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Elizabeth J. Hare
Talking About Race: How Do White
Clinicians Engage in Dialogue About Race
in Cross-racial Therapy with Black Clients?

ABSTRACT

This qualitative study explores how White clinicians engage in dialogue about race in cross-racial therapy with Black clients. Open-ended survey questions were used to gather narrative data from 12 White clinicians who have conducted therapy with Black clients. The central question of this research study is: when, how and why do White clinicians engage in dialogue about race in cross-racial therapy with Black clients? The study investigates how White clinicians think about their choices to broach the subject of race and their perceptions of the therapeutic alliance as it relates to conversations about race and racial difference. It also explores White clinicians' motivations regarding not broaching the subject of race, why they choose not to broach and how they perceive this choice as impacting the therapeutic alliance.

The study found that the White clinicians surveyed made a variety of choices regarding talking about race in therapy with their Black clients. While all clinicians surveyed felt it is important to talk about race in therapy, the findings revealed important differences in the choices they made as to how, when and why to talk about race in therapy with Black clients. These clinical decisions reflect a range of practices and beliefs including whether to take responsibility for broaching the subject of race, when in the process of therapy to broach the subject of race, and whether to talk about one's own race in the therapy. This range of responses reflects a significant disparity in clinical practice and raises concerns about quality of clinical treatment for Black clients working with White clinicians. The implications of these findings for clinical practice and training are discussed.

**TALKING ABOUT RACE:
HOW DO WHITE CLINICIANS ENGAGE IN DIALOGUE ABOUT RACE
IN CROSS-RACIAL THERAPY WITH BLACK CLIENTS?**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015

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CHAPTER I

Introduction

The purpose of this study is to explore how White clinicians engage in dialogue about race in cross-racial therapy with Black clients. Specifically, it explores how White clinicians think about their choices to broach the subject of race and their perceptions of the therapeutic alliance as it relates to conversations about race and racial difference. It also explores White clinicians' motivations regarding not broaching the subject of race, why they choose not to broach and how they perceive this choice as impacting the therapeutic alliance. The central question of this research study is: When, how and why do White clinicians engage in dialogue about race in cross-racial therapy with Black clients?

Due to the over representation of people-of-color in the mental health system (DiAngelo, 2012) and due to the growing diversity of the population in the United States (United States Census Bureau, 2010), research on cross-racial therapy is becoming increasingly important. Within the current racial construct in the United States, and in macro-level terms, Black and White is the foundational racial binary (DiAngelo, 2012). Thus, given the complexity of race and racism as a social, political, institutional and personal phenomena, and the reality that most clinicians are White (Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake & Douglass, 2007), how a White clinician addresses race in the clinical encounter with a Black client likely impacts the effectiveness of treatment. Studies indicate that cross-racial therapeutic interactions can be anxiety provoking for both majority and minoritized participants, and empirical research links cross-racial encounters to potentially

negative psychological and physiological outcomes (Clark, Anderson, Clark & Williams, 1999; Dovidio, Gaertner, Kawakami & Hodson, 2002). Yet, many aspects of cross-racial work can have a positive impact on the value and outcome of therapy for clients-of-color. For instance, some researchers (Cardemil et al., 2003, Daniel, 2000; Day-Vines et al., 2007; Knox et al., 2003; Miller et al., 2008) contend that discussing race and racial difference with clients supports the therapeutic alliance and resulting treatment outcomes. However, there is a dearth of research looking at how to best address race and racial difference in cross-racial therapy. It is hoped that the data gathered through this research will contribute to the discussion on cross-racial therapy.

This study gathered qualitative data on when, how, and why White clinicians discuss race when working with Black clients. Participants for this study were White mental health clinicians who are licensed in their field and may be from Social Work, Psychology or Mental Health Counseling disciplines. All data was collected electronically through a Survey Monkey survey. The sample was made up of twelve participants using snowball sampling. The participant criteria was that they identify as White, must have worked with clients who identify as Black or multiracial with Black as one racial identity, and were willing to reflect and comment on their experience conducting cross-racial psychotherapy.

The following chapter looks at the various terms used in cross-racial therapy such as culture, ethnicity, race, racism, and therapeutic alliance in order to clarify their meanings. Previous research in the area of cross-racial work is reviewed, including studies on the therapeutic alliance, ethnic matching, racial identity development, and discussing racial difference in cross-racial therapy.

CHAPTER II

Literature Review

Despite the inroads made by the civil rights movement, racism remains a foundational part of the United States and has critical implications within the field of mental health, and specifically within the context of cross-racial therapeutic work. Studies indicate that cross-racial therapeutic interactions can be anxiety provoking for both majority and minoritized participants, and empirical research links cross-racial encounters to potentially negative psychological and physiological outcomes (Clark, Anderson, Clark & Williams, 1999; Dovidio, Gaertner, Kawakami & Hodson, 2002). The current study aims to gather information about White clinicians' process of engaging in dialogue about race and racial difference in cross-racial therapy with Black clients. The literature suggests that there are many aspects of cross-racial work that have an impact on the value and outcome of therapy for clients-of-color. These aspects include issues related to the social context, the interplay of racial identities of the clinician and the client, as well as the salience of race for the client and the clinician. As a white clinician, I am interested in how to best address cross-racial dynamics with clients-of-color. Because Black people are the definitive racial "other" in the White mind (DiAngelo, 2012), this study focuses specifically on Black and White relationships in the therapeutic context and aims to gather information about how, when, and why White clinicians engage in dialogue about race and racial difference in cross-racial therapy with Black clients.

This literature review first outlines the historical context of cross-racial psychotherapeutic work and the cultural competence movement in counseling. It then reviews literature on therapeutic alliance in relation to therapy outcomes and client retention. Literature on therapist self-disclosure and how various forms of self-disclosure affect therapeutic alliance and therapy outcomes is explored. Issues in cross-racial therapy are then examined followed by a review of literature that specifically addresses broaching the subject of race and racial difference in cross-racial therapy.

Definition of Terms

Ethnicity, Culture, Race and Racism

The terms race, ethnicity and culture are often used interchangeably (Miller & Garran, 2008), however, defining these terms for the purpose of this study will allow a more precise analysis of the literature and a clearer understanding of issues that impact cross-racial therapy. Phinney (1996) defines ethnicity as “broad groupings of Americans on the basis of both race and culture of origin” (p. 919). The National Association of Social Workers, NASW (2001) defines culture as the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group.

