and to arise as a reaction to

transference (Goldsteing & Goldberg, 2004). Freud viewed countertransference negatively and believed this dynamic hindered the course of treatment. In a summary of the original paper on countertransference by Freud, Goldstein and Goldberg (2004) shared that countertransference "refers to unconscious reactions of the therapist to the patient which, causing blind spots, impeded therapeutic functioning" (p. 21). Presently, countertransference as defined by Freud is considered the "classical" view of countertransference. In addition to the classical view of countertransference, Hayes, Gelso, and Hummel (2011) noted three additional views: "totalistic, complementary, and relational" (pp. 88-89). The totalistic perspective views countertransference as all reactions of the therapist towards the client and posits that countertransference may be utilized to enhance the therapy work. From the complementary lens, countertransference provides insight into the interpersonal style of the client. The behaviors of the client are thought to elicit certain reactions from the therapist and therapist is able to use this material to enhance the interpersonal functioning of the client. The relational perspective views countertransference as "mutually constructed" in which the feelings, unresolved conflicts, and behaviors of the therapist and client interact with one another to contribute to the in-session experiences of the therapist (Hayes, Gelso, & Hummel, 2011, pp. 88-89).

Within contemporary descriptions of countertransference there is an integration of these four perspectives. Hayes et al. (2011) noted that there are important insights gained from each lens and that a comprehensive view of countertransference makes this phenomenon clinically and empirically useful (p. 89). Goldstein and Goldberg (2004) describe countertransference as "all the thoughts, reactions, and feelings that the therapist has towards the patient, both conscious and unconscious" (p. 22). Furthermore, Goldstein and Goldberg highlight that "character traits and attitudes, ethno-cultural, socioeconomic, and gender identification with their implicit biases

contribute to the therapist's perceptions, thoughts, attitudes and reactions toward the patient" (p. 22). Countertransference in its contemporary conceptualization is not necessarily problematic when addressed appropriately, but provides rich insight into the dynamics between the therapist and the client.

Gelso and Hayes (2007) contended that countertransference has five structural elements: "origins, triggers, manifestations, effects, and management" (p. 42). Origins refer to unresolved conflicts within the therapist's past. The conflicts may be conscious or unconscious and typically occur during childhood, but may also reflect the current experiences or vulnerabilities of the therapist. For example, a therapist who is going through a divorce due to infidelity may have difficulty working with a client who is cheating on her partner. Triggers are events in therapy or client characteristics that bring the conflict to the awareness of the therapist. In the example provided, traits or behaviors of the client that resemble the therapist's partner may trigger reactions within the therapist. Manifestations refer to expressions of countertransference reactions and these include: thoughts, emotions, and behaviors. Gelso and Hayes noted that the most common emotion that therapists experience is anxiety; the most common behaviors are avoidance, withdrawal, and under involvement with the client and the material presented in therapy; and the most common cognition is distortion of the material presented in therapy (pp. 42-46).

Effects refer to the impact that countertransference has on therapy process and outcome. Depending on how the therapist manages countertransference, the effects may either facilitate or hinder therapy. Gelso and Hayes (2007) noted that negative effects include: avoiding client emotions, inaccurate recall of client material, over involvement with the concerns presented by the client, and weak therapeutic alliances. Positive effects may develop such as providing

additional empathy and support to clients and building a stronger therapeutic alliance. Gelso and Hayes emphasized that management of countertransference is a key component to effective therapy. Countertransference management involves five skills: "therapist self-insight, self-integration, empathy, anxiety management, and conceptualizing skills" (pp. 46-48). Therapist self-insight necessitates frequent self-reflection in order to develop awareness into who he or she is as a person and as a therapist as well as the conflicts and biases associated with each of those roles. Self-integration is an understanding of one's own boundaries and the ability to recognize and separate client issues from personal issues. Empathy is the ability to be able to identify with the emotions experienced by the client regardless of the therapist's personal issues. Anxiety management involves tools to identify, "tolerate," and learn from feelings of anxiety. Conceptualizing skills require an application of theory in order to understand the concerns presented by the client and the dynamics occurring between client and therapist (pp. 46-48).

Gelso and Hayes (2007) provided a comprehensive review of the empirical research on countertransference from the 1980s through the present; however, of all the studies reviewed, no empirical studies examined cross-racial therapy. Relatively, few empirical studies investigated cross-cultural counseling in general, and of those that did, the focus was either on exploring therapist homophobia when working with gay or lesbian clients (e.g. Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993) or on gender and gender role conflict (e.g. Fauth & Hayes, 2006). The crux of the countertransference literature primarily centers on therapists' unresolved psychological conflicts, personality characteristics of the client, therapist behaviors, client behaviors, management strategies, and self-disclosure in therapy. Within studies centered on therapists' unresolved psychological conflicts, research shows that countertransference may derive from: "family of origin, narcissism, roles as a parent or a romantic partner, unmet needs,

grandiosity, and professional self-concept" (Gelso & Hayes, p. 115). Many of these studies rely on self-report and given the variety of experiences that a clinician may have, there is limited generalizability of the findings of these studies.

Research also demonstrates that there is an interaction between patient characteristics, events in therapy, and the unresolved conflicts of the therapist. Gelso and Hayes (2007) noted that within this research, client material, client similarities to significant people in the therapist's life, client similarities to the therapist, missed appointments, late appointments, and termination were triggers of countertransference. Gelso and Hayes highlighted that research demonstrates that countertransference is typically covert in its initial stages (e.g. internal thoughts and feelings), however, when mismanaged, develops into overt behaviors (e.g. withdrawal in session, being reactive, initiating early termination, etc.). In addition, research has shown that effective and successful therapists are more likely to engage in reflective practices to assess their countertransference and to utilize these reactions to enhance treatment (Gelso & Hayes, 2007).

Recently, Hayes et al. (2011) presented three meta-analyses of the countertransference literature. Within the first meta-analysis, Hayes et al. reviewed literature that examined the relationship between countertransference reactions and therapy outcomes. Of the 10 studies identified, findings suggested that countertransference reactions were inversely related to therapy outcomes with the exception of counseling dyads that reported strong working alliances (in these cases, no significant relationship was found). The second meta-analysis addressed the relationship between countertransference management and countertransference manifestations. There were 11 studies examined and the findings demonstrated that management strategies did not significantly decrease the manifestation of countertransference reactions. Hayes et al. explained that individual study findings have been inconsistent and that no consensus exists for

which management strategies are most effective. The third meta-analysis reviewed studies that investigated the relationship between countertransference management and therapy outcomes. Of the 7 studies examined, results revealed a strong, significant relationship between these two variables in which management strategies enhance therapy outcomes.

To date, no empirical studies have examined how the race and culture of the therapist influence the transference-countertransference relationship within therapy. In their exploration of the dynamics present in cross-racial counseling dyads, Comas-Diaz and Jacobsen (1995) suggested specific transference and countertransference reactions that could potentially occur when the therapist identifies with a racial minority group and is working with a White client. Comas-Diaz and Jacobsen explained that transference expressed by the client may include: cognitive dissonance, reaction formation, tokenism, cultural xenophobia, fear of abandonment, alien-transformation anxiety, ethno cultural disinhibition, and racial guilt and shame (pp. 99-100).

Cognitive dissonance describes the differences in power that occur in the therapy room which do not align with those in society. The client may seek to resist the power of the therapist through the use of defense mechanisms (e.g. denial, rationalization, etc.) and through the reluctance of forming a therapeutic alliance (Comas-Diaz and Jacobsen, 1995, p. 100). Reaction formation refers to the process of "perceiving the therapist as immensely superior considering the difficulties she/he presumably faced to get to his/her position." Tokenism implies that therapist may have attained his/her position as a result of affirmative action or may involve the therapist as the "spokesperson" for his/her racial group. From this perspective, the White client may ask personal questions frequently assessing the qualifications and experiences of the

therapist. Cultural xenophobia describes mistrust in the therapist as being someone who may be able to help the client with his or her concerns (Comas-Diaz & Jacobsen, 1995, pp. 99-100).

Fear of abandonment may include the client's fear that the therapist will discontinue their work at any given time or may have a preference for racial minority clients rather than White clients. Alien-transformation anxiety signifies the anxiety the client may experience upon recognition of the therapist's power as well as fears about forming a close relationship with the therapist. Ethnocultural disinhibition refers to the process in which clients may behave inappropriately with a therapist of color (and would not otherwise behave in this way when working with a White client). Racial guilt and shame may arise when clients recognizes the privileges afforded to them as well as recognition of stereotypes they held about the racial group of the therapist (Comas-Diaz & Jacobsen, 1995, pp. 101-102).

Comas-Diaz and Jacobsen (1995) posited that countertransference of the therapist may involve reactions such as: a need to prove competence, anger and resentment, avoidance, impotence, guilt, feeling good enough to work with White clients, and fear. Comas-Diaz and Jacobsen noted that therapists of color who have not yet matured in their racial identity development may feel pressure to prove their competence as a therapist. Therapists of color may feel inferior and therefore choose to remind clients of their power and credentials. Related to competence issues, therapists may experience anger and resentment towards their clients. Anger and resentment be triggered by the need to prove competence or by the defense mechanisms expressed by their clients. Avoidance may also be a countertransference reaction in which the therapist of color chooses to work with racial minority clients only, being minimally invested in their work with White clients, or minimizing the distress that their White clients experience. Impotence refers to the inability to accurately and adequately conceptualize the concerns

presented by the client due to the racial and cultural differences between the therapist and client (pp. 102-103).

Guilt is another potential countertransference reaction experienced by therapists of color. Guilt may derive from serving White clients predominantly and not offering services to their own communities. "Good enough" countertransference refers to the self-esteem and self-efficacy of the therapist. Therapists of color may question their own competence and wonder if they are "good enough" to serve White clients. When clients doubt the effectiveness of an intervention, the therapist may be more likely to question his/her own skills rather than exploring the client-therapist dynamics. Comas-Diaz and Jacobsen (1995) also highlighted fear as a common countertransference reaction particularly when White clients attempt to exert power over the therapist and to challenge the authority of the therapist (pp. 103-104).

Furthermore, Brown (2001) explained that countertransference can be conceptualized as a symbolic relationship in which the therapist must negotiate personal and cultural experiences as she or he interacts with clients. Specifically, Brown stated:

> The symbolic relationship for therapists consists of the way in which the therapists' own feelings, responses, and reactions to a client as well as the manner in which they relate to and with that client are informed by context and personal life experiences in a continuous, interactive loop between internal and external realities. That context includes the meanings of the personal and cultural heritage and history of therapist and client(s) alike as well as the manner in which each person represents certain social constructs to the other (p. 1006).

Brown (2001) highlighted that the symbolic relationship is highly influenced by the social and cultural contexts of the therapist, and therefore, may lead to complex and challenging

clinical interactions. Brown (2001) noted that it is essential for the therapist to attend to the interaction of the therapist's and client's cultural and social experiences in order to understand the therapy relationship.

Similar to the work of Brown (2001), Gelso and Mohr (2001) proposed a conceptualization of countertransference that acknowledged the influence of racial identity and sexual orientation on the clinician; however, no research has tested this model. Gelso and Mohr introduced the notion of "culture-related countertransference" which describes: "therapists' culture-related distortions of the patient and rigid interpersonal behaviors rooted in his or her vicarious experiences with members of the patient's racial group" (p. 59). Culture-related countertransference provides a broad understanding of how a range of cultural variables may influence the development of a strong working alliance between the therapist and client. Gelso and Mohr concluded that future research should continue examination of the role of culture in therapeutic processes such as transference and countertransference.

In sum, countertransference is a complex phenomenon that has a number of implications for the relationship between the client and therapist and for the outcomes of therapy. Although there is substantial theory that explicates the role of countertransference in therapy, significantly less empirical research exists to support these theories. Furthermore, of the available theory, limited attention is given to the role of culture. Likewise, scarce empirical research explores how culture may impact the countertransference reactions that therapists experience. The proposed study seeks to fill an important gap in the countertransference literature through an examination of the racial identity attitudes held by therapists and how these attitudes influence their countertransference reactions when working in cross-racial counseling dyads.

Purpose of Current Study

Considerable research documents the significance of Black racial identity attitudes on the psychological and affective development of African Americans. Comas-Diaz and Jacobsen (1995) proposed that within the therapist of Color-White client therapy dyad, unique dynamics arise due to the sociopolitical and racial history of the United States. Comas-Diaz and Jacobsen suggested eight types of transference that the White client may express and seven types of countertransference that the therapist of color may experience. Furthermore, scholars have proposed models to explain the role of race and culture in counseling and psychotherapy, specifically for Black/African American clinicians (Helms, 1984b; Helms, 1990; Helms & Cook, 1999). Although there have been studies of Black-White supervision dyads (e.g. Constantine & Sue, 2007; Cook, 1994; Cook & Paler Hargrove, 1997), fewer empirical studies have examined the Black-White counseling dyad. To this extent, the present study explored the relationship between Black racial identity attitudes and countertransference of Black therapists when they work with White clients.

Research Question 1. Does Black racial identity (i.e. Pre-Encounter, Post-Encounter, Immersion, Emersion, and Internalization) predict countertransference reactions (i.e. overwhelmed/ disorganized, helpless/inadequate, special/over-involved, positive, sexualized, disengaged, parental/protective, and criticized/mistreated) experienced by Black therapists when working with White clients?

Hypotheses were:

H_1: Pre-Encounter attitudes will account for a significant amount of variance in positive and special/over-involved countertransference reactions.

H_2: Post-Encounter attitudes will account for a significant amount of variance in overwhelmed/disorganized and helpless/inadequate countertransference reactions.

H_3: Immersion-Emersion attitudes will account for a significant amount of variance in disengaged and criticized/mistreated countertransference reactions.

H_4: Internalization attitudes will account for a significant amount of variance in positive countertransference reactions.

Given the exploratory nature of the current study, these preliminary hypotheses were developed based on Black racial identity theory and empirical research on potential emotional states individuals may experience within each identity status.

Research Question 2. What are the benefits and challenges that Black therapists self-report when working with White clients? No hypotheses were developed for this question due to its qualitative, exploratory nature. However, through examination of the range of experiences shared, consistent themes and response patterns were identified.

Chapter III

Method

Participants

The sample for the current study comprised 28 therapists who: (a) self-identified as African-American or Black, (b) had current enrollment in or completed a graduate training program in Counseling Psychology, Clinical Psychology, or a closely related field (e.g. Licensed Clinical Social Work, Marriage and Family Therapy, etc.), and (c) conducted therapy with at least one White client for at least two sessions. Sixty participants accessed the study, however, only 48 participants met eligibility criteria stated above (i.e. self-identified as African American/Black, current enrollment in or graduated from a clinically related graduate program, and experience providing therapy to White clients). Participants excluded from the study identified as White (n = 8), Asian (n =1), or Latina (n = 1), or did not have experience providing therapy to White clients (n = 2). Of the 48 participants who were eligible for the study, 20 participants exited the study after completing demographic data only, and were therefore excluded from the main analyses due to incomplete data. Chi-square difference tests and t-tests were calculated to determine if there were significant demographic differences between the participants who completed and who did not complete the survey, however, no significant differences were found with the exception of supervision hours (See Table 1).

Of the 28 participants who completed the study, 86% identified as female and 14% identified as male. Ethnically, 46% identified as African American, 7% identified as Afro-Caribbean, 18% identified as Multi-ethnic, and 29% did not indicate ethnicity. Participants had a mean age of 32 (SD = 8.3) and a mean of 6 years conducting therapy (SD = 5.3). In terms of level of clinical training, 18% reported their stage as Beginning Practicum, 21% reported their

level as Advanced Practicum, 25% reported being on Internship, 32% reported being a Graduate/Practicing in the field, and 4% did not indicate level of clinical training. Participants ranged in their experiences conducting therapy with White clients with a minimum of 1 client and a maximum of 360 White clients (Mean = 52.13, SD = 89.4). Similarly, participants reported a range of clinical experiences with racially diverse clients with a minimum of working with 1 racial minority client and a maximum of 150 racial minority clients (Mean = 44.04, SD = 39. 1).

In terms of academic programs, 46% attended Clinical Psychology programs, 29% attended Counseling Psychology programs, 7% attended Marriage and Family Programs, 4% attended Community Psychology Programs, 4% attended School Psychology Programs, 4% attended Clinical Social Work Programs, 4% stated "Other" program, but did not specify type of program, and 4% did not indicate program. Participants had a mean of 2.28 (SD = 1.49) multicultural courses taken and a mean 6.62 (SD= 6.89) multicultural seminars/workshops/ trainings attended. Participants were representative of all regions of the United States. Thirty-six percent identified the Northeast as their current region, 32% identified the Southeast as their current region, 14% identified the Midwest as their current region, 11% identified the West as their current region, and 7% identified the Southwest as their current region. Tables 2 and 3 contain demographic data for completed participants. Tables 4 and 5 show demographic data for participants who did not complete the survey.

Measures

Black Racial Identity Attitudes Scale (Helms, 1990). The Black Racial Identity Attitudes Scale (BRIAS) is a self-report measure that assesses racial attitudes. The measure contains 60 items measured on a 5-point Likert-type scale ranging from 1 = strongly disagree to 5 = strongly agree. The measure is based upon an adaptation of Cross' (1971) Nigrescence

Theory, a developmental process of understanding Black racial attitude formation and attitudes developed towards Whites (Helms, 1990).

The BRIAS is a widely used empirical measure of Black racial identity and the current version contains five subscales: Pre-Encounter, Post-Encounter, Immersion, Emersion, and Internalization. Pre-Encounter attitudes comprise an idealization of White culture and/or devaluation of Black identity. Post-Encounter attitudes include events or learning experiences in which the individual recognizes that she or he may not have the same opportunities or privileges as a White person, and may have questions concerning her or his Black racial identity. Immersion attitudes consist of individuals participating in a variety of activities that enhance their connection to their Black identity. Emersion attitudes involve the development of a positive Black identity. Internalization consists of the individual identifying with Black culture (in a positive and personally meaningful way) as well as valuing the racial identity of others.

Initial internal consistency estimates (Cronbach's Alpha) during instrument development were: Pre-Encounter = .76, Encounter = .51, Immersion-Emersion = .69, and Internalization =.80 (Helms, 1990). Later studies utilizing the BRIAS reported internal consistency estimates that ranged: Pre-Encounter = .60-.83, Post-Encounter = .53-.71, Immersion-Emersion = .71-.83, and Internalization = .66-.76 (Brown et al., 2013; Carter, Pieterse, & Smith, 2008; Forsyth & Carter, 2014). Reliability estimates for the current study are: Pre-Encounter = .59, Post-Encounter = .75, Immersion = .73, Emersion = .81, and Internalization = .68. Construct validity of the scales was investigated by factor analysis and the scale was also found to have a significant, positive relationship with the *Developmental Inventory of Black Consciousness,* another measure of Black racial identity development (Helms, 1990). Table 6 contains the means, standard deviations, and reliability estimates for this scale.

Therapist Response Questionnaire (Betan et al., 2005). The Therapist Response Questionnaire (TRQ) measures the emotional, cognitive, and behavioral responses that therapists have towards their clients. When responding to the questionnaire, participants were asked to think of a current or recent client (within the past year) who identified as White. Permission was obtained from the author to modify instructions to reflect a change from "Please think about your work with a recent patient" to "Please think about your work with a recent White patient." The measure is a self-report inventory that contains 79 items measured on a 5-point scale ranging from 1 = not true to 5 = very true. There are eight types of therapist reactions assessed within the inventory and these include: overwhelmed/disorganized, helpless/inadequate, positive, special/overinvolved, sexualized, disengaged, parental/overprotective, and criticized/mistreated (Betan et al., 2005).

"Overwhelmed/disorganized" assesses the desire of clinicians to avoid working with the client and the negative feelings they have towards the client. "Helpless/inadequate" measures feelings of incompetency and/or inadequacy. "Positive" refers to the positive feelings clinicians have towards clients and indicates a strong working alliance with client. "Special/overinvolved" assesses the extent to which clinicians treat clients differently, such as inappropriate self-disclosure and unclear boundaries. "Sexualized" measures sexual attraction that clinicians may have towards their clients. "Disengaged" refers to a sense of boredom and distractibility within sessions. "Parental/protective" examines clinicians' desires to want to take care of their clients in a nurturing way. "Criticized/mistreated" identifies feelings that a clinician may experience in which they feel that their clients dismiss, mistreat, and/or do not appreciate them (Betan et al., 2005).

Construct validity was studied by a factor analysis in which there was an "eight-factor

promax solution using maximum likelihood estimation" (Betan et al., 2005, p. 892). Item loadings ranged from .39 to .99. During instrument development, internal consistency reliability estimates were as follows: overwhelmed/ disorganized = .90, helpless/inadequate = .88, positive = .86, special/overinvolved = .75, sexualized = .77, disengaged = .83, parental/protective = .80, and criticized/mistreated = .83 (Betan et al., 2005). For the present study, internal consistency estimates were: hostile/mistreated = .83, helpless/inadequate = .66, positive/satisfying = .70, parental/protective = .59, overwhelmed/disorganized = .42, special/over-involved = .53, and disengaged = .71. The sexualized subscale was unreliable (α = -.07).

Within a primer on internal consistency estimates, Streiner (2010) noted a number of factors that influence alpha coefficients, some of which include: sample characteristics, length of scale, and the extent of correlations between items within the same subscale. In discussing negative alpha coefficients in particular, he explained if there are no reverse-scored items, in rare cases "the variability of individual items exceed their shared variance, which may occur when the items are tapping a variety of different constructs" (p. 102). Streiner (2010) also cautioned that reliability estimates in published reports may contrast with those of any given study in which the samples are "sufficiently different," emphasizing that "reliability depends as much on the sample being tested as on the test" (p. 101).

The absence of reverse scored items on the sexualized scale and the presence of item factor loadings ranging from .62-.99 suggest solid psychometric properties for the scale and point to other factors influencing reliability. The length of the scale (5 items) and sample characteristics may partially account for the unreliability of this scale. The current sample contrasted significantly from that in the original Betan et al. (2005) study, which comprised a predominantly White, male sample of practicing psychologists and psychiatrists. Also, therapists

in this sample were asked to think of a "White patient" rather than a "patient." In addition, given that the sexualized subscale contained five items and there was significant homogeneity in responses (e.g. item-level review of items demonstrated all participants responded with "1" on all items of the subscale with the exception of one participant indicating a "3" on one item), this too may have partially accounted for the unreliability of this subscale. For these reasons, the sexualized subscale was excluded from all analyses. Table 7 shows the means, standard deviations, and reliability estimates for all subscales.

Qualitative Questionnaire. The qualitative questionnaire was developed for the purposes of the current study. Based on the review of the literature, the principal researcher created a questionnaire that contained five open-ended questions addressing clinical experiences and multicultural training related to working in cross-racial counseling dyads. For example, "*How do racial differences impact your therapeutic work? Please address the influence of stereotypes that might exist as a result of being a member of your racial group.*" Please see Appendix C for the complete questionnaire. Responses to this questionnaire were analyzed utilizing the Discovery-Oriented method (Mahrer, 1988) in which consistent patterns in responses were identified and coded into themes.

Demographic Questionnaire. The demographic questionnaire assessed basic demographic information such as: race, ethnicity, gender, age, education level, program type, year in program, theoretical orientation, number of multicultural courses taken, number of multicultural seminars/ workshops/conferences attended, months providing therapy, current/most recent clinical setting, number of hours (per week) of supervision within clinical setting, total number of racial minority clients within all clinical experiences, and total number of White clients within all clinical experiences. Demographic information was used for descriptive

analyses and to assess differences between those who completed and who did not complete the study.

Procedures

Recruitment. Recruitment procedures involved contacting 320 Clinical, Counseling, and Marriage and Family Therapy graduate training program directors via email with a request to send the link to the study to their program listserves. Thirty-five training directors sent an email response indicating that they would forward the recruitment request to their program listserves and to former students who might be eligible to participate. Six training directors indicated that they would not forward the request to their programs for various reasons (e.g. too many online survey requests, need for endorsement from faculty members at their institution, requirement of completing IRB process at their institution, etc.). In addition to these 320 training directors, 24 additional programs were contacted, but undeliverable or away responses were received. Of those who agreed to forward the request and of those who did not respond after this initial contact and had deliverable email addresses, a follow-up email was sent to request additional participants. Initial and follow-up recruitment emails were also sent to Division 45 (The Society for the Psychological Study of Ethnic Minority Issues) of the American Psychological Association and to the Association for Black Psychologists. Also, consistent with the snowball sampling method, approximately 15 racial minority therapists practicing in the field were identified and asked to participate in the study and/or to forward the research request to eligible participants. The recruitment email contained a brief description of the study, eligibility criteria, and a direct link to participate in the study. See Appendix B for recruitment email.

Online Survey. The online survey was created using the Survey Monkey (1999) software, a web-based, password protected tool. The first page of the survey provided a brief

description of the study and a statement of informed consent. This page highlighted potential risks of participation, provided contact information for the researcher, and offered the opportunity for every 40th participant to be selected for 1 of 4 $25 Visa gift cards. Participants were instructed that completion of the measures served as informed consent. Participants completed four measures online in the following order: (a) Demographic Questionnaire, (b) Qualitative Questionnaire, (c) Black Racial Identity Attitude Scale, and (d) Therapist Response Questionnaire. See Appendix C for complete survey.

At the end of the study, participants were given the opportunity to be entered into a drawing for 1 of 4 $25 Visa gift cards by choosing to send their contact information to an email address provided at the end of the study. Eighteen participants elected to enter their name into the drawing for the Visa gift cards. To ensure confidentiality, this information was not connected in any way to participant data. Participants did not receive immediate feedback at the end of the study, however, were given the contact information of the researcher if interested in composite results of the research.

Design and Statistical Analyses

The current study is a mixed method design. Creswell and Plano Clark (2011) described mixed method research as the "rigorous collection and analysis of both qualitative and quantitative data in which the researcher mixes, integrates, or links the two forms of data concurrently by combining them or by having one build on the other, or embedding one within the other" (p. 5). Creswell and Plano Clark (2011) noted a number of research situations in which mixed methods research is appropriate and some of these situations include: "one data source is insufficient; a need exists to explain initial results; a need exists to generalize exploratory findings; and a need exists to enhance a study with a second method" (p. 7). In their discussion

of mixed methods research, the authors also noted that a specific paradigm should inform the mixed method design. The current study employs a pragmatic worldview. Creswell and Plano Clark (2011) described pragmatism as: "[the] focus and primary importance is on the question asked rather than the method, on the consequences of the research, on the use of multiple methods of data collection, is oriented to 'what works' and translating research to practice…[and] combines deductive and inductive thinking and mixes qualitative and quantitative data" (p. 41-43). Likewise, Creswell and Plano Clark (2011) highlight the importance of theory guiding mixed method research. Within the current study, Black racial identity theory undergirded the research questions, and according to Creswell and Plano Clark (2011), Black racial identity theory is an "emancipatory theory" in that it focuses on the experiences of historically oppressed groups.

Within the current study, a multivariate multiple regression analysis was proposed as the primary data analysis in order to test the relationship between Black racial identity attitudes and countertransference experienced by Black therapists when working with White clients. Tabachnick and Fidell (2001) noted that multivariate analyses are appropriate when examining complex relationships between multiple independent variables (e.g. Black racial identity statuses) and multiple dependent variables (e.g. countertransference responses) and highlighted the importance of conducting such an analysis to reduce overall Type I error rate (p. 3). Based on an apriori power analysis, 141 participants were needed to establish power of .80. As a general rule of thumb for regression analysis, Wilson VanVoorhis and Morgan (2007) suggested that there should be at least 10 participants per predictor, with no less than 50 participants in the sample.

In the current analysis, although 60 participants accessed the study, only 48 met eligibility criteria (i.e. self-identified as African America/Black, current enrollment in or graduated from a program in counseling psychology, clinical psychology, or a closely related program; and conducted therapy with at least one White client for at least two sessions). Ten participants identified with races other than African American/Black (White, *N*= 10; Asian, *N*=1; and Latina, *N*=1) and two participants had no experience providing therapy to White clients (as indicated on the demographic form). Of the 48 who met these criteria, only 28 participants completed the quantitative measures. Due to the insufficiently low sample size, the multivariate regression was not conducted. Therefore, means for the quantitative variables were calculated and a descriptive analysis examining mean differences in the quantitative data by primary themes was conducted.

To address the second research question, the Discovery-Oriented Approach (Hill, 1990; Mahrer, 1988) was utilized. According to Mahrer (1988), the Discovery-Oriented approach involves five stages: (1) selecting the target of investigation, (2) obtaining instances of the target of investigation, (3) obtaining an instrument for taking a closer look, (4) gathering the data, and (5) making discovery-oriented sense of the data. In the current study, the "target of investigation" was the qualitative examination of the clinical experiences reported by Black clinicians who work with White clients. Since there is relatively little known about the experiences of Black clinicians, the focus within this component of the study was the impact of racial differences on the therapeutic work and the benefits and challenges of working within cross-racial counseling dyads. "Obtaining instances of the target of investigation" refers to the identification and observation of the phenomenon under investigation (Mahrer, 1988, p. 698). As highlighted in the review of literature, there are a number of unique dynamics within the Black therapist-White

client dyad such as client transference of stereotypes unto the therapist and the balance and use of power that influence the progression and outcomes of therapy (Chapman, 2006; Comas-Diaz & Jacobsen, 1995; Kelly & Greene, 2010).

The instrument utilized "to provide a closer look" is the Qualitative Questionnaire developed specifically for this study (see Appendix C). The Qualitative Questionnaire provided participants with the opportunity to discuss their experiences with cross-racial counseling through responding to five open-ended questions. "Gathering the data" involves data collection, which occurred through the use of the online survey. "Making discovery-oriented sense of the data" is the process of analyzing the data and it involves scanning the data to find patterns or themes, organizing the data based on those patterns or themes, and rescanning the data to refine existing themes and/or develop new themes (Mahrer, 1988). Mahrer did not provide recommendations for sample size when outlining discovery-oriented analysis; however, prior research demonstrates that the sample size for this type of analysis can range from small to large. Sample sizes ranging from 9-11 participants (Howard, Inman, & Altman, 2006; Yeh, Inman, Kim, Okubu, 2006) are documented in the literature as well as sample sizes exceeding 100 participants (Kaduvettor, O'Shaughnessy, Mori, et al., 2009).

In order to "make discovery-oriented sense" of the data, a research team comprised of three graduate students studying counseling psychology at Lehigh University conducted the analysis. Research team members were recruited via email (to a program-wide listserv) soliciting students interested in multicultural research and interested in providing research assistance. The team included the primary researcher, a cohort member of the primary researcher/doctoral candidate in Counseling Psychology, and a master's student studying Counseling and Human Services. The team comprised one African American female (primary researcher) and two White

females. Both the primary researcher and doctoral candidate had extensive experience in qualitative analysis through conducting/participating in prior mixed method and qualitative empirical studies. The master's student had limited research experience. Training involved a review and discussion of relevant articles (e.g. Mahrer, 1988; Hill, 1990) and the application of the Discovery-Oriented Approach to a sample data set over two 1-hour sessions. The sample data set used during training was from the doctoral qualifying research of the primary researcher. This data included responses to a semi-structured interview that examined the career experiences of Black faculty and administrators who worked in academia at predominantly White institutions.

The data analysis process involved each member of the research team individually scanning the data for patterns in the responses and coding these patterns into specific themes. For consistency, clarity, and organizational purposes, data was coded by question (i.e. responses to Question 1, Question 2, Question 3, etc.). Upon establishing themes for each question individually, the research team met via conference call to compare their themes in order to come to a consensus on the themes that exist. There were five meetings (for each of the five qualitative questions). During these meetings, when necessary, the research team revised, discarded, and/or developed new themes. Inter-rater reliability was determined by entering each team member's response in the SPSS/PASW data analytic software and calculating Cohen's Kappa Coefficient. Landis and Koch (1977) provided descriptions of obtained kappa values and noted that Kappa values ranging from .61-.80 indicate substantial agreement. For the current study, Kappa coefficients exceeded .90 for established themes for each qualitative question.

Chapter IV

Results

Utilizing a mixed methods research design, the current study examined the relationship between Black racial identity attitudes and countertransference and explored the impact of racial differences on the therapeutic process when Black therapists work with White clients. Participants completed a qualitative questionnaire that assessed their cross-racial counseling experiences and completed two quantitative measures: (a) Black Racial Attitudes Identity Scale (to assess racial identity attitudes) and (b) Therapist Response Questionnaire (to assess countertransference experiences). In addition, participants responded to a demographic questionnaire.

A multivariate multiple regression analysis was proposed as the primary data analysis in order to test the relationship between Black racial identity attitudes and countertransference. However, due to an insufficient sample size resulting from a low return rate, the multivariate regression analysis was not conducted. Means for the quantitative variables were calculated and a descriptive analysis was conducted by examining mean differences in the quantitative data by primary themes. In addition, correlations between Black racial identity attitudes and countertransference responses were conducted. Qualitative data were analyzed using the Discovery-Oriented Approach (Mahrer, 1988), in which various themes emerged regarding the cross-racial counseling experiences of Black therapists. Themes from the qualitative data will be presented first and the descriptive quantitative data will follow.

Qualitative Analyses

The Discovery Oriented Approach (Mahrer, 1988) was utilized to analyze the qualitative data. In sum, this approach requires each member of a research team (which comprised three

graduate students, one of which was the primary investigator) to individually scan the data for patterns in the responses and to code these patterns into specific themes. Upon establishing themes for each question individually, the research team met via conference call to come to a consensus on the themes. During these meetings, when necessary, the research team revised, discarded, and/or developed new themes. Inter-rater reliability was determined through entering each team member's response in the SPSS/PASW data analytic software and calculating Cohen's Kappa Coefficient.

Twenty-nine themes were identified across the five questions described below. Depending on the length of the response, each response could receive up to three codes (collectively from the research team), and therefore, percentages may not total 100. Due to the distinct qualities of each question, themes are presented by question.

Question 1. *When working in a cross-racial counseling dyad, how do racial differences impact your therapeutic work? Within your response, please address any transference or countertransference issues that may influence your work.* Two primary themes (25% or more of participant responses) were identified: (a) *Awareness* and (b) *Limited Awareness/No Impact*. *Awareness*, defined as "therapist and/or client awareness of the impact of racial identity and racial dynamics on the therapeutic process," emerged in twenty-five percent of participant responses. An example of this type of response is when a participant stated, "*I am cognizant of being a Black male therapist and how these factors influence my clients…I have to be mindful of my reactions to racially-tinged issues that arise in sessions. Sometimes I am aware that my therapeutic response is different than my normal response.*" *Limited Awareness/No Impact* was a second primary theme and was defined as "therapists' beliefs that race does not have any impact

on the therapy process." Twenty-five percent of participants provided this type of response. For example, a participant noted, "*I don't think they really do. Of course clients report the same.*"

In addition to these primary themes, five secondary themes emerged from the analysis of responses to question #1. Secondary themes were themes that emerged in 10-25% of participant responses and these themes were: (a) *Focus on Therapeutic Relationship*; (b) *Disclosures*; (c) *Avoidance*; (d) *Stereotypes/Assumptions*; and (e) *Racism*. Fifteen percent of participants provided a response coded as *Focus on the Therapeutic Relationship*, which referred to "increased attention and focus on building the therapeutic alliance." For example, a participant indicated, "*Racial differences create an extra step in the therapeutic alliance where racial differences must be addressed*." *Disclosures*, defined as "client may withhold information due to racial/ethnic identity of therapist," emerged in 10% of participant responses. In an example of *Disclosures,* one participant stated, "*I often wonder whether my race impacts the way my client's perceive me and my therapeutic abilities. I wonder if they often don't share certain thoughts because of my race*." *Avoidance*, defined as "deliberate attempts to overlook, minimize, and/or avoid interactions and/or discussion of racial differences," was a theme in 10% of participant responses. An example of this type of response is noted when one participant shared, "*I think I really find myself trying to force myself to ignore race and really focus on the presenting problem. I feel like I do this because I find myself feeling insecurities when working with White clients and feeling like I have to be perfect. I find myself not bringing race up in sessions even though clients may attempt to…*"

*Stereotypes/Assumption*s and *Racism* each emerged in 10% of participant responses. *Stereotypes/Assumptions* referred to "stereotypes or assumptions expressed by the client about the therapist and/or therapist's background" and *Racism* referred to "client identification as racist

and/or discriminatory behaviors directed towards therapist due to race of therapist." To illustrate the difference between these two themes, one participant response that received the *Stereotypes/Assumptions* code stated, "*Clients are often confused by what race/ethnicity I am: Whites think I am White, Latina, and a few have thought Black; Blacks think I am Latina or Black or mixed; Latinas think I am Latina. As a result, all my clients have made assumptions of my experience and ability to directly relate to them*." This response was differentiated from those that indicated *Racism*. For example, a participant noted, "*I have had one client that did not want to work with me because of racial differences and I simply referred him to another clinician*." There were minor themes noted that were endorsed by less than 10% of the sample and these included: *Ambiguity,* and *Competence-related Countertransference*. These two themes were endorsed by only 1 participant. *Ambiguity* referred to "doubt about the therapeutic process and outcomes" and *Competence-related Countertransference* referred to "doubts, questions, insecurities about therapist's abilities." Inter-rater reliability for themes that emerged from this question was statistically significant (K = .97, p =.031). (See Table 8 for themes/sample responses to Question 1).

Question 2. *Please describe a rewarding multicultural experience when working with a White client. What made this experience rewarding? Please speak to how multicultural issues were addressed*. Three primary themes were identified among participant responses: (a) *Client Openness*; (b) *Multicultural Discussions*; and (c) *Establishing Therapeutic Relationship*. *Client Openness*, defined as "client openness to engage in the therapy process and to experience a positive change in attitude towards therapy," emerged in 26% of participant responses. One participant responded, "*I believe each White client who is willing to listen, establish rapport, and have "buy-in" from a young African American female in her 20s was rewarding as a whole*."