The meaning of the term race is related to, but distinct from, culture and ethnicity. For the purposes of this paper, the term race will be used in reference to the process of personal racial identity development as well as the social meaning given to racial categories. The term culture will include a wider range of social identities (e.g., race, ethnicity, socioeconomic status, sexual preference, religion, language, etc.) and domains of an individual’s experience. Historically, race has been thought of as a way to group people based on biological factors

such as skin color and facial features (Phinney, 1996). However, the American Anthropological Association as cited by Miller & Garran (2008) defines race not as a biological or genetic construct, but as an “ideology used to justify the domination of one identifiable group of people by another” (p. 15). Therefore, racism, as DiAngelo (2012) points out, can be understood as “economic, political, social, and institutional actions and beliefs, which systematize and perpetuate an unequal distribution of privileges, resources and power between whites and people of color” (p. 87).

Therapeutic Alliance

Therapeutic alliance is considered to be a core element of all therapeutic relationships (Burkard, Juarez-Huffaker, and Ajmere, 2003; Horvath, 2006). Constantine defines the therapeutic alliance as the “quality of the interactions between clients and therapists, the collaborative nature of these interactions with regard to the tasks and goals of treatment, and the personal bond or attachment that transpires” (p. 2). Horvath (2001) focuses on the collaborative relationship between therapist and client including the affective bond as well as the cognitive elements such as treatment tasks and goals.

Historical Context

Given the history in the United States of centuries of slavery and ongoing discrimination including the attempted extermination of Native American as well as oppression of Latino Americans and Asian Americans, it was inevitable that the helping professions developed within a context of racial injustice. Miller and Garran (2008) point out that “it is not surprising to find the nascent helping professions reflecting the racism of society and participating in its maintenance” (p. 52). They go on to suggest that despite tremendous progress in confronting racism since the founding of the country, the likelihood of racism to

endure is in part a function of the degree to which it is invisible to those who are most privileged by it. Therefore, it seems likely that racism would endure in counseling and psychology to the degree that White practitioners are blind to how race and racism operate within the therapeutic setting.

The growing awareness of multicultural issues within counseling and psychology has its roots in the Civil Rights Era. Passage of the Civil Rights Act in 1964 expanded access to education and employment for groups that were historically marginalized, including ethnic minority groups (Miller & Garran, 2008). Psychological associations addressing the needs of specific racial and ethnic groups began with the formation of the Association of Black Psychologists in 1968 (Association of Black Psychologists, 2007). Since then other groups that have formed include the National Hispanic Psychological Association, the Society of Indian Psychologists and the Asian American Psychological Association (Arredondo & Perez, 2006). The National Association of Social Workers, NASW (2014) suggests that social workers should “understand culture” and be able to “demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups”.

In 1982, Sue, Bernier, Durran, Feinberg, Pedersen, Smith, and Vasquez-Nuttal presented a model of multicultural counseling competencies (MCCs) when working with a culturally diverse clientele. This model outlined three specific areas affecting the therapeutic process: beliefs and attitudes, knowledge, and skills (Sue et al., 1982). Beliefs and attitudes refer to a clinician’s awareness of her or his assumptions, values and biases. The second area of competency is knowledge, or an understanding of the worldview of culturally different clients. Third, this model highlights the importance of a clinician’s skill set including the

application of culturally appropriate interventions and techniques. Many subsequent standards and research have been based on Sue et al.'s (1982) model of multicultural counseling competencies (Ridley & Kleiner, 2003).

A decade following Sue et al.'s (1982) model of multicultural counseling competencies, Sue, Arrendondo and McDavis (1992) expanded on the original model to create 31 multicultural counseling competencies, while keeping the core elements of the 1982 structure that focuses on beliefs and attitudes, knowledge, and skills. Throughout the remainder of the 1990's, discussion ensued about assessment guidelines and ways to implement multicultural counseling competencies into educational and training curricula (Ridley & Kleiner, 2003). Since this time, multicultural counseling competence has become an important goal of mainstream psychological and counseling standards and clinician education and practice.

Therapeutic Alliance

An examination of the research on therapeutic alliance is relevant to the current study because alliance is considered to be a core element of all therapeutic relationships. (Burkard et al., 2003; Horvath, 2006; Horvath, Re, Fluckiger, Symonds, 2011). Research suggests that alliance is an important factor contributing to therapy outcomes and that alliance is best developed by forging connection between therapist and client. Constantine (2007) defines the therapeutic alliance as the “quality of the interactions between clients and therapists, the collaborative nature of these interactions with regard to the tasks and goals of treatment, and the personal bond or attachment that transpires” (p. 2). Horvath (2001) focuses on the collaborative relationship between therapist and client including the affective bond as well as the cognitive elements such as treatment tasks and goals.

Horvath (2005) reviews the research on therapeutic alliance of the past 25 years, which has looked at two general areas of alliance. The first is the relationship between the therapeutic alliance and treatment outcomes. In looking at the data, Horvath (2005) reports consistency in the results, indicating a moderate correlation between therapeutic alliance and treatment outcome. These results highlight the importance of the relationship established between therapist and client.

The second area of investigation about the therapeutic alliance compares assessments of the client-therapist relationship from a variety of perspectives including client, therapist and third party observer. This research suggests that when compared with the opinions of the therapists or their third party observers, it is the client's perception of positive therapeutic alliance that most accurately determines successful treatment outcomes and retention (Horvath, 2005).

Bedi, Davis and Williams (2005) attempt to identify specific factors that affect the quality of the therapeutic alliance according to the perceptions of clients. Their results suggest that many therapist-initiated factors may be involved in alliance formation including eye contact, smiling, warm greeting, farewells, paraphrasing, identifying client feelings, encouraging the client and referring to material in previous sessions. Bedi et al. (2005) suggest that clients attribute the responsibility for fostering a positive relationship to the therapist and that therapeutic technique is perceived as important to the development of the alliance.

Ackerman and Hilsenroth (2003) review the research on the therapeutic alliance and identify therapist's personal characteristics considered to have an impact on therapeutic alliance. The review also looks at in-session treatment techniques as related to therapeutic

alliance. The review suggests that characteristics having a positive impact on the alliance include qualities that facilitate an environment of trust and respect and qualities that convey a sense of clinical competency. These qualities include being flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, open and warm. The techniques shown to positively influence the formation of a strong working alliance include facilitating exploration, being supportive, noting past therapeutic success, accurate interpretation, facilitating the expression of affect and attending to the client's experience. Ackerman et al. (2003) suggest that the personal characteristics and treatment techniques used to facilitate a positive therapeutic alliance cut across theoretical orientation and positively impact therapeutic treatment.

Reporting on their literature synthesis of the relation between alliance and the outcomes of individual psychotherapy, which included over 200 research reports, Horvath et al. (2011) conclude that the therapist does not "build alliance," but rather works in such a way that the process forges connection between therapist and client. Horvath, et al. suggest that therapist and client perceptions of the alliance, particularly early in treatment, do not necessarily match and that misjudging the client's felt experience of the alliance could decrease the efficacy of therapeutic interventions. Therefore, they suggest active monitoring of the client's sense of alliance throughout treatment.