Thirty percent of participants endorsed *Multicultural Discussions*, defined as "open discussions of issues related to race, culture, and diversity." For example, a participant shared "*It was very powerful to work with a White woman who described herself as growing up "dirt poor" in the deep South. Her perspective on race, class, and culture raised my awareness of regional differences and differing attitudes about race and class.*" *Establishing Therapeutic Relationship*, defined as "ability to form a strong working alliance," also emerged in thirty percent of participant responses. One participant noted, "*What was rewarding was building the rapport to come to common ground despite different racial backgrounds*." Seventeen percent of participants stated that they were either unable to recall or had no rewarding experience with a White client. A sub-theme, *Confidence in Multicultural Therapy*, defined as, "confidence client holds and expresses about multicultural therapy," emerged from 1 participant response. Inter-rater reliability for themes that emerged from this question was statistically significant (K = .95, *p* =.046). (See Table 9 for all themes/sample responses to Question 2).

Question 3. *Have you had a challenging experience in session when working with a White client (as a result of racial identity differences)? If so, please describe the experience and the ways you worked through the experience*. Two primary themes were identified: (a) *Racism*, and (b) *Termination/Referral*. *Racism*, defined as "client identification as racist and/or discriminatory behaviors directed towards therapist due to race of therapist," emerged in sixty-seven percent of participant responses. For example, one participant shared, "*A White male client identified as racist. We discussed what it was like for him to work with a Black therapist and the discussion is ongoing*." Forty-two percent of participants reported *Termination/Referral* as a challenging experience. *Termination/Referral* was defined as "a request to end therapy and/or to work with another therapist." One participant commented, "*I had a client who did not*

want to work with me because of racial differences. I asked him if he wanted to discuss any discomfort he had in order to validate and normalize his experience. However, he was unwilling to speak with me any further and asked to be referred, which I did."

Thirty-three percent of participant responses were coded as *Multicultural Discussions* (as defined above). For example, one participant stated, "…*Most frequently clients make a point of commenting on racial issues and discussing how they are not racist but someone else is. I typically work through this by discussing our racial identity differences*." Secondary themes were: *Avoidance*, and *Stereotypes/Assumptions*. *Avoidance* (as defined above) emerged among 10% of participant responses. For example one participant commented, "*Some challenging experiences include denial/avoidance of my race/ethnicity…*" *Stereotypes/Assumptions* also emerged among 10% of responses and an example of this is when a participant noted, "*Patient made references to how 'all Black guys get shaving waivers (military'…. Wasn't a major factor in counseling, but didn't necessarily help our rapport either*." Inter-rater reliability for themes that emerged from this question was statistically significant (K = 1, $p < .001$). (See Table 10 for all themes and sample responses for Question 3).

Question 4. *Please list some of the benefits and challenges you face when working with White clients.* Four primary themes emerged: (a) *Countertransference*; (b) *Proving Competence/ Disproving Stereotypes*; (c) *Multicultural Learning*; and (d) *Multicultural Discussions*. Thirty-seven percent of respondents indicated *Countertransference* as a prevalent factor in their work with White clients. *Countertransference* referred to "increased self-awareness and monitoring of biases towards and feelings about working with White clients." For example, one respondent stated, "*On a day to day I often times I find myself unable to trust White people and outside of professionally I do not have any relationships with Whites. I think that working with White*

clients helps monitor my own feelings about Whites because it reminds me that they are human too...it sort of distracts me from White privilege for a minute." *Proving Competence/Disproving Stereotypes* was a theme that emerged among thirty-seven percent of responses. This theme referred to "belief that one has to prove his/her competence and/or disprove stereotypes that client might hold." For example, one participant noted, "*Challenges include: the feeling that you have to prove yourself more than my White counterparts and not always given the chance to work with White clients due to their pre-conceived beliefs about African Americans*."

Multicultural Learning, defined as "exploring multicultural issues such as learning how to work with others of different backgrounds; recognizing similarities and differences among cultures; and identity exploration," emerged among 32% of participant responses. One participant stated, "*Benefits - Gaining different perspectives on what it means to be White in America to the client…*" *Multicultural Discussions*, defined as "open discussion of issues related to race, culture, and diversity," was a distinct theme from multicultural learning in that the focus was on conversations between therapist and client rather than a global learning (without any conversations about this learning). *Multicultural Discussions* emerged in 26% of participant responses. One participant shared, "*Benefits include being able to have difficult dialogues with clients about topics that can be too sensitive or challenging to have outside of the therapy space*."

Secondary themes derived from question #4 included: (a) *Establishing Therapeutic Relationship*, (b) *Shifting Approach to Therapy*, (c) *No Differences*, and *Termination/Referral*. *Establishing Therapeutic Relationship* (as defined above) emerged in 21% of participant responses. For example, one participant shared, "*Benefits: We are usually able to form a solid working alliance*." *Shifting Approach to Therapy* referred to "modifications to therapy style" and

this theme emerged in 16% of participant responses. An example of is when a participant noted, "*Challenges include working through initial countertransference and being comfortable sitting with a client while remaining true to myself. I want to avoid being more "White" in order to make the client comfortable because that is not my genuine self*." *No Differences* referred to participants who indicated "no benefits/challenges that are different from non-White clients" and this theme emerged in 16% of responses as well. For example, one participant stated, "*I have not found specific benefits or challenges.*" *Termination/Referral* (as defined above) emerged in 11% of participant responses and an example of this type of response is when a participant shared, "*Most Caucasian clients who don't prefer an Black clinician don't see me or ask to be referred to another person in the practice. No offense taken.*" Inter-rater reliability for themes that emerged from this question was statistically significant (K = .97, p =.033). (See Table 11 for all themes and sample responses for Question 4).

Question 5. *Based on your experiences (as an African American/Black therapist) are there gaps in multicultural training related to building multicultural counseling competency when working in cross-racial counseling dyads? If so, briefly note some of these gaps. If not, briefly explain the training you have received that has been directly relevant (and beneficial) to counseling White clients (i.e. working with White clients from a multicultural perspective*). Two primary themes emerged in participant responses to this question: (a) *Assumptions about Race of Therapist* and (b) *Limited/No Training*. *Assumptions about Race of Therapist* was defined as, "multicultural training that assumes a perspective of the therapist identifying as White and the client identifying as a racial minority." *Assumptions about Race of Therapist* emerged in 38% of participant responses. For example, one participant commented, "*I feel like in training there is so much emphasis placed on the majority working with the minority and not enough of the vice*

versa. There is the assumption that we all know how "White people live", when we don't so sometimes the theories that we learn just do not make sense." *Limited/No Training*, defined as "very limited or no training on working in cross-racial counseling dyads," emerged in 25% of participant responses. An example responses coded with this theme is when a participant highlighted, "*There is a lot of multicultural training for non-Black clinicians but minimal for Black clinicians. There is little discussion about what to do when a minority clinician is working with a White client*."

Five secondary themes emerged and these were: (a*) Expanding Multicultural Training*, (b) *External Training*, (c) *Addressing Microaggressions*, (d) *Multicultural Supervision*, and (e) *Self-Exploration/Self-Reflection. Expanding Multicultural Training*, defined as, "broadening the scope of multicultural training to be inclusive of more cultural variables" emerged in 17% of participant responses. For example, a participant noted, "*The gap is that the multicultural classes and trainings lump all racial minorities into one group: Multicultural. The reality is that they are not the same. Asians and the Asian experience is completely different from the Black or African American experience; and if one were to break it down further, the Chinese experience (for example) is vastly different from that of the Korean, as is the Haitian in comparison to the Jamaican...and so on. So these multicultural trainings are minimal in addressing what it is to be X, Y, Z; the disadvantages of categoristic labels; and the true realization of cultural difference. As a result, a lot of assumptions are actually being taught and then given the cautionary warning: But not all ____ are the same*." *External Training* referred to: "seeking out opportunities external to graduate program to learn more about multicultural issues" and this theme emerged in 8% of responses. One participant shared, *"...Diversity classes only give you*

the basics. I had to take multiple workshops and go to diversity conferences to broaden my cultural knowledge."

Addressing Microaggressions also emerged in 8% of participant responses and this was defined as: "training on how to handle/navigate microaggressions that occur in therapy." For example, one participant commented, "*One gap that exists is when, if, and how racial slurs should be addressed in therapy when a white client is receiving services from an African American therapist*." *Multicultural Supervision* referred to "understanding how to work in multicultural supervisory dyads" and this theme emerged in 8% of participant responses. An example of this theme is when a participant shared, *"...I believe that multicultural training should also include benefits and challenges with supervisors that are racially different*." *Self-Exploration/Self-Reflection*, defined as "increased emphasis on self-reflective practices to develop multicultural competence" also emerged in 8% of participant responses. For example, one participant noted, "*I think working on noting my biases and working to correct them has been helpful. Also, I'm always willing to address racial issues when they arise. I suppose that would be training of a self-reflective nature*." One theme, *Navigating Multicultural Discussions*, defined as, "learning how to discuss multicultural issues with clients," emerged in only one participant response. Inter-rater reliability for themes that emerged from this question was statistically significant ($K = 1$, $p < .001$). (See Table 12 for all themes and sample responses to Question 5).

Table 14. Overview of Qualitative Questions and Themes

Question	Primary Themes	%	Secondary Themes	%
Impact of Racial Differences	Awareness	25%	Focus on Therapeutic Relationship	10%
	Limited Awareness/No Impact	25%	Disclosures	10%
			Avoidance	10%
			Stereotypes/ Assumptions	10%
			Racism	10%
Rewarding Experiences with White Clients	Multicultural Discussions	30%	Unable to Recall/ No Rewarding Experience	17%
	Establishing Therapeutic Relationship	30%		
	Client Openness	26%		
Challenging Experiences with White Clients	Racism	67%	Avoidance	10%
	Termination/Referral	42%	Stereotypes/ Assumptions	10%
	Multicultural Discussions	33%		
	No Challenging Experiences	40%		
Benefits/Challenges Working with White Clients	Countertransference	37%	Establishing Therapeutic Relationship	21%
	Proving Competence/ Disproving Stereotypes	37%	Shifting Approach to Therapy	16%
			No Differences	16%
	Multicultural Learning	32%	Termination/ Referral	11%
	Multicultural Discussions	26%		
Multicultural Gaps/ Training Experiences	Assumptions about Race of Therapist	38%	Expanding Multicultural Training	17%
	Limited/ No Training	25%	External Training	8%
			Addressing Microaggressions	8%
			Multicultural Supervision	8%
			Self-Exploration/ Self-Reflection	8%

Quantitative Analyses

Participants completed two quantitative measures to assess Black racial identity and countertransference experiences: (a) Black Racial Identity Attitude Scale (BRIAS) and (b) Therapist Response Questionnaire (TRQ). A multivariate multiple regression analysis was proposed as the primary data analysis to examine the relationship between Black racial identity attitudes and countertransference. However, due to an insufficient sample size resulting from a low return rate ($N = 28$), the multivariate regression analysis was not conducted. Descriptive analyses and bivariate correlations for each subscale were conducted.

On the Black Racial Identity Attitudes Scale (BRIAS), the mean scores for each subscale were: Pre-Encounter (Mean = 29.14); Post-Encounter (Mean = 13.89); Immersion (Mean = 34.63); Emersion (Mean = 32.89); and Internalization (Mean = 54.07). There were several correlations among the subscales of the BRIAS. Pre-Encounter attitudes were significantly, positively correlated with Post-Encounter attitudes ($r = .79$, $p < .001$) and significantly, negatively correlated with Emersion ($r = -.43$, $p = .02$) and Internalization attitudes ($r = -.61$, $p = .001$). Post-Encounter attitudes were significantly, negatively correlated with Emersion attitudes ($r = -.45$, $p = .02$) and Internalization attitudes ($r = -.64$, $p < .001$). Emersion attitudes were significantly, positively correlated with Immersion attitudes ($r = .41$, $p = .03$) and Internalization attitudes ($r = .45$, $p = .02$).

On the Therapist Response Questionnaire (TRQ), the mean scores for each subscale were: Mistreated (Mean = 1.38); Helpless (Mean = 1.54); Positive (Mean = 3.71); Parental (Mean = 2.21); Overwhelmed (Mean = 1.33); Special (Mean = 1.33); Sexualized (Mean = 1.03); and Disengaged (Mean = 1.51). There were several significant correlations among the subscales of the TRQ. Mistreated feelings were significantly, positively correlated with Helpless feelings (*r*

= .70, $p < .001$) and significantly, negatively correlated with Positive feelings ($r = -.41$, $p = .03$). Helpless feelings were significantly, negatively correlated with Positive feelings ($r = -.41$, $p = .03$) and significantly, positively correlated with Disengaged feelings ($r = .46$, $p = .01$). Positive feelings were significantly, positively correlated with Parental feelings ($r = .51$, $p = .006$) and significantly, negatively related to Disengaged feelings ($r = -.46$, $p = .01$). Parental feelings were significantly, negatively correlated with Disengaged feelings ($r = -.42$, $p = .03$). Overwhelmed feelings were significantly, positively correlated with Special feelings ($r = - .46$, $p = .015$).

Tabachnick and Fidell (2001) suggest that multicollinearity causes "statistical instability" and may be present when bivariate correlations exceed .70 (p. 84). Using this guideline, it is beneficial to assess multicollinearity between the Pre-Encounter and Post-Encounter subscales of the BRIAS, and the Mistreated and Helpless subscales of the TRQ. Formal measures of multicollinearity include examination of: variable inflation factor (VIF), tolerance, and condition indices (Tabachnick & Fidell, 2001). Since the sample size was insufficiently low for multivariate regression analysis, resulting in an exclusion of this analysis, multicollinearity is not an issue for the present study, however, it will be important to examine in future replications of this study.

There were significant moderate correlations between subscales of the BRIAS and TRQ. Pre-Encounter attitudes were significantly, positively correlated with Helpless feelings ($r = .51$, $p = .005$). Post-Encounter attitudes were significantly, positively correlated with Disengaged feelings ($r = .43$, $p = .02$). Immersion attitudes were significantly, negatively correlated with Positive feelings ($r = -.38$, $p = .05$). Internalization attitudes were significantly, negatively correlated with Helpless feelings ($r = -.66$, $p < .001$) and Disengaged feelings ($r = -.57$, $p =$

.002); and significantly, positively correlated with Positive feelings ($r = .37$, $p = .05$) (See Table 13 for all correlations).

Mean Comparisons by Primary Themes

Due to insufficient sample size, the proposed multiple regression analysis could not be performed. However, for descriptive purposes means were examined for comparison by primary themes in the qualitative data. Primary themes for Qualitative Question 1 were: *Awareness* and *Limited Awareness/No Impact*. Generally scores were higher for Internalization attitudes (a higher level of racial identity development) and lowest for Post-Encounter attitudes. On the TRQ, scores were generally low across themes, with the exception of Positive countertransference. When comparing scores for each subscale of the BRIAS and the TRQ, means for *Awareness* and *Limited Awareness* were:

Table 15. BRIAS Mean Comparisons by Primary Themes in Qualitative Question 1

	Mean	SD	Range
Pre-Encounter			
Awareness	29.57	4.28	13.00
Limited Awareness	28.71	3.90	10.00
Post-Encounter			
Awareness	15.14	3.44	9.00
Limited Awareness	12.14	4.22	12.00
Immersion			
Awareness	34.00	4.80	14.00
Limited Awareness	34.86	2.91	7.00
Emersion			
Awareness	30.00	4.28	11.00
Limited Awareness	36.43	3.69	10.00
Internalization			
Awareness	52.57	5.62	15.00
Limited Awareness	55.29	3.04	10.00

Table 16. TRQ Mean Comparisons by Primary Themes in Qualitative Question 1

	Mean	SD	Range
Mistreated			
Awareness	1.61	.35	.83
Limited Awareness	1.15	.10	.33
Helpless			
Awareness	1.87	.58	1.67
Limited Awareness	1.33	.22	.56
Positive			
Awareness	2.95	.47	1.25
Limited Awareness	3.34	.66	1.63
Parental			
Awareness	2.17	.65	1.67
Limited Awareness	2.21	.71	1.67
Overwhelmed			
Awareness	1.41	.31	.89
Limited Awareness	1.30	.25	.67
Special			
Awareness	1.43	.44	1.20
Limited Awareness	1.09	.23	.60
Disengaged			
Awareness	1.89	.91	2.00
Limited Awareness	1.46	.62	1.50

Primary themes for Qualitative Question 2 were: *Multicultural Discussions, Establishing Therapeutic Relationship,* and *Client Openness*. Generally scores were higher for Internalization attitudes (a higher level of racial identity development) and lowest for Post-Encounter attitudes. On the TRQ, scores were generally low across each subscale with the exception of Positive countertransference. When comparing scores for each subscale of the BRIAS and TRQ by theme, means were:

Table 17. BRIAS Mean Comparisons by Primary Themes in Qualitative Question 2

	Mean	SD	Range
Pre-Encounter			
Multicultural Discussions	27.57	3.55	10.00
Establishing Therapeutic Relationship	28.67	1.15	2.00

Client Openness	25.75	3.30	7.00
Post-Encounter			
Multicultural Discussions	13.00	3.79	11.00
Establishing Therapeutic Relationship	14.33	2.89	5.00
Client Openness	10.25	1.71	4.00
Immersion			
Multicultural Discussions	33.71	4.35	13.00
Establishing Therapeutic Relationship	42.67	6.03	12.00
Client Openness	31.50	4.04	9.00
Emersion			
Multicultural Discussions	34.29	5.47	16.00
Establishing Therapeutic Relationship	33.00	.00	.00
Client Openness	34.75	4.27	9.00
Internalization			
Multicultural Discussions	57.43	3.51	10.00
Establishing Therapeutic Relationship	51.62	4.73	9.00
Client Openness	55.75	4.19	9.00

Table 18. TRQ Mean Comparisons by Primary Themes in Qualitative Question 2

	Mean	SD	Range
Mistreated			
Multicultural Discussions	1.34	.37	1.11
Establishing Therapeutic Relationship	1.46	.12	.22
Client Openness	1.04	.05	.11
Helpless			
Multicultural Discussions	1.32	.42	1.11
Establishing Therapeutic Relationship	1.81	.34	.67
Client Openness	1.04	.17	.33
Positive			
Multicultural Discussions	3.39	.60	1.75
Establishing Therapeutic Relationship	2.71	.56	1.13
Client Openness	3.63	.57	1.25
Parental			
Multicultural Discussions	2.26	.66	1.67
Establishing Therapeutic Relationship	2.39	.79	1.50
Client Openness	2.42	.52	1.17
Overwhelmed			
Multicultural Discussions	1.29	.26	.67
Establishing Therapeutic Relationship	1.41	.45	.89
Client Openness	1.33	.27	.67
Special			
Multicultural Discussions	1.37	.55	1.40
Establishing Therapeutic Relationship	1.47	.64	1.20

Client Openness	1.20	.23	.60
Disengaged			
Multicultural Discussions	1.07	.12	.25
Establishing Therapeutic Relationship	2.08	.80	1.50
Client Openness	1.19	.36	.75

Primary themes for Qualitative Question 3 were: *Racism, Termination/Referral*, and *Multicultural Discussions*. Generally scores were higher for Internalization attitudes (a higher level of racial identity development) and lowest for Post-Encounter attitudes. On the TRQ, scores were higher for Positive countertransference. When comparing scores for each subscale of the BRIAS and TRQ by theme, means were:

Table 19. BRIAS Mean Comparisons by Primary Themes in Qualitative Question 3

	Mean	SD	Range
Pre-Encounter			
Racism	29.71	4.82	13.00
Termination/Referral	26.00	.00	.00
Multicultural Discussions	32.00	2.83	4.00
No Challenging Experiences	27.73	4.13	15.00
Post-Encounter			
Racism	17.14	3.80	11.00
Termination/Referral	11.00	2.00	4.00
Multicultural Discussions	14.50	.71	1.00
No Challenging Experiences	12.37	3.78	12.00
Immersion			
Racism	31.86	3.72	11.00
Termination/Referral	40.00	2.65	5.00
Multicultural Discussions	44.00	8.49	12.00
No Challenging Experiences	35.55	7.69	31.00
Emersion			
Racism	32.14	3.72	11.00
Termination/Referral	35.00	4.00	8.00
Multicultural Discussions	37.59	.71	1.00
No Challenging Experiences	33.18	5.13	16.00

Internalization			
Racism	53.00	3.61	11.00
Termination/Referral	55.67	4.51	9.00
Multicultural Discussions	53.50	2.12	3.00
No Challenging Experiences	54.64	5.39	17.00

Table 20. TRQ Mean Comparisons by Primary Themes in Qualitative Question 3

	Mean	SD	Range
Mistreated			
Racism	1.43	.43	1.33
Termination/Referral	1.33	.48	.89
Multicultural Discussions	1.58	.59	.83
No Challenging Experiences	1.32	.31	1.11
Helpless			
Racism	1.43	.28	.78
Termination/Referral	1.44	.38	.67
Multicultural Discussions	1.89	.63	.89
No Challenging Experiences	1.54	.58	1.89
Positive			
Racism	3.41	.62	1.75
Termination/Referral	2.83	.29	.50
Multicultural Discussions	2.88	.71	1.00
No Challenging Experiences	2.95	.55	1.75
Parental			
Racism	2.57	.45	1.33
Termination/Referral	2.00	.58	1.00
Multicultural Discussions	1.83	.71	1.00
No Challenging Experiences	2.14	.71	2.00
Overwhelmed			
Racism	1.41	.38	1.11
Termination/Referral	1.15	.13	.22
Multicultural Discussions	1.50	.08	.11
No Challenging Experiences	1.26	.30	.89
Special			
Racism	1.49	.59	1.40
Termination/Referral	1.00	.00	.00
Multicultural Discussions	1.00	.00	.00
No Challenging Experiences	1.31	.51	1.40
Disengaged			
Racism	1.39	.61	1.50
Termination/Referral	1.33	.58	1.00
Multicultural Discussions	1.50	.71	1.00
No Challenging Experiences	1.70	.79	2.00

Primary themes for Qualitative Question 4 were: *Countertransference, Proving Competence/Disproving Stereotypes, Multicultural Learning,* and *Multicultural Discussions*. Generally scores were higher for Internalization attitudes (a higher level of racial identity development) and lowest for Post-Encounter attitudes. On the TRQ, scores were generally low, with the exception of Positive countertransference. When comparing scores for each subscale of the BRIAS and TRQ by theme, means were:

Table 21. BRIAS Mean Comparisons by Primary Themes in Qualitative Question 4

	Mean	SD	Range
Pre-Encounter			
Countertransference	27.00	3.83	8.00
Proving Competence/Disproving Stereotypes	26.60	2.41	6.00
Multicultural Learning	31.80	4.15	10.00
Multicultural Discussions	32.00	4.24	6.00
Post-Encounter			
Countertransference	13.00	2.94	6.00
Proving Competence/Disproving Stereotypes	11.80	4.32	11.00
Multicultural Learning	16.00	3.39	8.00
Multicultural Discussions	16.00	7.07	10.00
Immersion			
Countertransference	38.75	10.05	24.00
Proving Competence/Disproving Stereotypes	30.20	7.40	19.00
Multicultural Learning	34.40	2.97	8.00
Multicultural Discussions	31.00	.00	.00
Emersion			
Countertransference	33.00	3.16	7.00
Proving Competence/Disproving Stereotypes	30.00	5.75	15.00
Multicultural Learning	33.20	3.96	11.00
Multicultural Discussions	29.00	.00	.00
Internalization			
Countertransference	54.00	4.08	9.00
Proving Competence/Disproving Stereotypes	54.80	2.78	7.00
Multicultural Learning	53.80	7.56	18.00
Multicultural Discussions	53.50	.71	1.00

Table 22. TRQ Mean Comparisons by Primary Themes in Qualitative Question 4

	Mean	SD	Range
Mistreated			
Countertransference	1.53	.49	1.00
Proving Competence/Disproving Stereotypes	1.30	.21	.56
Multicultural Learning	1.63	.56	1.28
Multicultural Discussions	1.17	.08	.11
Helpless			
Countertransference	1.67	.48	1.11
Proving Competence/Disproving Stereotypes	1.49	.29	.67
Multicultural Learning	1.73	.73	1.78
Multicultural Discussions	1.44	.00	.00
Positive			
Countertransference	3.25	.71	1.63
Proving Competence/Disproving Stereotypes	3.05	.24	.63
Multicultural Learning	3.05	.52	1.25
Multicultural Discussions	3.25	1.24	1.75
Parental			
Countertransference	2.33	.76	1.83
Proving Competence/Disproving Stereotypes	2.40	.61	1.33
Multicultural Learning	1.49	.56	1.33
Multicultural Discussions	1.39	.71	1.00
Overwhelmed			
Countertransference	1.35	.26	.44
Proving Competence/Disproving Stereotypes	1.16	.21	.56
Multicultural Learning	1.49	.42	1.11
Multicultural Discussions	1.39	.39	.56
Special			
Countertransference	1.35	.70	1.40
Proving Competence/Disproving Stereotypes	1.16	.22	.40
Multicultural Learning	1.40	.47	1.20
Multicultural Discussions	1.30	.42	.60
Disengaged			
Countertransference	1.25	.50	1.00
Proving Competence/Disproving Stereotypes	1.40	.65	1.50
Multicultural Learning	1.75	.94	2.00
Multicultural Discussions	1.88	.18	.25

Primary themes for Qualitative Question 5 were: *Assumptions about Race of Therapist* and *Limited/No Training*. Generally scores were higher for Internalization attitudes (a higher level of racial identity development) and lowest for Post-Encounter attitudes. On the TRQ, scores were generally low across themes, with the exception of Positive Countertransference. When comparing scores for each subscale of the BRIAS and TRQ by theme, means were:

Table 23. BRIAS Mean Comparisons by Primary Themes in Qualitative Question 5

	Mean	SD	Range
Pre-Encounter			
Assumptions about Race of Therapist	28.67	3.08	11.00
Limited/No Training	32.20	8.76	21.00
Post-Encounter			
Assumptions about Race of Therapist	13.44	2.30	7.00
Limited/No Training	16.60	6.50	16.00
Immersion			
Assumptions about Race of Therapist	37.67	6.14	21.00
Limited/No Training	33.60	4.45	11.00
Emersion			
Assumptions about Race of Therapist	34.11	2.76	9.00
Limited/No Training	31.60	7.02	17.00
Internalization			
Assumptions about Race of Therapist	54.44	4.22	13.00
Limited/No Training	53.20	6.94	18.00

Table 24. TRQ Mean Comparisons by Primary Themes in Qualitative Question 5

	Mean	SD	Range
Mistreated			
Assumptions about Race of Therapist	1.33	.33	1.11
Limited/No Training	1.17	.06	.11
Helpless			
Assumptions about Race of Therapist	1.48	.42	1.11
Limited/No Training	1.36	.40	1.00
Positive			
Assumptions about Race of Therapist	3.17	.67	2.00
Limited/No Training	3.00	.63	1.25
Parental			
Assumptions about Race of Therapist	2.00	.55	1.50
Limited/No Training	2.43	.86	2.17

Overwhelmed			
Assumptions about Race of Therapist	1.39	.31	.89
Limited/No Training	1.16	.19	.44
Special			
Assumptions about Race of Therapist	1.51	.53	1.40
Limited/No Training	1.36	.61	1.40
Disengaged			
Assumptions about Race of Therapist	1.61	.72	2.00
Limited/No Training	1.50	.47	1.00

Chapter V

Discussion

The present study examined the relationship between Black racial identity and countertransference experiences within the Black therapist-White client counseling dyad. Due to the unique social and political history of race relations in the United States, there are distinct qualities to this particular dyad. Within the therapy setting, Black therapists occupy a space of power as therapists, however, are members of a (or multiple) historically oppressed group(s). This dynamic may have a number of implications for the therapeutic process. To date, few empirical studies have examined the clinical experiences of Black therapists, particularly their experiences with cross-racial counseling experiences (Carter, 1990; Carter & Helms, 1992; Chapman, 2006; Kelly & Greene, 2010; Knox et al., 2003). Utilizing a mixed-methods design, two research questions guided the current study: (1) Do Black racial identity attitudes predict countertransference reactions experienced by Black therapists when working with White clients? and (2) What are the benefits and challenges that Black therapists self-report when working with White clients?

To examine research question #1, a multivariate multiple regression analysis was proposed; however, due to an insufficient sample size ($N = 28$) as a result of a low return rate, this analysis was not conducted. Therefore, a descriptive analysis of mean comparisons by primary themes in the qualitative data was conducted. To examine research question #2, the Discovery-Oriented Approach was used to analyze qualitative data concerning the cross-racial counseling experiences of Black therapists. A discussion of the qualitative results occurs first, followed by a discussion of the descriptive quantitative results.

Perceived Impact of Racial Differences

Two primary themes emerged when participants discussed the perceived impact of racial differences on the therapeutic process: (a) *Awareness* and (b) *Limited Awareness/No Impact.* Sue, Arredondo, and McDavis (1992) proposed a tripartite model of multicultural competence comprised of three key elements: (1) self-awareness, (2) knowledge, and (3) skills. According to Sue et al. (1992), "culturally skilled counselors are aware of how their own cultural background and experiences, attitudes, and values and biases influence psychological processes" (p. 482). Within this context, awareness of the impact of racial differences on the therapeutic process is essential in understanding the therapy work. Findings from the current study are consistent with this model, highlighting that Black therapists consider the influence of racial dynamics when working with White clients. Prior research indicates that the racial identity of the therapist, client, and/or both, as well as their discussions of racial issues have implications for the therapeutic relationship and therapeutic outcomes (Burkard, Juarez-Huffaker, & Ajmere, 2003; Burkard, Ponterotto, Reynolds, & Alfonso, 1999; Helms, 1984b; Helms, 1990; Knox, et al., 2003).

Of note, is the finding that 25% of participants indicated *Limited Awareness/No Impact* of racial differences on the therapeutic process. This finding contrasts from multicultural counseling literature that suggests that the identities of the therapist and the identities of the client interact in complex ways and that these interactions influence therapy (Comas-Diaz & Jacobsen, 1995; Fuertes, et al., 2006; Helms, 1984b; Helms, 1990; Helms & Cook, 1999; Miles, 2012). For therapists who do not recognize racial differences as impacting therapy, this may be reflective of their own racial consciousness and/or racial identity attitudes. Prior research indicates that racial identity attitudes may contribute to how one perceives racial interactions in therapy. Within a

discussion of the effects of race on counseling, Helms (1984) observed that "sociocultural experiences, adaptability, and formal education opportunities" all influence "racial consciousness," and that racial consciousness plays an important role in counseling dyads (p.162). In light of this finding, future studies might explore what accounts for differences in the perceptions of the impact of racial and cultural variables on the counseling process, particularly among non-White therapists; as prior research suggests that non-White therapists typically score higher on multicultural competence measures (Chao, Wei, Good, & Flores, 2011; Pope-Davis & Ottavi, 1994).

In addition, findings revealed six secondary themes regarding the impact of racial differences: (a) *Focus on the Therapeutic Relationship*, (b) *Client Disclosures*, (c) *Avoidance*, (d) *Stereotypes/Assumptions*, (e) *Racism*, and (f) *Ambiguity*. Prior research demonstrates that the therapeutic relationship is one (if not the most) essential factors contributing to successful therapy outcomes (Beutler, et al., 2012; Falkenstrom, Granstrom, & Holmqvist, 2013; Fife, Whiting, Bradford, & Davis, 2014). Participants in the current study shared the importance of increasing their focus on the therapeutic relationship to build an alliance with their White clients. In addition, according to Comas-Diaz and Jacobsen (1995), White clients may have reactions to their therapists of color based on "intrapsychic dynamics, reality-based circumstances, and societal racial dynamics" (p. 94) all of which may impact therapy; and thus supports the finding that it is important to provide increased attention to the therapeutic relationship. Further, research demonstrates that the therapeutic relationship may determine information disclosed in session as well as topics raised in session (Farber, Berano, & Capobianco, 2004; Sloan & Kahn, 2005). This supports the finding that in a complex relationship such as the Black therapist-White client dyad,

client disclosures may be affected by how the client views the therapist and the therapeutic relationship.

In their discussion of their experiences as African American therapists, Kelly and Greene (2010) examined how skin color, hair texture, and sexual orientation elicited various reactions from their clients. Kelly and Greene (2010) noted that for the therapist and client in any counseling dyad "cultural stereotypes of each rather than realistic assessments" will inform therapy and constitutes important material for exploration in therapy (p. 196). Findings from the present study are consistent with this discussion, highlighting that stereotypes and assumptions as well as racism are at play in the cross-racial counseling experiences of participants in this sample. Although some empirical studies discuss the implications of stereotypes and racism directed towards the client (Owen, Tao, Imel, Wampold, & Rodolfa, 2014; Sue et al., 2007; Tinsley-Jones, 2003); few could be found that discuss Black therapists as the target of racism (Chapman, 2006; Kelly & Greene, 2010). Therefore, how Black therapists manage racism in the therapy room may be an area for future inquiry. In addition to these themes, *Ambiguity* was a theme that emerged from the data. Although there is variability in how therapists address ambiguity in therapy and in their tolerance for ambiguity; Ladany et al. (2008) contend that managing ambiguity is an essential skill for effective clinicians to master. Future research might explore how therapists who are engaged in cross-racial counseling tolerate and manage ambiguity.

Rewarding In-Session Experiences with White Clients

Three primary themes emerged regarding rewarding experiences with White clients: (a) *Multicultural Discussions*, (b) *Establishing Therapeutic Relationship*, and (c) *Client Openness*. Research indicates that multicultural counseling skills are distinct from general counseling skills

and studies examining these skills suggest that discussions of racial and cultural differences are instrumental in therapy (Coleman, 1998; Helms & Cook, 1999; Maxie, Arnold, & Stephenson, 2006; Sodowsky, Taffe, Gutkin, & Wise, 1994). This line of research supports the findings from the current study. For example, Maxie, Arnold, and Stephenson (2006) surveyed the experiences of licensed psychologists engaged in cross-cultural therapy and found that 84.5% discussed racial/ethnic differences with at least one client. The most common reasons for these discussions included "cultural component of the client's presentation" and "something the client said" (p. 89). These findings are consistent with the results of the present study in which addressing diversity was an important component of the therapy work.

Results from the current study reveal that when Black therapists establish rapport with White clients, it is a rewarding experience. According to Bordin (1979) the therapy working alliance is comprised of: (a) mutual agreement on the goals of therapy; (b) mutual agreement on the tasks of therapy; and (c) an emotional bond between the therapist and client. Although many factors may influence the alliance, these may be further complicated in cross-racial counseling situations. For example, in a study of the relationship between White racial identity attitudes and perceptions of the working alliance, Burkard, Juarez-Huffaker, and Ajmere (2003) found that participants rated their perceived ability to form a working alliance as higher with White counselors than with African American counselors. However, these ratings shifted with racial identity attitudes such that higher stages of racial identity development were related to higher ratings of African American counselors. Identifying the racial identity attitudes of clients are beyond the scope of the current study, however, it is important to note that depending on the racial identity attitudes held by the client, forming a strong alliance may have significantly added to participants' view of the relationship as being one of the most rewarding aspects of working

within cross-racial dyads. Furthermore, Burkard et al. (2003) suggest that therapists learn how to accurately assess the racial identity attitudes of their clients to better understand the alliance and therapeutic process.

Closely related to the therapy working alliance is *Client Openness*. Prior research indicates that when there is a strong working alliance, clients may be more likely to engage in therapy (Farber, Berano, & Capobianco, 2004; Sloan & Kahn, 2005). Within the present study, clients' ability to trust the therapist and the relationship, despite racial and cultural differences, proved to be rewarding for therapists in this sample. Future studies might further explore specific characteristics of the therapist and/or client that contribute to creating an environment that facilitates this level of trust within cross-racial counseling dyads. Of note, is the finding that 17% percent of the sample stated that they were unable to recall a specific rewarding experience. Reasons for this might be length of time since their last experience working with a White client, rewarding components being tied to variables other than multicultural/racial diversity issues, or difficulty recalling enough detail of the experience to provide a response when completing the survey.

Challenging In-Session Experiences with White Clients

Three primary themes emerged regarding challenging experiences with White clients: (a) *Racism*, (b) *Termination/Referral*, and (c) *Multicultural Discussions*. Participants indicated various forms of *Racism* such as clients identifying as racist or with racist supremacist groups; refusing to work with the therapist based on racial differences; and/or making racist statements. *Termination/referral*, also a form of racism in some cases, was also found to be a primary theme in the current study. *Termination/referral* was a distinct code from racism because not all clients

who expressed racism terminated from therapy, and likewise, not all clients who terminated cite racial differences as the cause.

In their discussion of their experiences as African American female psychologists, Kelly and Greene (2010) bring attention to the stereotypes clients may hold about African American female therapists and how this influences clients' expectations. Similarly, Chapman (2006) shared her account as an African American female psychologist working with a White male. She discussed the subtle forms of racism and the client's self-stated concern that a Black woman would not be able to effectively work with him. Although it took significant time for the client to disclose this, once he did, he chose to terminate with the therapist. Chapman (2006) discussed the impact this had on her identity as a therapist and as a Black woman as well as the countertransference she experienced. Subtle forms of racism included: "testing boundaries, coming late, questioning clinical judgment, and withholding payment" (Chapman, 2006, p. 224). The experiences shared by Chapman (2006) and Kelly and Greene (2010) are consistent with the themes of *Racism* and *Termination/Referral* that emerged in the current study. No studies other than that of Chapman (2006) and Kelly and Greene (2010) could be found that specifically address Black therapists' in-session experiences with racism. Of the few studies that do focus on Black therapists, attention is given to their experiences with racism in supervision (Constantine & Sue, 2007; Cook, 1994; Cook & Paler Hargrove, 1997). The current study adds to the multicultural literature, highlighting the need to understand Black clinicians in-session experiences with racism as well as the need to examine the training they receive on how to handle these occurrences.