Therapist Self-disclosure

Despite a growing body of recent evidence suggesting a relationship between certain forms of therapist self-disclosure and treatment satisfaction, therapist-self disclosure remains a contested practice (Barrett and Berman, 2001; Hanson, 2005; Knox, Hess, Peterson & Hill, 1997). Beliefs surrounding the relative harms and benefits of therapist self-disclosure vary

widely among theoretical orientations. This divide exists mainly between psychodynamic modalities which caution transference dilution and humanist approaches, which emphasize egalitarianism, empathy and “realness” in the therapeutic relationship (Barrett and Berman, 2001; Hanson, 2005; Knox et al., 1997). In recent years, multiple studies have attempted to settle this controversy by exploring client perceptions of therapist use of self-disclosure and subsequent implications for treatment.

Among the articles reviewed, therapist choice to disclose or withhold personal information was found to have significant effects on client experience of therapy, having the greatest impact on the therapeutic relationship itself (Hanson, 2005). Current research highlights the potential for both harm and hurt associated with the use of self-disclosure. In a literature review of research on the topic of therapist self-disclosure, Knox et al. (1997) note that although self-disclosure generally resulted in positive consequences, even disclosures perceived to be “helpful” could negatively influence the therapeutic alliance. In a qualitative study comparing client perceptions of self-disclosure and non-disclosure, Hanson (2005) prompted interviewees to discuss their experience of therapy broadly. Content analysis of participant's responses identified many incidents of both disclosure and non-disclosure, and revealed that both approaches were at times associated with positive and negative results. Effects of self-disclosure that damaged the therapist alliance include client feelings of decreased trust or safety, a need to manage the relationship, questions about boundaries, and uncomfortable intimacy (Hanson, 2005; Knox et al., 1997). However, participants in the articles reviewed reported greater positive experiences of therapist self-disclosure than negative.

The studies further suggest that self-disclosure shapes the therapeutic alliance in

specific ways having to do with the values of egalitarianism and authenticity. Participants in Hanson's (2005) study experienced disclosure as contributing to a “real” relationship. The article outlined distinct aspects of “real” relationships including a sense of being connected to and accepted by the therapist, feelings of trust and intimacy, and a belief that the therapist will take responsibility for mistakes (Hanson, 2005). Similarly, Knox et al. (1997) showed that clients experienced the therapeutic relationship as more equal when therapists appeared “real, human, or imperfect.” Clients indicated that this “realness” facilitated the therapy process by improving the connection between therapist and client. Barrett and Berman (2001) write that participants in their study report “liking” therapists more following modest increases in self-disclosure, an effect associated with reduction in symptom distress. The authors relate their findings to previous research demonstrating that clients are more likely to see the therapist as “friendly, open, helpful, and warm” when self-disclosure is used judiciously.

The articles reviewed demonstrate the salience of self-disclosure to the quality of the therapeutic relationship. They also highlight the potential for self-disclosure to equalize and humanize the relationship between client and practitioner, as well as the possibility for self-disclosure to cross boundaries and alienate clients. Given the centrality of self-disclosure and therapeutic alliance to successful therapy, investigation of these issues specifically in cross-racial dyads is warranted.

Cross-racial Therapeutic Dyads

The rapid population growth of racial and ethnic minoritized groups in the United States highlights the importance of discussion and research related to cross-racial dyads in the therapeutic setting (Chang & Berk, 2009). Race and racism have critical implications within the field of mental health, and specifically within the context of cross-racial therapeutic dyads.

Studies indicate that cross-racial therapeutic interactions can be anxiety provoking for both majority and minoritized participants. Research links those cross-racial encounters to potentially negative psychological and physiological outcomes for both majority and minoritized participants (Clark, Anderson, Clark & Williams, 1999; Dovidio, Gaertner, Kawakami & Hodson, 2002; Goff, Steele, & Davies, 2008; Pearson, Dovidio & Gaertner, 2009).

For example, Goff et al. (2008) showed that nonverbal avoidant behaviors by Whites, like blinking or lack of eye contact, may increase when they are fearful of appearing racist. DiAngelo (2012) addresses the way in which being White is an experience of being *just normal*, or outside of race altogether. She suggests that this position functions as a kind of blindness or an inability to think about whiteness as an identity that has or could have an impact on one's own life. Therefore, it is possible that White therapists who address race only if and when clients-of-color broach the subject of race may perpetuate a sense that race is something people-of-color have and that Whites are somehow immune to. "These negative perceptions and experiences can fuel tensions in social interactions and lesson Blacks' and Whites' interests in initiating and sustaining cross-group contact" (Pearson et al., 2009, p. 10).

The question of ethnic matching as a strategy to improve therapeutic outcomes has led to research that has produced varying results. Ethnic matching is an intentional strategy to match clients and clinicians based on ethnic and or racial similarities (Farsimadan, Draghi-Lorenz & Ellis, 2007). Proponents of ethnic matching believe that therapists of similar background with their clients can better understand their client, therefore improving alliance and outcome. Conversely, those who support cross-racial therapy focus on the commonalities of human experience and argue that culturally competent clinicians can work effectively with

racially and ethnically different clients. In addition, those who support cross-racial/ethnic therapy maintain that effective matching is improbable given the difficulty matching dyads on multiple cultural, ethnic and racial factors such as ethnicity, socioeconomic status, sexual orientation, race and religion.

The research on treatment of ethnically matched and unmatched dyads is inconclusive as to the extent to which ethnic matching impacts therapeutic alliance and treatment outcomes. Farsimadan et al.'s (2007) research looked at the process and outcome of therapy in ethnically similar and dissimilar therapeutic dyads and suggests that ethnic matching can have a significant impact on treatment outcomes because it can result in strong therapeutic alliance. However, Wintersteen, Mensinger, and Diamond (2005), looking at racial difference in the therapy dyad, found that race did not appear to be a deciding factor in developing the early therapeutic alliance after two sessions. The results suggest that matching can affect treatment retention. In particular, White therapists treating clients of color had notably lower retention rates than the other therapeutic dyads in the study.

Most research in the 90's indicated that "ethnic match" between client and therapist was preferable in that it was associated with increased attendance, a decrease in therapy drop-out rates, and improved therapeutic outcomes overall (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). More recent research, however, contradicts this. A recent meta-analysis of seven ethnic match studies from the last twenty years by Maramba and Hall (2002), indicates that while ethnic match is associated with attendance frequency and a decrease in drop-outs, ethnic match alone is not a strong predictor for client attendance and drop-out, and concludes that "therapists of all ethnicities may be able to deliver culturally competent psychotherapeutic services" (p. 295). Other recent studies highlight that ethnic matching alone does not enhance

therapeutic outcomes, and suggest that cultural values, worldview, and therapist cultural competence are important variables (Helms & Cook, 1999).

Therapist Self-disclosure in Cross-racial Therapeutic Dyads

Some theorists (Helms et al., 1999; Sue & Sue, 2003) suggest that clients-of-color may benefit from therapists who demonstrate sensitivity to and skills in working with cultural and racial issues in therapy. For example, in Thompson and Jenal's (1994) study, African American women appeared to become more frustrated with therapists who withdrew from discussions of racial issues. In this study, clients-of-color who had therapists who were more responsive to cultural issues than not responsive were more likely themselves to self-disclose in therapy, potentially increasing the effectiveness of the therapy (Thompson et al., 1994).

Burkard, Knox, Groen, Perez and Hess (2006) look at the effects of white therapists use of self-disclosure in cross-racial therapy. In this study of European American therapists working in cross-racial dyads with African American, Asian American, Middle Eastern and Pakistani clients, when therapists did self-disclose, they reported most often disclosing their feelings and reactions to clients' experiences of racism/oppression. Many of the participants noted a sense of unease in their clients, as indicated by nonverbal cues. Noting this sense of discomfort, the participants reasoned that it was important to validate clients' experiences by acknowledging the role of racism/oppression in clients' lives, or to acknowledge their own racist/oppressive beliefs. The authors suggest that in building positive relationships with clients-of-color, therapists, particularly White therapists, need to be open to discussing racial and cultural concerns, validate clients' experiences of discrimination, and demonstrate willingness to self-disclose their own experiences and reactions in such discussions. (Burkard et al., 2006). The study suggests that White therapists who are able to communicate their

sensitivity to racial concerns and be open with clients about their own perceptions and attitudes may help build an effective cross-racial therapy alliance, potentially improving the efficacy of therapy. The study also supports the idea that when race is addressed in cross-racial therapy, self-disclosure by White therapists can strengthen the therapeutic relationship.

Such therapeutic strategies are consistent with those hypothesized to be of importance in general (Hill & Knox, 2002) and in cross-cultural counseling (Helms et al., 1999; Sue et al., 2003). Given the demographic reality of today's helping profession—which is largely made up of White clinicians—and given the growing diversity of the general public in the United States (U.S. Department of Health and Human Services, 2001), it is unlikely that ethnic or racial matching can be a realistic strategy to support treatment outcomes for clients of color. As such, the current study attempts to further explore how discussion of issues related to race in cross-racial therapy impacts the therapeutic alliance and, ultimately, therapy outcomes.

Broaching the Subject of Race in Cross-racial Therapeutic Dyads

The literature suggests that successful therapy relies on a strong therapeutic alliance. It also suggests that talking about race in cross-racial therapeutic relationships can strengthen the therapeutic alliance, thereby improving therapeutic outcomes. In light of these findings, how might therapists best broach the subject of race in order to facilitate a strong therapeutic alliance?

Cardemil and Battle (2003) discuss supporting an open dialogue with clients about race and ethnicity and outline reasons therapists may choose not to discuss race with their clients. These reasons include fear of raising emotionally charged issues, concerns about saying something offensive, not knowing when and how to address race, and waiting for clients to initiate discussions about race. The authors suggest that not acknowledging racial

differences could send an implicit message to the client that the therapist is uncomfortable discussing race or does not view issues of race as important. Cardemil et al. (2003) make recommendations for clinicians when talking about race and ethnicity with clients. They suggest questioning clients about how they identify rather than making assumptions about an individual's racial or ethnic identity by appearance. They also suggest that therapists should consider how racial difference affects the therapeutic relationship and the therapeutic process. The authors recommend that therapists discuss race rather than being more passive or conservative and that therapists continue learning about race and ethnicity through introspection, experience and education.

Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake, and Douglass (2007) examine how counselors broach racial, ethnic, and cultural differences in the counseling process and relate broaching style to the clinician's process of racial identity development. The authors describe broaching behavior as, "a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (p. 402). Implicit in this description is the clinician's responsibility to be aware of how race influences the client as well as to provide the client with opportunities to explore the role of race in their experience.

Day-Vines et al. (2007) describe a continuum of five different broaching styles including avoidant, isolating, continuing/incongruent, integrated/congruent and infusing. These broaching styles are compared with levels of racial identity development. For example, an avoidant broaching style is characterized as one in which the therapist gives little attention to race due to a color-blind stance in which differences are minimized. The isolating broaching style addresses race superficially or out of obligation. Therapists with an isolating

broaching style may hesitate to discuss race out of fear that it will be offensive or a belief that race is a taboo subject. A continuing or incongruent broaching style looks at broaching as a skill. Day-Vines et al. (2007) suggest that clinicians who have a continuing or incongruent broaching style may have an understanding of how sociopolitical factors affect clients personally, but they are limited in their understanding of how to explore race and racism with openness within the therapy. Integrated/congruent counselors are described as having a well-established awareness of diverse racial, ethnic, and cultural norms and their impact on clients' presenting concerns. "Infusion", the most advanced broaching style Day-Vines et al. (2007) present, extends the broaching behavior beyond the clinician's professional identity to a greater personal commitment to social justice. Day-Vines et al. (2007) assert that those therapists who are more advanced in their own racial identity development are more likely to foster open and trusting therapeutic relationships with their clients. Therapist responsibility is highlighted throughout this article as critical in developing an understanding of one's own racial identity and to provide opportunities for the client's exploration of race and racism and their personal impact.

Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) studied the experiences of African American and European American therapists addressing race in cross-racial therapy dyads. Their results show that African American therapists typically felt comfortable discussing race with their European American clients while European American clinicians were more likely to feel uncomfortable talking about race with their African American clients. European American therapists who recalled instances of avoiding discussions about race with particular clients cited reasons such as patient suicidality, acuity of symptoms, a client's stated

preference not to discuss race and the clinician's fear that discussing race would have negative consequences.

Maxie, Arnold, and Stephenson (2006) investigate whether clinicians and clients discuss racial differences and examine reasons for discussing racial difference in therapy. In this study, therapists disclosed that they discussed difference with less than half of their racially or ethnically different clients (Maxie et al., 2006). When identifying reasons for bringing up racial difference, therapists pointed to "cultural components" of the client's "presentation" and "something the client said". Fewer respondents cited their clinical training as a reason for discussing difference. When looking at therapists' perceptions of their skill and comfort addressing racial difference, a majority of participants felt addressing racial difference was like addressing other sensitive issues in therapy. The majority of therapists identified feeling either very comfortable or somewhat comfortable discussing difference. Almost all described themselves as somewhat skilled or very skilled at addressing difference. Most felt that addressing racial difference facilitates the therapeutic process.