In addition to *Racism* and *Termination/Referral*, *Multicultural Discussions* were also identified as challenging experiences. Racial conversations in Black-White counseling dyads

may be particularly complex given the racial dynamics and sociopolitical history of the United States. Depending on the racial consciousness and racial identity development of the therapist and of the client, these conversations may be even more difficult to navigate (Utsey, Garnet, & Hammar, 2005; Helms, 1984). In an investigation of Black therapists' and White therapists' experiences of addressing racial issues in cross-racial counseling dyads, Knox and colleagues (2003) found that for Black therapists, timing, method, and client defensiveness played important roles in managing these conversations. When studying White trainees responses to racial issues in counseling, Utsey, Garnet, and Hammar (2005) identified six categories influencing the discussion of racial issues in cross-racial counseling dyads: White racial consciousness, White racial awareness, minimizing race, discomfort with racial issues, reducing the threat of race, and finding a comfort level (p. 462). Furthermore, Kisileca (1999) discussed the impact of exploring racial issues on his personal development and his development as a therapist, noting that such conversations evoked guilt, shame, and fear of being labeled "racist." For these reasons, multicultural discussions may present a number of complex dynamics for both involved; however, when navigated successfully, may serve as rewarding therapeutic experiences.

In addition to challenges related to *Racism*, *Termination/Referral,* and *Multicultural Discussions*, secondary themes that emerged included: (a) *Avoidance* and (b) *Stereotypes/ Assumptions*. Avoidance of racial issues may be influenced by a variety of factors such as comfort with discussing racial issues and concerns about how such discussions will impact the therapy alliance and therapeutic outcomes (Knox, et al., 2003; Utsey, Garnet, & Hammar, 2005). Knox and colleagues (2003) found that for African American therapists working in cross racial counseling dyads who chose not to discuss racial differences this was because: therapists "sensed" client discomfort with discussing racial issues, the client was not interested in

discussing racial differences, or the therapist felt that it was his or her own countertransference that would prompt the discussion rather than material presented by the client (p. 473).

Within their study of racial discussions in therapy, Maxie, Arnold, and Stephenson (2006) found that diversity experience, gender, therapist age, and race/ethnicity were associated with choice to discuss racial issues. Within the current sample, each of these factors may have impacted Black therapists' choice to avoid racial discussions. For clients, their choice to not bring up these issues may have been related to their own racial identity development, their perceptions of the therapeutic alliance, and/or feelings of fear, shame, and guilt (Burkard, Juarez-Huffaker, & Ajmere, 2003; Chapman, 2006; Helms, 1984; Kiselica, 1999). Assumptions about the therapist may have also played a role in the avoidance of racial discussions. Furthermore, as noted earlier, the finding of *Stereotypes/Assumptions* as a challenging component in cross-racial therapy is consistent with prior research that documents that Black therapists are often confronted with their clients making assumptions about them based on their race (Chapman, 2006; Kelly & Greene, 2010).

Of note is that 40% of participants reported no challenging experiences within cross-racial counseling dyads. This finding is inconsistent with prior research that demonstrates that racial differences add complexity to the therapy work (Comas-Diaz & Jacobsen, 1995; Fuertes, et al., 2006; Helms, 1984b; Helms, 1990; Helms & Cook, 1999; Miles, 2012). Participants who indicated no challenging experiences may have worked with clients with acute presenting issues (e.g. suicidal ideation, psychosis) that outweighed challenges related to racial differences (Knox et al., 2003); may have limited experience in providing therapy to White clients (Maxie, Arnold, & Stephenson, 2006); or may have not had the opportunity to engage in on-going work as a result of the client terminating.

Overall Benefits/Challenges to Working with White Clients

Three primary themes emerged concerning benefits and challenges to working with White clients: *Countertransference, Proving Competence/Disproving Stereotypes*, and *Multicultural Learning*. According to Comas-Diaz and Jacobsen (1995), for the therapist of color, there may be a number of reactions that a White client may have to the therapist based on their own beliefs and personal history and these experiences may "transfer" onto the therapist. As a result, the therapist may then experience his or her own reactions, or "countertransference," in their work with White clients. Likewise, Gelso and Mohr (2001) discussed culture-related countertransference in which therapists' reactions to their clients are based in "direct or vicarious experiences." Gelso and Mohr (2001) noted that countertransference is "inevitable" and "universal" and if attended to, can be beneficial to the alliance (pp. 53-54). Within the current study, participants described their countertransference as increased awareness of their feelings toward White clients. For example, one participant noted that they were able to move beyond their personal feelings about White privilege and develop an alliance with their White client (which may have been more difficult in a different setting), while another participant indicated having different standards for White clients than non-White clients.

Comas-Diaz and Jacobsen (1995) described seven types of countertransference that therapists of color might experience in their work with White clients: anger and resentment; need to prove competence; avoidance; impotence; guilt; good enough; and fear (p. 99). Results from the current study are consistent with these findings. Black therapists within this sample identified *Proving Competence/Disproving Stereotypes* as a challenge when working in cross-racial dyads. Comas-Diaz and Jacobsen (1995) explained that this type of response may be the result of "tokenism" transference by which White clients view the therapist as a representative for his or

her race. Prior research indicates that "tokenism" has a number of taxing psychological implications for African Americans (Kelly, 2007; Linkov, 2014; Stroshine & Brandl, 2011). Comas-Diaz and Jacobsen (1995) also noted that a need for a therapist to prove competence may not only be influenced by their White clients' transference, but also by their own racial identity development. Future research might further explore therapist and client characteristics that contribute to the response of *Proving Competence/Disproving Stereotypes* and how this dynamic impacts the therapeutic process.

Multicultural Learning is a primary theme that emerged as a benefit that Black therapists receive when working with White clients. Prior research suggests that building multicultural competency involves awareness, knowledge, and skills (Alberta & Wood, 2009; Cartwright, Daniels, & Zhang, 2008; Cates, et al. 2007; Fawcett, Briggs, Maycock, & Stine, 2010; Seghal et al., 2011; Sue, Arredondo, & McDavis, 1992). Furthermore, literature on multicultural counseling makes a distinction between general counseling skills and multicultural counseling skills (Cates, et al., 2007; Maxie, Arnold, & Stephenson, 2006). Through direct experience working in cross-racial dyads, participants in the current study reported learning more about what it means to be "White in America" (causing a shift in some of their previous attitudes) as well as gaining skills in how to adjust/modify interventions that they might typically use with non-White clients. For many participants in this study, reflecting on and/or understanding how their work with White clients might contrast with non-White clients was not addressed in multicultural courses, thus making their cross-racial counseling experience a valuable and beneficial learning opportunity. Future research might continue to explore how multicultural training for non-White clinicians might contrast with that of White clinicians.

Secondary themes that emerged regarding benefits and challenges to working with White clients included: *Multicultural Discussions, Establishing a Therapeutic Relationship, Shifting Approach to Therapy*, and *Termination/Referral*. Multicultural Discussions were noted as equally beneficial and challenging, such that the initiation of these conversations was difficult, however, when worked through successfully, positively impacted the therapeutic relationship. This finding is consistent with prior research that suggests the racial consciousness and racial identity development of the therapist and the client; comfort with discussing racial issues; and therapist and client characteristics impact the initiation of (or avoidance of) multicultural discussions (Helms, 1984; Knox, et al., 2003; Maxie, Arnold, & Stephenson, 2006; Utsey, Gernat, & Hammar, 2005). Similarly, these factors also influence the therapeutic alliance. Prior research suggests that White clients may typically perceive more difficulty establishing an alliance with a non-White therapist in comparison to a White therapist (Burkard, Juarez-Huffaker, & Ajmere, 2003; Burkard, Ponterotto, Reynolds, & Alfonso, 1999). Furthermore, managing racial dynamics, may add further complexity to developing rapport within cross-racial counseling dyads (Bartoli & Pyati, 2009; Comas-Diaz & Jacobsen, 1995; Helms, 1984). For these reasons, participants in the current sample indicated establishing a therapeutic relationship as both a challenge and a benefit—a challenge to establish trust, however, a benefit once this challenge was overcome.

Shifting Approach to Therapy described participants' change in their usual therapy style in order to facilitate therapy. Examples of such changes included changing cultural references that would typically be used with non-White clients and monitoring the extent to which the therapist conforms to the client to minimize the client's discomfort in therapy. When working in cross-cultural dyads, prior research suggests that there are skill sets specific to multicultural

work. Adapting communication to fit with a different worldview and processing style, discussing racial differences, utilizing verbal and non-verbal responses that are most relevant and/or appropriate to the cultural background of the client, and selecting culturally appropriate interventions are all multicultural skills that have been distinguished from general counseling skills (Alberta & Wood, 2009; Cates et al., 2007; Sodowsky et al., 1994; Sue et al., 1992). Findings from the current study are consistent with this line of research, indicating that for some therapists, they adapted their usual interventions to fit with the cultural background of the client. Research also suggests that for Black individuals who work in predominantly White settings, "code switching" or the adaptation of language and behaviors to align with those of the predominant culture may serve as coping strategy in managing race-related stress (Hall, Everett, & Hamilton-Mason, 2012). In this sample, shifting approach to therapy may be reflective of either a multicultural intervention and/or a coping strategy. Future research might further clarify this distinction. In addition, *Termination/Referral* was also a challenge noted by therapists in the current sample and this is consistent with prior research that demonstrates that the complexities of cross-racial dyads (e.g. building the alliance, perceptions of the therapist) may result in early termination (Burkard, Juarez-Huffaker, & Ajmere, 2003; Chapman, 2006).

Sixteen percent of participants indicated there are no differences in the benefits or challenges they experience with White clients in comparison to their work with non-White clients. This finding is noteworthy given that prior research demonstrates that cross-racial dyads may experience unique challenges to building the therapeutic alliance and in addressing racial differences (Bartoli & Pyati, 2009; Burkard, Juarez-Huffaker, & Ajmere, 2003; Comas-Diaz & Jacobsen, 1995; Helms, 1984; Knox, et al., 2003; Maxie, Arnold, & Stephenson, 2006; Utsey, Gernat, & Hammar, 2005). This view that racial differences do not present distinct benefits/

challenges may be reflective of the therapists' racial identity attitudes. In describing Pre-Encounter racial attitudes, the earliest phase of racial identity development, Helms (1990) writes, "…the Black person who espouses the Pre-encounter perspective must find some way to separate himself or herself from the devalued reference group in order to minimize the psychological discomfort that arises when one's cognitions are incompatible" (p. 20). Furthermore, in their discussion of the different dimensions of color-blind racial attitudes, Neville, Awad, Flores, and Bluemel (2013) note that individuals may try to " 'not see race' to promote racial equality" (p. 456). Other reasons for not acknowledging or recognizing the benefits and challenges to working in cross-racial dyads may also be reflective of the therapist's clinical training in which such reflection has not been practiced and/or limited clinical experience with White clients.

Multicultural Training Experiences

Two primary themes emerged regarding Black therapists' multicultural training experiences: *Assumptions about Race of Therapist* and *Limited/No Training*. Participants in the sample indicated that much of their multicultural training was from the perspective of White therapists working with non-White clients. Participants also indicated that as a non-White therapist, there was limited/no training on the specific skills needed to work in cross-racial counseling dyads. These findings are consistent with much of the multicultural literature that focuses on the development of multicultural counseling competency for White therapists (Burkard, Juarez-Huffaker, & Ajmere, 2003; Chao, Wei, Good, & Flores, 2011; Gushue & Constantine, 2007; Middleton et al., 2005; Utsey, Gernat, & Hammar, 2005; Vinson, Neimeyer, 2003). While it is critical to ensure that White therapists are delivering culturally appropriate services to non-White clients, there is also increasing racial diversity among service providers

(Hart, Wicherski, & Kohout, 20llb). Future studies might further explore how multicultural training might differ based on the racial and cultural backgrounds of trainees.

Secondary themes that emerged regarding Black therapists' multicultural training experiences were: *Expanding Multicultural Training, External Training, Addressing Microaggressions, Multicultural Supervision*, and *Self-Exploration/Self-Reflection*. Expanding multicultural training referred to moving beyond simplistic descriptions of racial minority groups as well as being inclusive of multiple cultural variables beyond race. For therapists, multicultural training involves: self-awareness, knowledge, and skills and is viewed as a process/journey that includes racial diversity as well as other cultural variables such as gender, sexual identity, ethnic identity, ability status, etc. (Balkin, Schlosser, & Levitt, 2009; Chao & Nath, 2011; Constantine, Hage, Kindaichi, & Bryant, 2007; Helms & Cook, 1999; Johnson, 2014; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008). Although graduate programs are challenged with the task of developing multiculturally competent practitioners, prior research indicates that for many programs, this consists of 1-2 multicultural courses and there is a need for more integration across courses/throughout the program, an emphasis on reflective exercises, and engagement in cultural immersion experiences (Fawcett, Briggs, Maycock, & Stine, 2010; Neville, Poteat, Lewis, & Spanierman, 2014; Peters, et al., 2011; Rivera, Phan, Maddux, Wilbur, & Arredondo, 2006). This line of research is consistent with participant responses that indicated that training offered by their program was limited, and that in many cases they had to seek out training opportunities external to their programs.

Microaggressions was another secondary theme that emerged in the data. Much of the literature on microaggressions gives attention to clients who are racially minorities who have experienced microaggressions perpetuated by White therapists (Owen et al., 2014; Owen et al.,

2011; Sue et al., 2007; Sue et al., 2008). However, in the present study, Black therapists report experiencing microaggressions perpetrated by their White clients and a lack of training regarding how to navigate these situations when they occur. Only one empirical study could be found that focused on Black therapists' experiences with microaggressions (Constantine & Sue, 2007) and this study focused on the occurrence of microaggressions within supervision. Research indicates that microaggressions can negatively impact the working alliance and can have damaging psychological and emotional effects (Constantine, 2007; Constantine & Sue, 2007; Sue et al., 2007; Sue et al., 2008). Future research might further explore the microaggressions non-White therapists encounter in their work with White clients and how multicultural training might equip them to navigate these situations.

In addition, participants in the present study indicated that *Multicultural Supervision* should also be a focus of multicultural training. Participants identified challenges to working in cross-racial supervision dyads and this finding is consistent with prior research (Constantine & Sue, 2007; Cook, 1994). Within a qualitative study of cross-racial supervision dyads, Constantine and Sue (2007) found that racial microaggressions were common occurrences for Black therapists. Racial microaggressions fell within one of seven categories: invalidating racial-cultural issues; stereotypic assumptions about Black clients; stereotypic assumptions about Black supervisees; reluctance to give performance feedback for fear of being viewed as a racist; focusing primarily on clinical weaknesses; blaming clients of color for problems that stem from oppression; and offering culturally insensitive treatment recommendations (pp. 146-148). Findings from the current study, along with those of Constantine and Sue (2007), suggest that within cross-racial supervisory dyads a number of race-related issues may arise, and therefore,

future research might further explore these issues as well as how non-White trainees address them.

Participants also noted that *Self-Exploration/Self-Reflection* was a gap in their multicultural training, emphasizing a desire to include this within their courses to increase their awareness of racial attitudes and biases. Sue, Arredondo, and McDavis (1992) highlight that self-awareness is a key component of building multicultural competency and involves awareness of "assumptions, values, and biases" as well as awareness of "emotional reactions towards other racial groups" (p. 482). Furthermore, Rivera et al. (2006) found that a focus on "personal development" (via an "honest" and "real relationship" with self) within multicultural courses was associated with multicultural counseling skills (p. 43). Rivera et al. (2006) posited that not only are didactic and clinical experiences necessary, but that personal development and growth are also essential to developing multicultural competency. Future studies examining the development of multicultural counseling skills might consider the extent to which self-exploration and self-reflection exercises increase multicultural competence.

Black Racial Identity Attitudes and Countertransference

Correlational analyses revealed a significant positive relationship between Pre-Encounter racial attitudes and Helpless countertransference. This finding contrasts with the hypothesis that Pre-Encounter attitudes would be related to positive and special/over involved countertransference. According to Helms (1990), Pre-Encounter attitudes reflect an "idealization" of Whiteness and White culture (p. 20) and these attitudes may be "passive" or "active" (p. 22). It may be possible that Black therapists who "idealize" their White clients or on some level view their White clients as better than or superior to them, may in fact feel helpless at times in therapy. Relatedly, if the White client engages in "tokenism" and "cognitive

dissonance" transferences (Comas Diaz & Jacobsen, 1995) in which the client either: raises questions about competence of the therapist; doubts the abilities of therapists; and/or resists the therapist through various defense mechanisms, this may also lead to feelings of helpless experienced by the therapist.

There was a positive significant correlation between Post-Encounter racial attitudes and Disengaged countertransference. Post-Encounter attitudes reflect circumstances in which a Black person may have a direct experience or encounter with racism that raises their awareness about the racial dynamics of US society and how society views Black persons in America. Helms (1990) explained that following such events/experiences, individuals may experience: "confusion, hopelessness, anxiety, depression, or anger" (p. 25). Similarly, Comas Diaz and Jacobsen (1995) explained that racial minority therapists might experience anger and resentment as they work with White clients as a result of clients' transferences onto the therapist. As the therapists in this sample highlighted in their qualitative responses, many have encountered racism within the cross-racial therapy dyad. These experiences in tandem with those outside of the therapy room may result in less engagement when working with White clients. Future research might explore how Black therapists' experiences of racism (both within and outside the therapy context) impact the therapeutic process when they work with White clients.

Immersion racial attitudes were significantly negatively correlated with Positive countertransference. Immersion attitudes reflect deep engagement with Black communities and Black culture, stereotypic ideas of what it means to be Black, and an individual's view of the Black identity as superseding all other parts of their identity (Helms, 1990). Immersion attitudes may also include a devaluing of other groups, particularly Whites. Prior research demonstrates that Immersion attitudes are significantly related to anger and hostility, in which the individual

may be angry and hostile towards Whites as they recognize the legacy of oppression faced by Blacks (Carter, Pieterse, & Smith; Helms, 1990). These findings are consistent with those of the present study in which Immersion attitudes are negatively correlated with Positive countertransference.

As individuals develop a more integrated Black identity and engage in activities that are personally relevant (rather than stereotypic activities or holding stereotypic beliefs of what it means to be Black), they move into Emersion. Within the Emersion stage, research indicates that anger and hostility began to decrease and the person develops a "non-stereotypic Afro-American perspective on the world" (Helms, 1990, p. 28). Emersion attitudes in this study were not significantly related to any of the countertransference attitudes assessed, and therefore, future research might explore how Emersion attitudes impact the therapy process.

Internalization racial attitudes reflect an integrated, stable, and internally defined Black racial identity (Helms, 1990). Individuals are aware of racism and oppression and are actively engaged in social justice activities; however, they are able to develop relationships with Whites, in which they relinquish negative emotions, they understand the diversity of racial attitudes held by Whites, and they recognize the importance of fighting institutional/systemic forces involved in the perpetuation of racism (Helms, 1990). Findings in the present study revealed a significant positive correlation between Internalization attitudes and Positive countertransference and significant negative correlations with Helpless and Disengaged Countertransference. Given the positive orientation towards self and others espoused within Internalization attitudes, therapists in this sample were able to have positive feelings towards their White clients, felt confident in their abilities (i.e. did not feel helpless), and were able to be fully engaged when working with White clients.