Summary

Due to the growing diversity of the population in the United States (United States Census Bureau, 2010), as well as the over-representation of people of color in the mental health system (DiAngelo, 2012) cross-racial therapy is likely to only increase in frequency in the future. As the literature suggests, there are many aspects of cross-racial work that have an impact on the value and outcome of therapy for clients-of-color. These include issues related to the social context, the interplay of racial identities of the clinician and the client, as well as the salience of race for the client and the clinician.

Some researchers (Cardemil et al., 2003; Day-Vines et al., 2007; Knox et al., 2003;

Miller et al., 2008) contend that discussing race and racial difference with clients supports the therapeutic alliance. Thus, it is important to further investigate how therapists might best broach the subject of race in order to facilitate a strong alliance. The current study examines how White clinicians engage in dialogue about race and racial difference in cross-racial therapy with Black clients. Specifically, it explores how White clinicians think about their choices to broach the subject of race and their perceptions of the therapeutic alliance as it relates to these conversations about race and racial difference. It also specifically explores White clinicians' process and motivations around not broaching the subject of race, why they choose not to broach and how they perceive this choice as impacting the therapeutic alliance.

CHAPTER III

Methodology

The current study asks how White clinicians engage in dialogue about race and racial difference in cross-racial therapy with Black clients. Specifically, it explores how White clinicians think about their choices to broach the subject of race and their perceptions of the therapeutic alliance as it relates to these conversations about race and racial difference. It also explores White clinicians' process and motivations when they choose not to broach the subject of race and how they perceive this choice as impacting the therapeutic alliance.

Research Design

The study uses qualitative methods and is exploratory in nature. It attempts to understand how White clinicians conceptualize racial dynamics in cross-racial therapy and how they make choices on whether or not to talk about race and racial difference with Black clients. I have employed qualitative research methods in order to pursue an exploratory inquiry that has the potential to delve deeply into the experiences of White clinicians as they consider issues of race and racial difference in their work with Black clients. Open-ended survey questions were designed to gather narrative data from participants. In this way, the hope was to engage in an in depth exploration of the complex and nuanced aspects of the topic (Steinberg, 2004, p. 116).

Sample

The purpose of this study was to gather and analyze narrative data from White clinicians who have worked with Black clients in psychotherapy. Therefore, the primary inclusion criteria for candidates to participate in this research study were White individuals who hold at least one clinical credential such as Social Work, Psychology, Psychiatry, Mental Health Counselor, Marriage and Family Therapist or any other credential that allows for work as a psychotherapist. Participants may have been working under supervision or independently. Participants must have conducted therapy with at least one self-identified Black client and be willing to respond to questions about their work with their Black client/s. Exclusion criteria included clinicians who had not yet graduated from a clinical program, clinicians who had not worked with at least one Black client, as well as those who did not identify as White or White European.

The primary means of recruitment for this survey was by word of mouth and through the snowball method. A recruitment email, which briefly described the purpose of the study and the inclusion criteria for participation, was sent to all potential participants. Potential participants then received the informed consent form outlining the study and their participation in greater detail. Through the informed consent process, participants learned about the potential benefits and risks of participation, the ethical standards and safeguards used to protect confidentiality and received the researcher's contact information in case questions or concerns arose.

Potential participants were identified through listings of clinicians in the local geographic area of the researcher. In addition, Robin DiAngelo, research advisor for the study, supplied contact information for several professional contacts as potential participants.

Additional participants were recruited through a snowball method in which interested individuals contacted other clinicians who might have interest in the study. Once identified, potential participants received the introductory email briefly explaining the study and inviting participation. If a reply was returned to the researcher, the informed consent was sent electronically to the potential participant. Once the signed document was received, an online link to the survey was sent to the participant. The snowball sampling technique employed in this study may have limited the diversity of experiences and backgrounds of the individuals in the sample. It is possible that a more random sampling technique could have resulted in a sample of participants from more diverse educational and socioeconomic backgrounds.

Ethics and Safeguards

Participation in the study was voluntary. Participants had the option to refuse to answer any question on the survey and to withdraw from the study at any point during the recruitment, informed consent, and survey process. Participants who had already completed the survey had a deadline by which to formally withdraw from the study. If anyone had decided to withdraw, all of the data gathered from that participant would have been removed from the study and destroyed. No participants chose to withdraw from the study.

Potential benefits of participating in the study included the opportunity for participants to reflect on and communicate thoughts and feelings related to their professional work across race. Potential risks to the participants included the risk that individuals may experience complex and difficult emotions while reflecting on their clinical work across race or may feel uncomfortable disclosing or sharing their experiences in regards to race. In addition, because of the non-probability snowball sampling method used to recruit participants, some participants may have disclosed to each other that they were participating in the study. In

order to mitigate any vulnerability this may have produced, it was made clear to all participants that all identifying information would be held in confidence. Several steps were taken to protect confidentiality and participants were informed of these steps through the informed consent process. For instance, participants were cautioned not to reveal identifying information that may be associated with themselves or a client. Identifying information was removed from the survey responses. In addition, participants were notified that all research materials including recordings, transcriptions, analyses and consent/assent documents would be stored in a secure location for three years according to federal regulations.

It is important to address my bias as the researcher, including my background, education, racial identity and my values as a social worker in training, and how these biases may have affected this research. I am a White, heterosexual, cis-gender, able bodied, middle class, non-religious Christian-raised woman who has a previous Masters in Education. I have been raised and educated in a white supremacist culture while more recently entering an anti-racist education as a social worker. I value talking about race and racial identity in my therapeutic work and I seek to develop my own understanding of the intersectionality of oppression- the connection between different identities and different kinds of oppression (Miller & Garran, 2007). In my work as a clinician and in this research, I try to illuminate my potential biases while recognizing the invisible nature of many of these biases.

Data Collection

Data collection began upon receipt of the Smith College School of Social Work Human Subjects Review approval letter (Appendix C) for this study. Using a non-probability snowball sampling method, I gathered qualitative data from participants. In addition, I

gathered data about the clinical degree of each participant and confirmed that they identified as White.

The qualitative data was gathered through an online survey consisting of primarily open-ended questions. Participants responded in writing to the following questions:

1. Please describe a time when you discussed race in therapy with a Black client by responding to the following questions:

- When during the therapy did the subject of race come up? (e.g. first session, second session, last session, etc.)
- How did the subject of race come up and who initiated this discussion?
- During this discussion about race, what do you think your client's concerns were?
- Was your race discussed and, if so, please describe how your race was brought into the conversation.
- Was your client's race discussed and, if so, please describe how your client's race was brought into the conversation.

2. Considering your experience talking about race with Black clients, please discuss how you think talking about race has affected the therapy relationship between yourself and your Black client/s?

3. When you initiate discussions of race with clients, what motivates you to do so?

4. Have there been times when you chose not to address race with your Black clients?

Why did you choose not to address race at these times? Please discuss any positive and negative consequences you observed as a result of not discussing race.