Due to insufficiently low sample size, the proposed multiple regression analysis could not be performed. However, for descriptive purposes, means on the Black Racial Identity Attitudes Scale (BRIAS) and the Therapist Response Questionnaire (TRQ) were compared based on primary themes in the qualitative data. It is difficult to make general inferences based on the small sample size; however, it is important to note that across themes, scores were highest for Internalization attitudes (highest level of racial identity development) and lowest for Post-Encounter attitudes. Prior research demonstrates that for White therapists, racial identity attitudes are associated with multicultural competence (Chao, 2013; Johnson & Jackson, 2014). No studies could be found that examine this relationship with Black therapists. Future research might further explore the relationship between Black racial identity attitudes and multicultural competence for Black therapists who work in cross-racial counseling dyads. For the Therapist Response Questionnaire, across themes, means were generally low for all countertransference responses, with the exception of Positive countertransference. This finding may indicate that Black therapists enjoy their work overall with White clients regardless of the challenges they may encounter.

Limitations

Attrition and sample size were major concerns in the present study. Of the 60 individuals who accessed the study, only 48 were eligible to participate (i.e. identified as African American/Black; current enrollment in or graduated from a counseling, clinical, or closely related program; and conducted therapy with at least one White client for two sessions). Of these 48, 20 did not complete the study. Eligibility criteria, recruitment methods, and population access may have impacted the sample size. Research demonstrates that there are disproportionately less African American clinicians in comparison to the number of White

clinicians (Hart, Wicherski, & Kohout, 2011). For this reason, the population from which to draw prospective participants from is significantly less. In addition, African American therapists who had no experience providing therapy to White clients were ineligible for the study, further reducing the number of prospective participants.

Sample size may have also been affected by online recruitment. Trainees may be overwhelmed by the number of online research requests they receive, and may therefore be very selective in choosing which studies they participate in. Online recruitment was the primary method for obtaining participants. In future studies, personal contacts and/or increased emphasis on the snowball sampling method may be an important consideration. In terms of attrition, no statistical differences (with the exception of number of supervision hours per week) were found between those who completed and those who did not complete the survey. Given the sensitive nature of racial issues, it may be likely that some participants were reluctant to share their cross-racial counseling experiences. For others, fatigue and/or time limitations, may have caused them to exit the study prior to completion. Due to these reasons, the sample size was extremely low, and therefore, results from the study may not generalize to other Black therapists. Future research might further investigate Black therapists' experiences with cross-racial counseling using larger sample sizes.

Additional limitations of the current study include internal and external threats to validity (Heppner, Wampold, & Kivlighan, 2008). Unreliability of measures may be a potential threat to statistical conclusion validity. The Therapist Response Questionnaire is a recently developed instrument and has not been widely tested with diverse populations. One subscale (Sexualized) that was reliable in prior studies (Betan et al., 2005) was not found to be reliable in the present study. Few studies have used this scale, and therefore, future research might utilize the scale with

different populations and/or with different constructs to better understand the psychometric properties of the subscales. It is unclear if the unreliability of the Sexualized subscale is due to the response pattern of the current sample or to methodological issues with the scale. Similarly, the qualitative questionnaire may also present a limitation to statistical conclusion validity because it was developed specifically for the present study. This questionnaire may not be inclusive all dynamics that exist in cross-racial counseling dyads. Therefore future studies might consider different ways of capturing the cross-racial counseling experiences of Black therapists.

Generalizability is another limitation to the present study. Of note, is that the current sample primarily included Black female therapists (86%) and therefore the present findings may not generalize to Black male therapists. Future studies might include larger male samples to determine if the present findings are consistent (or differ) across gender. In addition, the majority of the sample primarily endorsed Internalization attitudes (highest level of racial identity) and therefore their experiences working in cross-racial counseling dyads may not generalize to a sample of Black therapists who primarily endorse other racial identity attitudes such as Pre-Encounter or Post-Encounter attitudes.

Future Directions

Utilizing a mixed-method research design, the current study provided insights into the cross-racial counseling experiences of Black therapists. Quantitative findings highlighted that there appear to be relationships between Black racial identity and countertransference experienced by Black therapists working in cross-racial counseling dyads. Qualitative results indicated a number of ways in which racial differences impact the therapeutic process, some of which include: establishing the therapeutic relationship, working through racism in therapy/working with racist clients; managing countertransference when working with White

clients; and limited training on how therapy with White clients might contrast with that of non-White clients.

Given the findings of the present study, future research might address a number of areas related to cross-racial therapy with particular attention given to race, gender, and multicultural training. With regard to race, this study highlights that race plays an important role in the counseling process and that racism is prevalent in cross-racial counseling dyads. Future studies might include the following: examining the relationship between Black racial identity attitudes of therapists and their awareness of, identification of, and sensitivity to in-session events related to race; examining the nature and type of racist events that occur in therapy (with a particular focus on the therapist as the target of racism); exploring how, when, and why Black therapists might (or might not) have discussions of racial differences when working in cross-racial counseling dyads; exploring the impact that racial discussions have on the therapeutic alliance/therapy process; examining the process by which training programs prepare racial minority therapists for the possibility of racist events occurring in session; and investigating how training programs provide support to Black therapists when racist events occur as well as how programs intervene to address racism.

Of note, is that the majority of the sample was female (86%) and this raised the question as to whether the findings of the current study generalize to Black male therapists. Future research might utilize larger samples of Black male therapists and investigate if their experiences are similar to and/or contrast from that of Black female therapists. Prior research indicates that Black females may face unique stressors due to their identification with multiple historically oppressed groups (Hall, Everett, Hamilton-Mason, 2012; Szymanski & Stewart, 2010). In addition, future studies may also explore the intersection of race and gender through exploring

various gender groupings across cross-racial counseling dyads and investigate differences that may exist in same-gender versus different gender dyads (i.e. Black male therapist-White male client dyads, Black male therapist-White female client dyads, Black female therapist-White female client dyads, and Black female therapist-White male client dyads).

Findings from the present study reveal a number of concerns regarding multicultural training. Participants in the current study indicated that they received limited or no training on how to work in cross-racial counseling dyads. Future research might examine the differences that may exist in the multicultural training needs of White and non-White therapists. Based on the data from this sample, multicultural training involves 1 or 2 courses and typically assumes that the therapist is White and is working with a non-White client. Within this context, future studies might examine the assumptions that training programs make with regard to their multicultural courses (e.g. determining the content of the courses, assumptions made about the audience in these courses). Additionally, future studies might also examine if the approach to multicultural training varies by program type (e.g. Clinical, Counseling, Marriage and Family, etc.) and/or by theoretical orientation (e.g. Psychodynamic therapies, Cognitive-Behavioral therapy, insight-oriented therapies, solution-focused therapies); how training programs assess the effectiveness of their multicultural training; and what measures are in place to ensure that (all) students' needs are being addressed within multicultural courses. Investigating such questions may challenge training programs to evaluate how they conceptualize multicultural training and to consider if modifications are necessary given the needs of their trainees/students. The complexity of exploring such issues require diverse and innovative research designs/methods; however, investigations of this nature can provide invaluable data regarding the service delivery and training needs of non-White therapists who work in cross-racial counseling dyads.

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Tables

Table 1. Comparison of Participants Who Completed and Who Did Not Complete Survey

	Completed	Not Completed	Test Statistic	*df*	*p*
Variable	*N*	*N*			
Gender	29	19	$\chi 2 = 1.039$	2	.60
Current Geographic Region	29	19	$\chi 2 = 4.293$	4	.37
Academic Program	29	18	$\chi 2 = .894$	2	.64
Specialty Area	29	18	$\chi 2 = 2.255$	7	.94
Level of Clinical Experience	28	18	$\chi 2 = .994$	3	.80
Theoretical Orientation	28	19	$\chi 2 = 9.905$	6	.13
Current Therapy Setting	29	19	$\chi 2 = 1.849$	6	.93
Age	29	19	t = -.341	46	.74
Current Year in Program	21	14	t = .791	33	.44
Length of Training Program	26	18	t = .563	42	.58
Total Number of Years Conducting Therapy	29	19	t = -.470	46	.64
Total Number of Supervision Hours Per Week	26	18	t = -2.501	42	.02*
Number of Multicultural Courses Taken	26	18	t = -.396	42	.70
Number of Multicultural Seminars Attended	27	18	t = 1.719	43	.09
Total Number of Racial Minority Clients	25	17	t = -.558	40	.58
Total Number of White Clients	25	16	t = .137	39	.89

Table 2. Descriptive Data for Participants Who Completed Survey

Variable	N	Mean	SD
Age	28	32.14	8.30
Year in Program	20	3.90	2.15
Length of Training Program	25	5.00	1.70
Number of Years Conducting Therapy	28	5.91	5.30
Supervision Hours Per Week	25	1.68	1.07
Number of Multicultural Courses Taken	25	2.28	1.49
Number of Multicultural Seminars/Trainings Attended	26	6.62	6.87
Total Number of Racial Minority Clients	24	44.04	39.07
Total Number of White Clients	24	52.13	89.35

Table 3. Descriptive (Frequency) Data for Participants Who Completed Survey

Variable	N	%
Gender		
Female	24	86
Male	4	14
Race		
African American/Black	22	79
Multi-racial	5	18
Ethnicity		
African American	13	46
Afro-Caribbean	2	7
Multi-Ethnic	5	18
Current Geographic Region		
Northeast	10	36
Southeast	9	32
Midwest	4	14
Western	3	11
Southwest	2	7
Academic Program		
PhD	16	57
PsyD	7	25
Masters	5	18
Specialty Area		
Clinical	13	46
Counseling	8	29
Community	1	4
School	1	4
Clinical Social Work	1	4
Marriage and Family	2	7
Other	1	4
Current Level of Experience		
Beginning Practicum	5	18
Advanced Practicum	6	21
Internship	7	25
Graduate/Practicing in Field	9	32
Theoretical Orientation		
Psychodynamic	1	4
Cognitive/Behavioral	2	7
Humanistic/Experiential	2	7
Systems	1	4
Feminist Therapy	2	7
Integrative	17	61
Other	2	7
Current Therapy Setting		
College Counseling	8	29
Community Mental Health	5	18
Hospital	5	18
Private Practice	4	14
Prison/Detention Center	1	4
Other	3	11
Multiple Settings	2	7

Table 4. Descriptive Data for Participants Who Did Not Complete Survey

Variable	N	Mean	SD
Age	20	32.50	10.06
Year in Program	15	3.40	1.81
Length of Training Program	19	4.66	1.31
Number of Years Conducting Therapy	20	6.47	7.10
Supervision Hours Per Week	19	2.89	2.18
Number of Multicultural Courses Taken	19	2.40	2.51
Number of Multicultural Seminars/Trainings Attended	19	3.05	4.34
Total Number of Racial Minority Clients	18	55.50	113.89
Total Number of White Clients	17	45.71	95.43

Table 5. Descriptive (Frequency) Data for Participants Who Did Not Complete Survey

Variable	N	%
Gender		
Female	16	80
Male	4	20
Race		
African American/Black	19	95
Multi-racial	1	5
Ethnicity		
African American	15	79
Afro-Caribbean	3	16
Multi-Ethnic	1	5
Current Geographic Region		
Northeast	11	55
Southeast	5	25
Midwest	1	5
Southwest	3	15
Academic Program		
PhD	14	74
PsyD	3	16
Masters	2	11
Specialty Area		
Clinical	10	53
Counseling	6	32
Clinical Social Work	1	5
Marriage and Family	1	5
Other	1	5
Current Level of Experience		
Beginning Practicum	2	11
Advanced Practicum	6	32
Internship	6	32
Graduate/Practicing in Field	5	26
Theoretical Orientation		
Psychodynamic	4	20
Cognitive/Behavioral	5	25
Systems	1	5
Integrative	9	45
Other	1	5
Current Therapy Setting		
College Counseling	6	30
Community Mental Health	3	15
Hospital	3	15
Private Practice	2	10
Prison/Detention Center	1	5
Other	2	10
Multiple Settings	3	15

Table 6. Descriptives for Black Racial Identity Attitudes Scale (BRIAS)

Scale	N	Mean	SD	α
Pre-Encounter	28	29.14	5.02	.59
Post-Encounter	28	13.90	4.37	.75
Immersion	27	34.63	6.60	.72
Emersion	28	32.90	4.77	.81
Internalization	28	54.07	4.88	.68

Table 7. Descriptives for Therapist Response Questionnaire (TRQ)

Scale	N	Mean	SD	α
Mistreated	28	1.38	.38	.83
Helpless	28	1.54	.45	.66
Positive	28	3.11	.58	.71
Parental	28	2.21	.62	.59
Overwhelmed	28	1.33	.28	.42
Special	28	1.33	.46	.53
Sexualized	28	1.03	.09	--
Disengaged	28	1.51	.64	.71

Table 8. Themes and Sample Responses to Qualitative Question 1: When working in a cross-racial counseling dyad, how do racial differences impact your therapeutic work? Within your response, please address any transference or countertransference issues that may influence your work.

Theme	Definition	% of Responses	Sample Response	Sample Response
Awareness	Therapist and/or client awareness of the impact of racial identity and racial dynamics on the therapeutic process	25%	"I am cognizant of being a Black male therapist and how these factors influence my clients…I have to be mindful of my reactions to racially-tinged issues that arise in sessions. Sometimes I am aware that my therapeutic response is different than my normal response."	"I must be aware of my stimulus value and be willing to address any differences in the room…"
Limited Awareness/ No Impact	Therapist beliefs that race does not have any impact on the therapy process	25%	"I don't think they really do. Of course clients report the same…"	"Rarely if at all. Every once in a while a client will makes statements like "I don't care what race someone is." Other times, stereotypical statements about Black folks (such as a Latina client discussing how much she prefers to date "chocolate men") will come out. Either scenario is very rare."
Focus on Therapeutic Relationship	Increased attention and focus on building the therapeutic alliance	10%	"Racial differences create an extra step in the therapeutic alliance where racial differences must be addressed"	"…I understand that my client's are trying to gain a sense of connection and a shared experience. They are trying to feel incorporated into a larger system or a greater existence that acknowledges that although they are unique, there are still a lot of commonalities between me and them, providing them with a sense of distant attachment (for example, therapy will work with you because we're the same or I can trust you because you know what I'm talking about). I seem to spend a lot of time upfront addressing race-related ideals and assumptions, which long-term, I feel help to develop a stronger therapeutic bond and relationship."
Disclosures	Client may withhold information due to racial/ethnic identity of	10%	"I often wonder whether my race impacts the way my client's perceive me and my therapeutic abilities. I wonder if they often don't share certain	"…When working with white clients I am aware that my ethnicity may impact what they decide to talk to me about…"

	therapist		thoughts because of my race."	
Avoidance	Deliberate attempts to overlook, minimize, and/or avoid interactions or discussion of racial differences	10%	"I think I really find myself trying to force myself to ignore race and really focus on the presenting problem. I feel like I do this because I find myself feeling insecurities when working with White clients and feeling like I have to be perfect. I find myself not bringing race up in sessions even though clients may attempt to…"	"all the time. it's in all interactions with client although I rarely bring it up in the room."
Stereotypes/ Assumptions	Stereotypes/assumptions expressed by the client about the therapist and/or therapist's background	10%	"Clients are often confused by what race/ethnicity I am: Whites think I am White, Latina, and a few have thought Black; Blacks think I am Latina or Black or mixed; Latinas think I am Latina. As a result, all my clients have made assumptions of my experience and ability to directly relate to them…"	"I am curious about what stereotypes clients come in with and also careful about checking my own."
Racism	Client identification as racist and/or discriminatory behaviors directed towards therapist due to race of therapist	10%	"I have had one client that did not want to work with me because of racial differences and I simply referred him to another clinician."	"…client focused on "proving" they are not racist."
Ambiguity	Doubt about the therapeutic process and outcomes	4%	"In the beginning, there is always a period of uncertainty from the client and myself that I will be able to relate to a client of a different race…"	--

Competence-Related Countertransference	Doubts, questions, insecurities about abilities	4%	"I think I really find myself trying to force myself to ignore race and really focus on the presenting problem. I feel like I do this because I find myself feeling insecurities when working with White clients and feeling like I have to be perfect…"	--

Table 9. Themes and Sample Responses to Qualitative Question 2: Please describe a rewarding multicultural experience when working with a White client. What made this experience rewarding? Please speak to how multicultural issues were addressed.

Theme	Definition	% of Responses	Sample Response	Sample Response
Multicultural Discussions	Open discussions of issues related to race, culture, and diversity	30%	"It was very powerful to work with a White woman who described herself as growing up "dirt poor" in the deep South. Her perspective on race, class, and culture raised my awareness of regional differences and differing attitudes about race and class."	"There have been several different rewarding experiences involving work with white clients (and colleagues). Most recently, a dialogue occurred about stereotyping related to people of color and relational patterns."
Establishing Therapeutic Relationship	Ability to form a strong working alliance	30%	"What was rewarding was building the rapport to come to common ground despite different racial backgrounds."	"I worked with a 21 year old white female who was dealing with issues of anxiety and anger. She was very resistant to speaking openly in session. After an instance of self-disclosure she opened up and we continued working together for an entire academic year."
Client Openness	Client openness to engage in the therapy process and to experience a positive change in attitude towards therapy	26%	"I believe each White client who is willing to listen, establish rapport, and have "buy-in" from a young African American female in her 20s was rewarding as a whole."	"The experience was rewarding because the client's attendance was regular, she reflected on questions raised or comments made to discuss in next session, and she was truly grateful for the experience. Furthermore, we both demonstrated growth."
Unable to Recall/ No Rewarding Experience		17%	"Can't think of any."	"I haven't had any."
Confidence in Multicultural Counseling	Confidence held and expressed about multicultural therapy	4%	"…I was able to experience that regardless of race a therapeutic relationship can occur. I still would seek out a therapy with a Black woman but I think I gained more faith in the possibility that cross-cultural dyads in therapy can work."	--

Table 10. Themes and Sample Responses to Qualitative Question 3: Have you had a challenging experience in session when working with a White client (as a result of racial identity differences)? If so, please describe the experience and the ways you worked through the experience.

Theme	Definition	% of Responses	Sample Response	Sample Response
Racism	Client identification as racist and/or discriminatory behaviors directed towards therapist due to race of therapist	67%*	"A White male client identified as racist. We discussed what it was like for him to work with a Black therapist and the discussion is ongoing."	"I had a white male client refuse to have counseling with me because I was black…"
Termination/Referral	A request to end therapy and/or to work with another therapist	42%*	"I had a client who did not want to work with me because of racial differences. I asked him if he wanted to discuss any discomfort he had in order to validate and normalize his experience. However, he was unwilling to speak with me any further and asked to be referred, which I did."	"An intake was scheduled with a White client over the phone, but the client assumed I was White because I did not speak in the stereotypical "Black" manner he had grown up with. Upon meeting me, he was taken aback and became uncomfortable when explaining what brought him to treatment (he was beaten by a group of Black men at a night club and suffered severe injuries). He returned to a follow-up session, but discontinued without returning my phone calls."
Multicultural Discussions	Open discussion of issues related to race, culture, and diversity	33%*	"…Most frequently clients make a point of commenting on racial issues and discussing how they are not racist but someone else is. I typically work through this by discussing our racial identity differences."	"I have helped clients with racial prejudice toward myself or other clients. It really took a non-judgmental stance to help them with the presenting problem/s."
Avoidance	Deliberate attempts to overlook, minimize, and/or avoid interactions or discussion of racial differences	10%*	"Some challenging experiences include denial/avoidance of my race/ethnicity or assumptions about my race/ethnicity."	"…When doing a parent consultation, I had a White parent refer to her friend's problems as "White girl problems." I had never heard this term and was unsure how to respond. She said this phrase twice, indicating she was not embarrassed to use the term around me. I responded by smiling pleasantly without appearing to laugh."

Stereotypes/Assumptions	Stereotypes/assumptions expressed by the client about the therapist and/or therapist's background	10%*	"Patient made references to how 'all Black guys get shaving waivers (military)'…. Wasn't a major factor in counseling, but didn't necessarily help our rapport either."	"Some challenging experiences include denial/avoidance of my race/ethnicity or assumptions about my race/ethnicity."
No Challenging Experience	No challenging experience reported	40%	"No."	"Not as of yet."

Table 11. Themes and Sample Responses to Qualitative Question 4: Please list some of the benefits and challenges you face when working with White clients.

Theme	Definition	% of Responses	Sample Response	Sample Response
Countertransference	Increased self-awareness and monitoring of biases towards and feelings about working with White clients	37%	"On a day to day I often times I find myself unable to trust White people and outside of professionally I do not have any relationships with Whites. I think that working with White clients helps monitor my own feelings about Whites because it reminds me that they are human too...it sort of distracts me from White privilege for a minute."	"I believe I hold White clients to a different standard sometimes than I do Black clients -- the countertransference I have with some non-White clients is oftentimes less apparent to me... at least, at first."
Proving Competence/ Disproving Stereotypes	Belief that one has to prove his/her competence and/or disprove stereotypes that client might hold	37%	"…Challenges include: the feeling that you have to prove yourself more than my White counterparts and not always given the chance to work with White clients due to their pre-conceived beliefs about African Americans."	"I sometimes worry if a white client will listen to my advice or think I am incompetent."
Multicultural Learning	Exploring multicultural issues such as learning how to work with others of different backgrounds; recognizing similarities and differences among cultures; and identity exploration	32%	"Benefits - Gaining different perspectives on what it means to be White in America to the client…"	"Exposure, building competence, refining techniques, sometimes having to be creative in my interventions, becoming more mindful of my counter-transference."
Multicultural Discussions	Open discussion of issues related to race, culture, and diversity	26%	"Benefits include being able to have difficult dialogues with clients about topics that can be too sensitive or challenging to have outside of the therapy space."	"Challenges - honestly acknowledging and moving past stereotypes that we both bring into the room."
Establishing Therapeutic Relationship	Ability to form a strong therapeutic alliance	21%	"Benefits: We are usually able to form a solid working alliance."	"Challenges - trust, building a therapeutic alliance."
Shifting Approach to Therapy	Modifications to therapy style	16%	"Challenges include working through initial countertransference and being comfortable sitting with a client while remaining true to myself. I want to avoid being more "White" in order to make the client comfortable because that	"Sometimes I use humor with African American clients that related to black cultural norms that I cant use with white clients."

			is not my genuine self."	
No Differences	No benefits/challenges that are different from non-White clients	16%	"I have not found specific benefits or challenges."	"Neither benefits nor challenges compared to any other non-white client."
Termination/Referral	Request to end therapy and/or to work with another therapist	11%	"Most Caucasian clients who don't prefer an Black clinician don't see me or ask to be referred to another person in the practice. No offense taken."	--

Table 12. Themes and Sample Responses to Qualitative Question 5: Based on your experiences (as an African American/Black therapist) are there gaps in multicultural training related to building multicultural counseling competency when working in cross-racial counseling dyads?

Theme	Definition	% of Responses	Sample Response	Sample Response
Assumptions about Race of Therapist	Multicultural training that assumes a perspective of the therapist identifying as White and the client identifying as a racial minority	38%	"I feel like in training there is so much emphasis placed on the majority working with the minority and not enough of the vice versa. There is the assumption that we all know how "White people live", when we don't so sometimes the theories that we learn just do not make sense."	"There are absolutely gaps! I have yet to learn how to work with white clients as a black therapist. Thus far I have taken what I have learned and modified it as I see fit. That is a huge gap in the multicultural training!"
Limited/No Training	Very limited or no training on working in cross-racial counseling dyads	25%	"There is a lot of multicultural training for non-Black clinicians but minimal for Black clinicians. There is little discussion about what to do when a minority clinician is working with a White client."	"…taking 1 multicultural class in all of graduate school is lie taking one abnormal psychology class and knowing how to diagnose clients. Diversity classes only give you the basics…Very limited training on working with white clients."
Expanding Multicultural Training	Broadening the scope of multicultural training to be inclusive of more cultural variables	17%	"The gap is that the multicultural classes and trainings lump all racial minorities into one group: Multicultural. The reality is that they are not the same. Asians and the Asian experience is completely different from the Black or African American experience; and if one were to break it down further, the Chinese experience (for example) is vastly different from that of the Korean, as is the Hatian in comparison to the Jamaican...and so on. So these multicultural trainings are minimal in addressing what it is to be X, Y, Z; the disadvantages of categoristic labels; and the true realization of cultural difference. As a result, a lot of assumptions are actually being taught and then given the cautionary warning: But not all ____ are the same."	"Culture is more than just race. There are subcultures based on SES, education, or occupation. Those are just a few…This aspect of multiculture was just as important as their race, but this is not an aspect of multicultural training I remember."
External Training	Seeking out opportunities external to graduate	8%	"…Diversity classes only give you the basics. I had to take multiple workshops and go to diversity conferences to broaden my cultural	"Accountability for my awareness/training and development of cultural competence is on me. Programs may only give the bare minimum and I have

	program to learn more about multicultural issues		knowledge."	frequently had to seek out other experiences/trainings to augment and facilitate my cultural competence."
Addressing Microaggressions	Training on how to handle/navigate microaggressions that occur in therapy	8%	"One gap that exists is when, if, and how racial slurs should be addressed in therapy when a white client is receiving services from an African American therapist."	"Perhaps prejudice when it manifest in the form of hostility and having a myriad of techniques to manage it before having to resort to referring out."
Multicultural Supervision	Understanding how to work in multicultural supervisory dyads	8%	"…I believe that multicultural training should also include benefits and challenges with supervisors that are racially different."	"as I work towards gaining the supervised hours necessary for my license I realized that for me it was imperative that I have a Black supervisor that I could be honest about race with because of my own Afrocentric beliefs. However, finding this was a struggle and I wish there was a forum for others with the same desire to find what I have. The supervisor/supervisee relationship is so important and I do not recall discussing how this is a stressor for Black therapist that have to work with White Supervisors in school. I certainly found this out as I entered the workforce."
Self-Exploration/ Self-Reflection	Increased emphasis on self-reflective practices to develop multicultural competence	8%	"I think working on noting my biases and working to correct them has been helpful. Also, I'm always willing to address racial issues when they arise. I suppose that would be training of a self-reflective nature."	"An additional gap is that many academic programs do not do a sufficient job in addressing racial issues within the individual (i.e., therapist); therefore, a lot of young clinicians enter the field without truly identifying and owning their own race and racial/racist issues."
Navigating Multicultural Discussions	Learning how to discuss multicultural issues with clients	4%	"I think one training gap regards distinguishing between when there is a clinical need to address more about racial dynamics vs. the therapist's personal motivations to do so."	--

Table 13. Correlations Between Black Racial Identity Attitudes Scales (BRIAS) and Therapist Response Questionnaire (TRQ) Scales

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Pre-Encounter	-										
2. Post-Encounter	.794**	-									
3. Immersion	-.146	-.003	-								
4. Emersion	-.434*	-.450*	.384*	-							
5. Internalization	-.613**	-.641**	.078	.445*	-						
6. Mistreated	.320	.316	.131	-.202	-.350	-					
7. Helpless	.512**	.320	.036	-.306	-.655**	.695**	-				
8. Positive	-.219	-.206	-.381*	.073	.374*	-.413*	-.414*	-			
9. Parental	.055	.000	-.245	-.011	.191	-.227	-.107	.510**	-		
10. Overwhelmed	.226	.239	-.031	-.174	-.332	.311	.311	.165	.103	-	
11. Special	.056	.129	-.112	-.142	-.249	.207	.207	.277	.090	.457*	-
12. Disengaged	.269	.430*	.251	-.222	-.569**	.209	.209	-.459*	-.421*	.035	.059

** Correlation is significant at the 0.01 level.
* Correlation is significant at the 0.05 level.

Appendix A
Informed Consent

Dear Participant:

You are invited to participate in a research study exploring the cross-racial counseling experiences of African American therapists. This study is being conducted by Terrina A. Price, Counseling Psychology Doctoral Candidate, Lehigh University under the supervision of Dr. Arnold R. Spokane, Professor, Counseling Psychology Program at Lehigh University. The purpose of this study is to learn about the role of Black racial identity attitudes and their relationship to therapists' reactions to clients when working in cross-racial counseling dyads. If you choose to participate in the study, you will complete three inventories that will explore your racial identity attitudes, your reactions to clients within cross-racial counseling dyads, and a demographic questionnaire. It is anticipated that the study may take approximately 40-50 minutes to complete. Every 40th participant will receive a $25.00 Visa Gift Card, and therefore, if you choose to participate in this study, you may be eligible to receive 1 of 4 $25.00 Visa Gift Cards.

Participation in this study is completely voluntary and you may choose to withdraw from the study at any time. All information that is obtained during this study will be kept confidential. Research records will be stored securely and only researchers will have access to records. In any report we might publish, we will not include any information that will make it possible to identify a participant. The current study does not intend to present any discomforts or inconveniences, and it poses minimal risk to participants. Risks may include psychological discomfort as a result of reflecting on personal experiences and attitudes. Your decision of whether or not to participate in this study will not affect any future relations or interactions with Lehigh University or its affiliates. If you have any questions or concerns at any time, please do not hesitate to contact the Principal Investigators, Terrina Price at tap308@lehigh.edu or Dr. Arnold Spokane at ars1@lehigh.edu and either will be happy to respond to your concerns.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researchers, **you are encouraged** to contact Susan E. Disidore at (610)758-3020 (email: sus5@lehigh.edu) or Troy Boni at (610)758-2985 (email: tdb308@lehigh.edu) of Lehigh

University's Office of Research and Sponsored Programs. All reports or correspondence will be kept confidential.

Your choice to complete the online survey indicates that you have read the information provided above and that you have decided to participate in this study. Again, you may withdraw from the study at any time without any penalty or loss of benefits.

Appendix B
Recruitment Email

Dear Training Director (or Division Member),

My name is Terrina Price and I am a doctoral candidate in the Counseling Psychology Program at Lehigh University. Currently, I am recruiting participants for my dissertation study and would like to request your assistance in forwarding the request for participation and link to the study (attached) to graduate students (and/or eligible prospective participants) in your program (or division). The purpose of this study is to examine the relationship between racial identity attitudes and therapists' responses to clients when working in cross-racial counseling dyads. As an important multicultural training issue, we would like to gain insight into the cross-racial counseling experiences of Black clinicians. Students may be enrolled in or graduated from doctoral or master's level programs. Inclusion criteria for the current study are: (a) self-identify as African American or Black, (b) currently enrolled in or graduated from a counseling-related graduate program (e.g. counseling, clinical, marriage and family therapy programs, etc.), and (c) has conducted therapy with at least one White client for a minimum of two sessions.

Lehigh University's Institutional Review Board (IRB) has approved this study (Protocol Number: 369396-1). If you have any questions you may contact either Terrina Price or Dr. Arnold Spokane.

Thank you for your time and assistance.

Sincerely,

Terrina A. Price
Doctoral Candidate
Lehigh University
tap308@lehigh.edu

Arnold R. Spokane, Ph.D.
Professor
Counseling Psychology
Lehigh University
ars1@lehigh.edu

Appendix B
Recruitment Email

Dear Prospective Participant,

You are invited to participate in a research study exploring the cross-racial counseling experiences of African American therapists. This study is being conducted by Terrina A. Price, Counseling Psychology Doctoral Candidate, Lehigh University under the supervision of Dr. Arnold R. Spokane, Professor, Counseling Psychology Program at Lehigh University. The purpose of this study is to learn about the role of Black racial identity attitudes and their relationship to therapists' reactions to clients when working in cross-racial counseling dyads. It is anticipated that the study may take approximately 40-50 minutes to complete. If you choose to participate in this study, you may be eligible to receive 1 of 4 $25.00 Visa Gift Cards.

Inclusion criteria for the current study are: (a) self-identify as African American or Black, (b) currently enrolled in or graduated from a counseling-related graduate program (e.g. counseling, clinical, marriage and family therapy programs, etc.), and (c) has conducted therapy with at least one White client for a minimum of two sessions. If you are interested in completing this study, please click on the link below. Lehigh University's Institutional Review Board (IRB) has approved this study (Protocol Number: 369396-1). If you have any questions you may contact either Terrina Price or Dr. Arnold Spokane.

Thank you for your time and consideration.

Sincerely,

Terrina A. Price
Doctoral Candidate
Lehigh University
tap308@lehigh.edu

Arnold R. Spokane, Ph.D.
Professor
Counseling Psychology
Lehigh University
ars1@lehigh.edu

Appendix C
Survey

Demographic Questionnaire

Age: ____

Gender: _____

Your race (check one):

_____ African-American/Black (not Hispanic)
_____ American Indian or Alaskan Native
_____ Asian American or Pacific Islander
_____ European American/White (not Hispanic)
_____ Hispanic/Latino
_____ Multi-racial
_____ Other (please specify)

Your Ethnicity (please specify): _____

Current Region (check one):

_____ Northeast United States
_____ Southeast United States
_____ Mid-West United States
_____ Western United States
_____ Southwest United States
_____ International (please specify): _____

Academic program:

_____ Ph.D.
_____ Psy.D.
_____ Master's
_____ Other (Please Specify): _____

Specialty Area (e.g. Counseling Psychology, Clinical Psychology, Marriage and Family Therapy, etc.): _____

If currently completing training, year in the program: _____

Average Length of training program: _____

What is your current level of clinical experience? (Please choose one)

____ Beginning Practicum (1st year)
____ Advanced Practicum (2nd year +)

____ Internship
____ Graduate/Practicing in Field

Total number of months (or years) you have conducted counseling/therapy with individual clients: _____

Theoretical orientation for counseling/therapy:

_____ Psychodynamic
_____ Behavioral/Cognitive
_____ Humanistic/Experiential
_____ Systems
_____ Feminist Therapy
_____Integrative
_____ Other (please specify) _____

Setting where you conduct therapy:

_____ College Counseling Center
_____ Community Mental Health Agency
_____ Hospital (specify)
_____ Other (Specify):

Hours of individual supervision per week: _____

Number of Multicultural Courses Taken: _____

Number of Multicultural Seminars/Workshops/Trainings Attended: _____

Total Number of Racial Minority Clients: _____

Total Number of White Clients: _____

Qualitative Questionnaire

1. When working in a cross-racial counseling dyad, how do racial differences impact your therapeutic work?
    a. Within your response, please address any transference or countertransference issues that may influence your work.
2. Please describe a rewarding multicultural experience when working with a White client. What made this experience rewarding?
    a. Please speak to how multicultural issues were addressed.
3. Have you had a challenging experience in session when working with a White client (as a result of racial identity differences)?
    a. If so, please describe the experience and the ways you worked through the experience.
4. Please list some of the benefits and challenges you face when working with White clients.
5. Based on your experiences (as a Black therapist) are there gaps in multicultural training related to building multicultural counseling competency when working in cross-racial counseling dyads?
    a. If so, briefly note some of these gaps.
    b. If not, briefly explain the training you have received that has been directly relevant (and beneficial) to counseling White clients (i.e. working with White clients from a multicultural perspective).

Janet E. Helms

BRIAS Social Attitudes Scale

Instructions: This questionnaire is designed to measure people's attitudes about social and political issues. There are no right or wrong answers. Different people have different viewpoints. So try to be as honest as you can. Beside each statement, circle the number that best describes how you feel. Use the scale below to respond to each statement.

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

1	2	3	4	5	1. I believe that being Black is a positive experience.
1	2	3	4	5	2. I know through personal experience what being Black in America means.
1	2	3	4	5	3. I am increasing my involvement in Black activities because I don't feel comfort table in White environments.
1	2	3	4	5	4. I believe that large numbers of Blacks are untrustworthy.
1	2	3	4	5	5. I feel an overwhelming attachment to Black people.
1	2	3	4	5	6. I involve myself in causes that will help all oppressed people.
1	2	3	4	5	7. A person's race does not influence how comfortable I feel when I am with her or him.
1	2	3	4	5	8. I believe that Whites look and express themselves better than Blacks.
1	2	3	4	5	9. I feel uncomfortable when I am around Black people.
1	2	3	4	5	10. I feel good about being Black, but do not limit myself to Black activities.
1	2	3	4	5	11. When I am with people I trust, I often find myself using slang words to refer to White people.
1	2	3	4	5	12. I believe that being Black is a negative experience.
1	2	3	4	5	13. I am confused about whether White people have anything important to teach me.
1	2	3	4	5	14. I frequently confront the system and the (White) man.
1	2	3	4	5	15. I constantly involve myself in Black political and social activities (art shows, political meetings, Black theater, etc.)
1	2	3	4	5	16. I involve myself in social action and political groups even if there are no other Blacks involved.
1	2	3	4	5	17. I believe that Black people should learn to think and experience life in ways which are similar to White people.
1	2	3	4	5	18. I believe that the world should be interpreted from a Black or Africentric perspective.
1	2	3	4	5	19. I'm not sure how I feel about myself racially.
1	2	3	4	5	20. I feel excitement and joy in Black surroundings.
1	2	3	4	5	21. I believe that Black people came from a strange, dark, and uncivilized continent.
1	2	3	4	5	22. People, regardless of their race, have strengths and limitations.
1	2	3	4	5	23. I find myself reading a lot of Black literature and thinking about being Black.
1	2	3	4	5	24. I feel guilty or anxious about some of the things I believe about Black people
1	2	3	4	5	25. I believe that a Black person's most effective weapon for solving problems is to become part of the White person's world.
1	2	3	4	5	26. My identity revolves around being a Black person in this country.
1	2	3	4	5	27. I limit myself to Black activities as much as I can.
1	2	3	4	5	28. I am determined to find my Black identity.
1	2	3	4	5	29. I like to make friends with Black people.
1	2	3	4	5	30. I believe that I have many strengths because I am Black.
1	2	3	4	5	31. I feel that Black people do not have as much to be proud of as White people do.
1	2	3	4	5	32. I am at ease being around Black people.
1	2	3	4	5	33. I believe that Whites should feel guilty about the way they have treated Blacks in the past.
1	2	3	4	5	34. White people can't be trusted.
1	2	3	4	5	35. In today's society if Black people don't achieve, they have only themselves to blame.