5. What was influential in the development of your thinking regarding talking about race in cross-racial therapy? Please consider your education, clinical supervision, upbringing,

friends, family relationships, learning from clients and other factors that may have influenced you.

6. Please discuss your reasons for not talking about race with Black clients.

A possible limitation of the survey as a data collection method was the inability to deepen or clarify questions during the data collection process. Not being with interviewees eliminated the possibility of addressing their questions or concerns about the questions as they arose. In addition, I was not able to assess the emotional response of the participants, gather this as additional data, and respond to any emotional needs that may have arisen in the moment as participants responded to the survey. However, it is possible that this was not a significant drawback as no respondents contacted me after participation to report or seek assistance with any concerns during or after completing the survey.

One of the possible benefits of data collection using the anonymous survey was that it allowed participants to be unguarded in their responses. In-person interviews may have proved more limiting to individuals who felt ill at ease with the subject matter or wanted to appear skilled at addressing race in the therapeutic interaction. In addition, I did not want the appearance of my racial identity to influence how participants interacted with the questions. My hope is that the anonymous nature of the study allowed for more thoughtful and unguarded responses than in-person interviews may have allowed.

Data Analysis

The study participants responded in writing to primarily open-ended survey questions. After all surveys were complete, the data was coded by content. This was done by organizing responses to each interview question in word documents, noting similarities, differences, and other important content areas in participant's responses. The data obtained from the

interviews were subjected to a content/theme analysis and responses were coded for themes. The coding process included reading each interview numerous times, analyzing the content for relevant and repeating themes and phrases, as well as noting material that did not fit into thematic areas (Engel & Schutt, 2013). Any quotes from the participants that best illustrated high frequency responses or the emergent themes were noted for use in the following findings chapter.

CHAPTER IV

Findings

The purpose of this research project was to explore how White clinicians engage in dialogue about race and racial difference in cross-racial therapy with Black clients.

Specifically, it explores how White clinicians think about their choice to broach the subject of race and their perceptions of the therapeutic alliance as it relates to these conversations about race and racial difference. It also explores White clinicians' process and motivations to not broach the subject of race, why they choose not to broach, and how they perceive this choice as impacting the therapeutic alliance.

This chapter presents findings from a survey of open-ended responses solicited from 12 White clinicians who have conducted therapy with Black clients. The interview questions were designed to explore how White clinicians conceptualize how they discuss race in their therapeutic work with Black clients. The survey centered on several broad areas of inquiry, with at least one question directed toward each area of inquiry. The areas of inquiry were: White clinicians' thought processes when broaching the subject of race in therapy; how White clinicians perceive talking about race as impacting the therapeutic alliance; why White clinicians don't talk about race in therapy; and White clinicians' influences related to talking about race in therapy. Data regarding participants' credentials was also collected through the survey.

This chapter begins with an explanation of the findings related to participant credentials. It proceeds with findings presented according to three themes that emerged from the data during analysis. Each main theme encompasses several subthemes. This section will explain and describe the three main themes and their respective subthemes using examples from the survey responses. The three main themes are: *broaching the subject of race, power dynamics and white privilege*, and *race and the therapeutic alliance*. Findings are presented with examples from the interviews using pseudonyms for the purpose of anonymity.

Demographic Data

A total of 12 individuals participated in a Survey Monkey survey and answered all questions. All study participants identified as White. All answered positively to the qualifying question inquiring whether they had ever worked with a Black client for the purposes of therapy. The participants responded to a survey question about credentials. Three participants reported being a LICSWA (Licensed Independent Clinical Social Work Associate). Three participants reported being a LMHC (Licensed Mental Health Counselor). Three participants were LICSW's (Licensed Independent Clinical Social Worker). Two participants were licensed psychologists with Ph.D. One was a Licensed Marriage and Family Therapist.

Broaching the Subject of Race

For the current study, participants explored their thoughts and feelings about talking about race in therapy with one or more of their Black clients. This section presents findings related to how participants think about how to broach the subject of race in therapy. The subthemes that emerged are: *letting trust emerge, taking responsibility*, and *broaching race – is it the clinician's job?* Some participants felt it was important to approach the subject of race slowly, allowing trust to emerge in the relationship before talking about race. Others felt it

was important to broach the subject of race immediately or early in the therapy in order to take responsibility to address power dynamics in the therapy relationship. All but one of the twelve participants recalled having discussed race in therapy with at least one Black client. Linda was the only participant who indicated that she had never talked about race with her Black clients. Linda struggled with questions related to whether it was her role to raise the topic of race with her Black clients. Findings will be presented according to these themes and subthemes with examples from the interviews using pseudonyms for purposes of confidentiality.

Letting trust emerge.

Three of the twelve clinicians surveyed felt it was important to broach the subject of race slowly or “as trust developed.” For example, Isabel noted that she did not bring the subject of race up for the first few months of therapy with a Black client:

The subject of race came up within the first few months of the sessions. I wondered what it was like to discuss race with me, a White therapist and she, a Black client. She told me she had never had a therapist bring up race before...she was grateful that I brought it up.

Although Isabel notes that her client was thankful that Isabel broached the subject of race, Isabel does not elaborate as to why she waited several months to discuss race with her client or why exactly her client was grateful.

George states that he waited for a “natural” time to talk about race with his Black client:

I brought up the cross racial (therapy) relationship at a time when it seemed to naturally be part of the conversation... We discussed the client's experience as a racial minority.

George states that he brought up race when it was "naturally part of the conversation," but does not explain how it is evident to him when race becomes a natural part of the conversation.

Jenny reports that:

Talking about race early in the therapy does not lead to an extensive conversation about race; it seems that talking freely about race happens more often after a relationship has been established.

Jenny voices the idea that the relationship must be established before 'talking freely about race happens.' This echoes George's notion that race is best broached when it is "natural."

Letting trust emerge is one of the ways participants described their thinking about waiting to broach the subject of race with their Black clients. The idea that trust must develop before broaching the subject of race was central to this theme. The notion of letting trust emerge was described primarily as the desire to allow the subject of race to arise over time in a manner perceived as "natural" to the white clinician.

Taking responsibility.

Contrary to those above, three of the twelve participants felt that it was important to broach the subject of race early in the therapy, sometimes in the first session. These participants report that they consider broaching the subject of race early in the therapy to be their "responsibility." Holly explains that she feels it is her responsibility to broach the subject

of race early in the therapy in order to address power dynamics or the need to “take responsibility” for the “power differential” in the therapy relationship as a White clinician working with Black clients:

As a person benefiting from privilege (white privilege in this case), it is my responsibility to call out the power differential and create a space in which it is okay to talk about. I typically bring it up when discussing my background, experience, and approach by stating something to the effect of, "You listed you identify as Black, and clearly I walk through the world identified as White and as such I benefit from White privilege. How do you feel about working with a White therapist?" In almost every case, the client has responded with some visible relief that the topic was just brought up from the beginning. They have either then stated they are not concerned (which could be a by-product of the fact that it was brought up), or they took the opportunity to educate about their experience of being Black and/or being underprivileged in some way. These conversations typically have led right into a deepening of the relationship.

Holly explains that by taking responsibility for addressing a power differential in the relationship, she helps “create a space to talk about race.” Holly also notes that this results in “a deepening” of the relationship. Likewise, Marc broaches the subject of race within the first several sessions:

I would guess it was first discussed within the first several sessions but we continued to return to it on a semi-regular basis.

Marc writes that he brings up the topic of race in his work with Black clients, specifically focusing on his own White identity. He focuses on the ways in which his White

identity influences his own thinking and behavior and how these dynamics may play out in the therapy:

I attempt to discuss my race with all of my clients during our initial conversations about the therapy relationship. I discuss how my identity as a white person living in a white supremacist and racist culture influences how I think and act and that these dynamics will be present in our therapy relationship. I discuss how it is my intention not to perpetuate racism but that it is inevitable and I will work hard to recognize this when it occurs and encourage my patients to discuss race and racism openly in our sessions.

Cassandra reports broaching race in the intake session. She and her client discuss race in the relationship as well as in the “context of the overall culture”. Cassandra states:

I make it a point to discuss race in intake and invite the dialogue. With most of my clients who are people of color they identify it as not being an issue to discuss in therapy and that they have no issues with me being white. However, in the course of treatment race has always come up as an issue in bigger ways and we have been able to work through issues of oppression and identity. I take a here and now approach and have discussed our bi-racial therapeutic relationship in context of the overall culture. I have a social justice viewpoint and bring that into the room.

Taking responsibility is one of the ways clinicians described their motivation to broach the subject of race early in the therapy with their Black clients. Responsibility was described primarily as the desire to address racial identity, oppression and power dynamics both in the room and in the larger social context. The passages above illustrate the varying

ways participants expressed their thoughts and feelings about taking responsibility as White clinicians working with Black clients.

Broaching race – is it the clinician’s job?

It is interesting to note that all but one of the twelve participants were able to recall having discussed race in therapy with at least one Black client. Linda was the only participant who indicated that she had never talked about race with her Black clients. Here Linda describes her thinking about her choice not to broach the subject of race with her Black clients:

I did not talk about race with black clients because it wasn't something they talked about with me. It wasn't that I wasn't thinking about race and how it was impacting them, me and our relationship but I wasn't sure that it was my job to centralize race in the conversation if they weren't. This is a question I was raising both from a clinical perspective and from the idea that deciding what is centralized as a person who held several points of privilege could be an enactment in and of itself. However, ...I could have surfaced the question in a way that honored our identities and gave the clients the choice to talk or not talk about race, as the fact that they weren't could very well have been because I was white. And from the perspective that mistrust related to racism is a barrier in the therapeutic relationship, I could argue...that it is the white clinician's role to address this mistrust, i.e. racism, in order to do meaningful work. It is a question I continue to grapple with, and sadly have very little chance to practice it as most of my clients are white.

Linda states that she was not sure if it was her "job to centralize race in the conversation". She was unsure if she should decide what is central to her client given her position of privilege. She worries about the possibility of 'an enactment' if she were to broach the subject of race. Yet she also wonders if she could have "surfaced the question in a way that honored" their respective identities. She questions whether it is her role, as the White clinician, to address racism.

The passages above illustrate the varying ways participants conceptualize how, when and why they talk about race in the therapy with their Black clients. The question of whether it is the clinician's job to broach the subject of race is one of the ways participants discussed their choices to broach or not broach the subject of race with their Black clients.

Another theme that arose in the data analysis is that of power dynamics and white privilege. The next section describes this theme and specific participant responses related to power dynamics and white privilege in therapy with Black clients.

Power Dynamics and White Privilege

Participants explored issues of power and privilege in their survey responses. This section is broken down into subheadings in order to capture the varied ways that the participants addressed issues of White privilege and power dynamics in their work with Black clients. Subthemes that emerged in this area included: *Race as a Black issue*, and *Whiteness avoided*.

Race as a Black issue.

Nora looks to her client for help on how to address her client's experience of race. Nora describes her wish that her client might be able to help her learn what she needs to know in order to conduct the therapy:

She asked me directly how would I be able to help her as an African American female when I was a privileged White woman. I addressed her concerns in that I would not be able to completely understand what it was she experienced and would empathize with her and hope that she would help me learn what it was I needed to know to help her work on the issues she was having in her life.

Here Nora suggests that the Black client should help Nora learn about how race and racism impacted the client in order to receive the benefits of therapy. Thus, the power dynamics remain unaddressed despite the fact that race has been broached and discussed in the therapy.

Kevin explained that he broaches race early in the therapy because he believes race is “an important aspect...for any Black person in this country”:

I bring up race in the first session and in many sessions because race is an important aspect of social context for any Black and African American person in this country.

Kevin broaches the subject of race early in therapy because he feels it’s important for his Black clients to address race in therapy. Kevin does not address his Whiteness or White privilege here, but rather brings up race in order for his Black clients to explore their experience of being Black. In contrast to Kevin, Marc writes that he brings up the topic of race in his work with Black clients, specifically focusing on his own White identity. As reported earlier, he states:

I attempt to discuss my race with all of my clients during or initial conversations about the therapy relationship. I discuss how my identity as a white person living in a white supremacist and racist culture influences how I

think and act and that these dynamics will be present in our therapy relationship. I discuss how it is my intention not to perpetuate racism but that it is inevitable and I will work hard to recognize this when it occurs and encourage my patients to discuss race and racism openly in our sessions.

Marc focuses here on the ways in which his White identity may influence his own thinking and behavior and how these dynamics may play out in the therapy.

Another theme that arose in the data is how White clinicians avoid or broach their own Whiteness in therapy with Black clients. The next section describes this theme.

Whiteness broached and avoided.

Eight of the 12 clinicians surveyed broach the subject of race by talking about their own racial identities as White. Three clinicians out of 12 surveyed avoided talking about their own race in therapy with their Black clients. These clinicians talk about race in the therapy without directly broaching the subject of their own racial identities.

George reports having broached the subject of race as a discussion about the client's race, but not his own race.

I brought up the cross racial (therapy) relationship at a time when it seemed to naturally be part of the conversation... We discussed the client's experience as a racial minority.

In contrast, Marc brings up his race as White and talks with his client about how his race might impact the power dynamics in the therapy. He specifically suggests that his being White will affect how he conducts therapy and names this early in the therapy:

I would guess it was first discussed within the first several sessions but we continued to return to it on a semi-regular basis. I first brought up the topic of

race when discussing power dynamics and how my identity as a white person will affect how I conduct therapy.