THERAPIST RESPONSE QUESTIONNAIRE
(Betan et al., 2005)

The statements below describe a number of ways clinicians feel about or react to their patients. Please think about your work with a recent White patient. Please rate the following items on the extent to which they are true of you in your work with your patient, where 1=not true at all, 3=somewhat true, and 5=very true. We know it is hard to generalize across a treatment of many weeks or months, but try to describe the way you have felt with your patient over the course of the entire treatment. Do not worry if your responses appear inconsistent, since clinicians often have multiple responses to the same patient.

1. I am very hopeful about the gains s/he is making or will likely make in treatment.	1 2 3 4 5
2. At times I dislike him/her.	1 2 3 4 5
3. I find it exciting working with him/her.	1 2 3 4 5
4. I feel compassion for him/her.	1 2 3 4 5
5. I wish I had never taken him/her on as a patient.	1 2 3 4 5
6. I feel dismissed or devalued.	1 2 3 4 5
7. If s/he were not my patient, I could imagine being friends with him/her.	1 2 3 4 5
8. I feel annoyed in sessions with him/her.	1 2 3 4 5
9. I don't feel fully engaged in sessions with him/her.	1 2 3 4 5
10. I feel confused in sessions with him/her.	1 2 3 4 5
11. I don't trust what s/he's telling me.	1 2 3 4 5
12. I feel criticized by him/her.	1 2 3 4 5
13. I dread sessions with him/her.	1 2 3 4 5
14. I feel angry at people in his/her life.	1 2 3 4 5
15. I feel angry at him/her.	1 2 3 4 5
16. I feel bored in sessions with him/her.	1 2 3 4 5
17. I feel sexually attracted to him/her.	1 2 3 4 5
18. I feel depressed in sessions with him/her.	1 2 3 4 5
19. I look forward to sessions with him/her.	1 2 3 4 5
20. I feel envious of, or competitive with him/her.	1 2 3 4 5
21. I wish I could give him/her what others never could.	1 2 3 4 5
22. I feel frustrated in sessions with him/her.	1 2 3 4 5

23. S/he makes me feel good about myself. 1 2 3 4 5

24. I feel guilty about my feelings toward him/her. 1 2 3 4 5

25. My mind often wanders to things other than what s/he is talking about. 1 2 3 4 5

26. I feel overwhelmed by his/her strong emotions. 1 2 3 4 5

27. I get enraged at him/her. 1 2 3 4 5

28. I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible. 1 2 3 4 5

29. S/he tends to stir up strong feelings in me. 1 2 3 4 5

30. I feel anxious working with him/her. 1 2 3 4 5

31. I feel I am failing to help him/her or I worry that I won't be able to help him/her. 1 2 3 4 5

32. His/her sexual feelings toward me make me anxious or uncomfortable. 1 2 3 4 5

33. I feel used or manipulated by him/her. 1 2 3 4 5

34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out. 1 2 3 4 5

35. S/he frightens me. 1 2 3 4 5

36. I feel incompetent or inadequate working with him/her. 1 2 3 4 5

37. I find myself being controlling with him/her. 1 2 3 4 5

38. I feel interchangeable—that I could be anyone to him/her. 1 2 3 4 5

39. I have to stop myself from saying or doing something aggressive or critical. 1 2 3 4 5

40. I feel like I understand him/her. 1 2 3 4 5

41. I tell him/her I'm angry at him/her. 1 2 3 4 5

42. I feel like I want to protect him/her. 1 2 3 4 5

43. I regret things I have said to him/her. 1 2 3 4 5

44. I feel like I'm being mean or cruel to him/her. 1 2 3 4 5

45. I have trouble relating to the feelings s/he expresses. 1 2 3 4 5

46. I feel mistreated or abused by him/her. 1 2 3 4 5

47. I feel nurturant toward him/her. 1 2 3 4 5

48. I lose my temper with him/her. 1 2 3 4 5

49. I feel sad in sessions with him/her. 1 2 3 4 5

50. I tell him/her I love him/her. 1 2 3 4 5

51. I feel overwhelmed by his/her needs. 1 2 3 4 5

52. I feel hopeless working with him/her. 1 2 3 4 5

53. I feel pleased or satisfied after sessions with him/her. 1 2 3 4 5

54. I think s/he might do better with another therapist or in a different kind of therapy. 1 2 3 4 5

55. I feel pushed to set very firm limits with him/her. 1 2 3 4 5

56. I find myself being flirtatious with him/her. 1 2 3 4 5

57. I feel resentful working with him/her. 1 2 3 4 5

58. I think or fantasize about ending the treatment. 1 2 3 4 5

59. I feel like my hands have been tied or that I have been put in an impossible bind. 1 2 3 4 5

60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her. 1 2 3 4 5

61. I feel sexual tension in the room. 1 2 3 4 5

62. I feel repulsed by him/her. 1 2 3 4 5

63. I feel unappreciated by him/her. 1 2 3 4 5

64. I have warm, almost parental feelings toward him/her. 1 2 3 4 5

65. I like him/her very much. 1 2 3 4 5

66. I worry about him/her after sessions more than other patients. 1 2 3 4 5

67. I end sessions overtime with him/her more than with my other patients. 1 2 3 4 5

68. I feel less successful helping him/her than other patients. 1 2 3 4 5

69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients. 1 2 3 4 5

70. I return his/her phone calls less promptly than I do with my other patients. 1 2 3 4 5

71. I disclose my feelings with him/her more than with other patients. 1 2 3 4 5

72. I call him/her between sessions more than my other patients. 1 2 3 4 5

73. I find myself discussing him/her more with colleagues or supervisors than my other patients. 1 2 3 4 5

74. S/he is one of my favorite patients. 1 2 3 4 5

75. I watch the clock with him/her more than with my other patients. 1 2 3 4 5

76. I self-disclose more about my personal life with him/her than with my other 1 2 3 4 5

patients.

77. More than with most patients, I feel like I've been pulled into things that I didn't realize until after the session was over.	1	2	3	4	5
78. I begin sessions late with him/her more than with my other patients.	1	2	3	4	5
79. I talk about him/her with my spouse or significant other more than my other patients.	1	2	3	4	5

*Permission was obtained from the authors to modify instructions to reflect a change from "Please think about your work with a recent patient" to "Please think about your work with a recent White patient."

CURRICULUM VITAE

Terrina A. Price
3210 Chestnut Street
Philadelphia, PA 19104
tap69@drexel.edu

EDUCATION

Lehigh University, Bethlehem, PA — May 2015
Doctor of Philosophy, Ph.D.
Program of Study: Counseling Psychology (APA-Accredited)

Lehigh University, Bethlehem, PA — May 2013
Masters of Education, M.Ed.
Program of Study: Counseling and Human Services

Howard University, Washington, DC — May 2008
B.S., Summa Cum Laude
Major: Psychology, Minor: English

CLINICAL EXPERIENCE

Drexel University Counseling Center
Staff Therapist
Present-November 2014

- Provide individual therapy to undergraduate and graduate students under the supervision of licensed psychologist. Presenting issues include: mood disorders, personality disorders, relationship issues, trauma, academic concerns, identity issues, and adjustment/transitional issues.
- Provide consultation to faculty, staff, students, and parents
- Rotate as an on-call therapist
- Triage students through "walk-in" hours
- Facilitator of Sexual Assault Survivor Support Group
- Case management tasks

Immaculata University Pre-Doctoral Internship Consortium (APPIC-Member Institution)
Site Placement: Drexel University Counseling Center
Pre-Doctoral Intern
July 2013-June 2014

- Provided individual therapy to undergraduate and graduate students under the supervision of licensed psychologist. Presenting issues included: mood disorders,

personality disorders, trauma, academic concerns, pervasive developmental disorders, identity issues, and interpersonal relationships.
- Participated in on-call rotation and triaged students through "walk-in" hours.
- Served as supervisor for doctoral practicum student.
- Co-facilitator of Mindfulness Meditation Group and Women's Process Group.
- Participated in campus outreach programming.
- Case management included: conducting intakes, providing consultation, completing progress notes, and developing treatment plans.

Good Shepherd Rehabilitation Hospital
Allentown, PA
Psychometrician
April 2011-February 2013

- Within outpatient, neuropsychology department, completed neuropsychological assessments of patients (ages 16-79) with presenting problems such as: traumatic brain injury, dementia, cognitive dysfunction, memory impairment, ADHD, and mental health concerns.
- Administered and scored a battery of standardized mental health, IQ, memory, and achievement tests resulting in more than 200 hours of assessment experience.
    - Psychological inventories included: MMSE, WAIS-IV, WMS-III, MCMI-III, DKEFS, TOMM, WIAT-III, WRAT-4, Boston Naming Test, and Dementia Rating Scale-2.
- Completed formal practicum (August-December 2012) in which additional duties included test interpretation and integrated report writing. In addition, received training and individual supervision by licensed neuropsychologists.

University Counseling and Psychological Services
Lehigh University, Bethlehem, PA
Practicum Trainee
August 2011-May 2012

- Provided individual counseling services to undergraduate and graduate students under the supervision of a senior staff psychologist and pre-doctoral intern. Client concerns included: mood disorders, personality disorders, trauma, academic concerns, pervasive developmental disorders, identity issues, and interpersonal relationships.
- Administered, scored, and interpreted personality inventories such as MCMI-III and NEO-PI-R.
- Co-facilitator of Women's Trauma Group and Alcohol and Other Drug Groups.
- Participated in campus outreach programming (with international students and first-generation college students).
- Caseload management included: conducting intakes, consultation, completing progress notes, and developing treatment plans.

University Counseling and Psychological Services
University of Pennsylvania, Philadelphia, PA
Practicum Trainee
September 2010-May 2011

- Provided individual counseling services to undergraduate and graduate students under the supervision of a licensed staff psychologist and pre-doctoral intern. Client concerns included: mood disorders, trauma, academic concerns, ADHD, adjustment, family relationships, and romantic relationships.
- Administered, scored, and interpreted psychological inventories such as: Conners Adult ADHD Rating Scales (CAARS), Myers-Briggs Type Indicator (MBTI), and Strong Interest Inventory.
- Caseload management included: conducting intakes, completing progress notes, developing treatment plans, and consultation.

Counseling and Human Services Masters Program
Lehigh University, Bethlehem, PA
Doctoral Supervisor/Supervision Apprenticeship
September 2010-July 2012

- Conducted individual weekly supervision (under supervision of licensed psychologist) with three international trainees and three local trainees completing internship in community and school settings as a pre-requisite for Counseling and Human Services Master's Degree.
- Reviewed counseling tapes and provided feedback via full-length tape transcripts.
- Completed counselor evaluations for each supervisee at mid-semester and at the end of the semester.
- Caseload management included: weekly progress notes, establishing learning goals, engaging in relevant tasks to meet goals, and consultation.

University Counseling Services
Kutztown University, Kutztown, PA
Practicum Trainee
August 2009-May 2010

- Provided individual counseling services to undergraduate students under the supervision of a licensed psychologist. Client concerns included: anxiety, depression, academic concerns, managing physical and learning disabilities, ADHD, roommate issues, interpersonal relationships, sexual abuse, and domestic violence.
- Administered, hand-scored, and interpreted psychological inventories.
- Participated in campus-wide outreach programming (primary prevention activities).
- Caseload management included: completing progress notes, consultation, and developing treatment plans.

Washington DC Rape Crisis Center
Washington, DC
Volunteer Advocate
September 2006- April 2008

- Provided support to survivors of sexual assault by taking shifts on a 24-hour crisis hotline.
- Distributed information about services and attended monthly seminars and training sessions.
- Completed courses concerning sexual harassment, rape, and discrimination.
- Attended workshops concerning basic counseling techniques.

University Counseling Services
Howard University, Washington, DC
Outreach Volunteer
August 2006- April 2007

- Participated in development and organization of outreach events.
- Distributed information concerning mental health to college students during health fairs.
- Assisted counselors with office duties as needed.

TEACHING EXPERIENCE

Course Title: Measurement and Assessment in Psychology
Delaware Valley University
Adjunct Instructor
Spring 2015

- Provide foundational knowledge of the various forms of psychological assessment, the psychometric principles undergirding the construction of psychological tests, and the utility of psychological assessment across diverse settings
- Introduce students to the theories and measurement of intelligence, achievement, aptitude, and personality
- Discuss ethical, legal, and cultural implications of psychological testing

Course Title: Counseling Psychology
Drexel University, Department of Psychology
Guest Lecturer
Spring 2014

- Provided lecture on multicultural counseling, assessment, and intervention to undergraduate students.

Course Title: Research Methods (I & II)
Private Tutor
Fall 2012/Spring 2013

- Provided individual tutoring and consultation to graduate student needing additional support in understanding qualitative and quantitative research designs.
- Provided consultation to student regarding research writing.
- Provided lessons on APA style and format.

Course Title: Standardized Tests, Measurements, and Appraisal
Lehigh University, College of Education
Teaching Assistant
Spring 2011

- Co-taught and presented lectures on psychological assessment.
- Co-taught and presented lectures on multicultural sensitivity in assessment.
- Provided technical support through management of course website.
- Assisted in syllabus construction, test development, selection of class readings, and evaluation/grading.

Strong Moms, Strong Girls
Bethlehem, PA
Workshop Co-Facilitator
February 2010-June 2012

- Co-facilitated workshops that educated parents and their daughters about relational aggression and school violence prevention.

Additional Lectures:
2010-2013

- Multicultural Counseling and Supervision
- Assessment, Diagnosis, and Treatment of Mood Disorders
- Prodromal Psychosis in College Students
- Working with Narcissistic Personality Disorder
- Sexual Assault Prevention on College Campuses
- Social Psychological Perspective of Stereotypes, Prejudice, and Discrimination

PROFESSIONAL ACADEMIC EXPERIENCE

Educational Leadership Program, College of Education
Lehigh University, Bethlehem, PA
Graduate Assistant
August 2010-May 2013

- Assisted Program Director in administrative duties related to the function of graduate program.
- Coordinated and organized faculty meetings.
- Provided administrative support to faculty search committees.
- Served as research assistant to faculty members when requested.

Law School Admissions Council
Lehigh University, Bethlehem, PA
Test Proctor
May 2010-May 2012

- Assisted in administration of Law School Admissions Test (LSAT).

Joint Multicultural Program
Lehigh University, Bethlehem, PA
Graduate Assistant
August 2008-May 2010

- Fostered relationships between students and faculty with particular attention given to diversity initiatives undertaken by the university.

RESEARCH PAPERS

Price, T.A. (2015). The Black therapist-White client counseling dyad: The relationship between Black racial identity and countertransference. Dissertation.

Bertsch, K.N., Bremer-Landau, J.D., Inman, A.G., DeBoer Kreider, E.R.; Price, T.A., DeCarlo, A.L. (2014). Evaluation of the critical events supervision model using gender-related critical events. Training and Education in Professional Psychology, 8(3), 174-181.

Price, T.A. (2010). Exploring opportunities and challenges for African American faculty at predominantly White institutions: A qualitative study. Doctoral Qualifier.

Price, T.A. (2008). Perceived racial discrimination and academic achievement among minority youth. Senior Thesis.

Price, T.A. (2007). Racial identity, social support, and psychological well-being among African American women. Ronald E. McNair Postbaccalaureate Program Journal of Research.

Price, T.A. (2007). Social identity threat: Implications for self-presentation strategies. NIMH-COR Colloquium Program and Abstracts, G-1.

Rohlehr, L.N., Robinson, D.M., Price, T.A., Clincy, A., & Brown, A.C. (2006). Are we there yet? The effects of gender, race, and attire on receiving helping behavior. NIMH-COR Colloquium Program and Abstracts, 25, A-3.

ACADEMIC PRESENTATIONS

Bertsch, K., Kreider, E., Price, T.A., DeCarlo, A., Bremer Landau, J., & Inman, A.G. (2012). Evaluation of the Critical Events in Supervision Model Using Gender Related Events. Teacher's College Winter Roundtable. (2012, February).

Richardson, T.Q., Price, T.A., & Beverly, C. (2011). African American Faculty and Administrator Success in Academia: Navigating Higher Education Institutions. American Psychological Association Annual Convention, Washington, DC. (2011, August).

Krieder, E.R., Bremer, J., & Price, T.A. (2011). Discussing Dreams about Clients in Clinical Supervision: Trainees' Perspectives. American Psychological Association Annual Convention, Washington, DC. (2011, August).

Richardson, T.Q., Price, T.A., & Beverly, C. (2010). African American Faculty and Administrator Success in Academia: Navigating Higher Education Institutions. Diversity Challenge Conference, Boston, MA. (2010, October).

Price, T.A. (2007, November). Social Identity Threat: Implications for Self-Presentation Strategies. 26th Annual NIMH-Career Opportunities in Research Training and Education (COR) Colloquium, Albuquerque, NM. (2007, November).

Price, T.A., Harmon, J., Mixon, L., Brown, A., Wilburn, G., and Van Camp, D. (2007, November). Stereotype Threat's Debilitating Impacts in Minority Intellectual Testing Settings Appear to Require Both White Presence and Expected Out-Group Evaluation. 26th Annual NIMH-Career Opportunities in Research Education and Training (COR) Colloquium, Albuquerque, NM.

Price, T.A. (2007, September). Racial Identity, Social Support, and Psychological Well-Being of African American Women. 12th Annual Rocky Mountain Ronald E. McNair Research Symposium, Colorado State University, Ft. Collins, CO.

Price, T.A. (2007, July). Social Identity Threat: Implications for Self-Presentation Strategies. Taking the Next Step: The Transfer of Knowledge, The Leadership Alliance Symposium 2007, Stamford, CT.

Price, T.A., Harmon, J.E., Mixon, L., Brown, A.C., Wilburn, G., Camp, D., Sloan, L., & Barden, J. (2007, May). Stereotype Arousal in Minority Diagnostic Testing Settings May Require White Presence and Expected Evaluation. Leslie H. Hicks Research Symposium, Department of Psychology, Howard University, Washington, DC.

Price, T.A., Chipungu, K., Meares, K., Mixon, L., Brown, A.C., Sloan, L., Wilburn, G., Van Camp, D., & Barden, J. (2007, April). Potentially Stereotyping Out-Group (White)

Participation and Evaluation May Be Needed For Stereotype Threat's Damage to Academic Performance in Minority Settings. Graduate Research Symposium and Honors Day, Howard University, Washington, DC.

AWARDS

Student Travel Grant, Graduate Student Senate, Lehigh University	2011
Student Travel Grant, Graduate Student Senate, Lehigh University	2010
Student Travel Grant, College of Education, Lehigh University	2010

PROFESSIONAL AFFILIATIONS

Pennsylvania Psychological Association, Student Affiliate
American Psychological Association, Student Affiliate
National Honor Society in Psychology (Psi Chi) Member