In contrast to Marc, Linda does not address her racial identity in the therapy. Linda describes using her Whiteness to secure services for her client, but does not broach the subject of race or talk with her client about the power inherent in her race and in her professional position. Linda wonders whether addressing race and power in the therapy could have been useful:

I wondered in the work that I did with one particular client if not addressing how his and my social identities affected our ability to get his needs met, was an enactment. I was able to secure services and equipment for him that he was not able to secure for himself. This was not entirely because of race, but I was definitely using my privilege as a social worker and a white woman to secure these services for him and acknowledging that may have changed the way we both experienced that support.

Linda explores her White privilege directly by noticing, after the fact, that she used her Whiteness in order to gain access to services. She wonders whether talking in therapy about her privilege as a White woman and the resulting power differential with her black client may have been beneficial to the therapy and to her client.

Jenny writes that the topic of race comes up “in the middle of therapy” and observes that, “talking freely about race” happens more often “after a relationship has been established.” She does not talk about her position as a White woman therapist. Instead, she made note of comments that generally indicated that she was “not like other White people”. She writes:

Clients have also addressed my race by saying that I am different from other white people they know. Once a middle aged, male client who is Black said during our conversation about his experiences as a Black man, ‘When we talk about this I feel like you can hang. You’re like a real homegirl’.

Jenny does not interrupt her clients positioning her as like them and different from other White people; she does not convey to her clients that she still has white privilege and that it impacts her racial experience. In contrast, Alice writes about her experience talking about her identity as a White woman early in the therapy with a Black client who was transferred to her after working with a therapist who the client felt had been racist. Alice identifies her race as White. Alice explains why she identifies her Whiteness upfront:

I named my identity as a white woman early, because this client was already describing feeling judged and dealing with racism from white women. She’s sitting with me who’s also white, and I wanted to communicate that I do identify myself as a racial being so that we could have a meaningful therapeutic conversation. Hopefully to interrupt the racism she was experiencing and not perpetuate it.

Alice hopes that by identifying herself as a “racial being” she might engage in a “meaningful therapeutic conversation.” In this way she addresses her Whiteness in an attempt to forge a strong therapeutic alliance.

The following section presents findings related to how White clinicians think about and try to impact the therapeutic alliance with their Black clients.

Race and the Therapeutic Alliance

All eleven participants who talked about race in therapy with Black clients stated that talking about race had a positive impact on the therapeutic alliance. Cassandra states:

I have had feedback and my experience has been that it (talking about race) was core in building trust and understanding. It has given a safe platform to work through many subtle and obvious layers of emotion and experience that come from being black in this culture.

George has a similar perspective and states:

Talking about race was an important part of establishing an open trusting relationship and I think was essential in the client understanding that it was an acceptable and important topic.

Holy explains that she has experienced “a deepening” of the relationship as a result of broaching the subject of race.

In almost every case, the client has responded with some visible relief that the topic (of race) was just brought up from the beginning...these conversations typically have led right into a deepening of the relationship.

In addition to participants’ positive comments about the impact of talking about race on the therapeutic alliance, participants wrote about concerns they have in relation to talking about race in therapy with their Black clients. Specifically, participants struggled with wanting to avoid discomfort, both the client’s and their own. In addition, participants did not want to be seen by their clients as racist or ignorant. The subthemes, *avoiding discomfort* and *not wanting to be seen as ignorant or racist* are explored below.

Avoiding discomfort.

Elizabeth addresses the theme of discomfort, suggesting that her Black clients may have been uncomfortable with discussions of race:

For the most part, I think that talking openly about race has strengthened my relationship with clients. I have a lot of clients who seem to feel fairly safe talking about their anger at white people and white privilege. In some cases, black clients have been uncomfortable with discussions of race, don't want to make an issue out of it, or feel like I am trying too hard to be racially aware,

Jenny also mentions discomfort, but worries that her clients did not want to make her uncomfortable. She explains:

Both the client and I have initiated the conversation but often there has been some topic of conversation that is related from which it flows. I think in many conversations on race I think my clients concerns have been not wanting to make me feel uncomfortable as well as not wanting to appear like they are 'playing the race card' or making excuses.

Jenny wonders if her clients worry about making her "uncomfortable". She wonders if they worry about being seen by Jenny as "making excuses" or "playing the race card." She wonders about how her clients think about her and themselves in relations to race, racism and their respective racial identities.

Marc writes about his concern that his client might be confused or uncomfortable if he brings up their racial identities. In contrast to Jenny, however, he pursues a conversation about race in order to name the power dynamics in their relationship.

My concerns when I first brought up both my race and the race of my black client was that she would be confused as to why I was bringing it up or feel uncomfortable with me raising this issue. I think once the client realized I was bringing up the issue of both her race and mine in order to acknowledge the power differential and privilege/oppression dynamics inherent in our relationship that she was made more comfortable by this discussion.

Marc names his concern that his client would be confused or uncomfortable with the topic of race and racial difference, yet he broaches and pursues the subject nonetheless. Marc reports that once the client understood that his intention was to acknowledge power, privilege and oppression inherent in the relationship, his client became more comfortable.

Not wanting to be seen as ignorant or racist.

Nora writes about acknowledging that she does not “know everything”. She explains that when she has questions it is out of “a need to be sensitive” and not “out of ignorance”.

She writes:

I think the fact that I am open to acknowledge I do not know everything or have experience puts them at ease that I will not try to overly identify and not pay attention to issues that arise. I cannot recall a time where the persons I counsel where race has not been brought up. I think this is because I acknowledge early on that biases exist even in myself that I will need help with and that when I have questions it is out of a need to be sensitive and provide the best care and not out of ignorance.

Alice described an attempt to address what she imagined to be her client’s internalized racism. She speaks about trying to be empathic, yet feels she was seen as “missing the point”.

Alice also describes her conflict around wanting to address what she observes in her client as ‘internalized racism’, yet not wanting to state something that may be so obviously part of her client’s experience as a Black man.

I was working with a black male in his 20s. Probably our 4th session he was talking about feelings of frustration that he could never finish what he started, that he could never follow through on things. He then shared that he had been picked up by police walking into work for having a bench warrant for unpaid child support. I perceived the client as being very self-blaming; he constantly expressed that everything going wrong in his life was his fault. I theorized there was a strong influence of internalized racism in that, and so I reflected: "I'm hearing you blaming yourself for what happened, and I'm also thinking about how black men are constantly profiled." He responded, "I've been black all my life, I know that, but I'm still the one that didn't pay." It was like he was saying, "Yeah, obviously racism is always there and I still have control over some things" Thus he did not find my comment empathetic but rather missing the point. However it was really tough for me to know how to explore that further. I didn't want to join with the self-blaming part, especially knowing how much internalized racism could be a part of that. However I also didn't want to dismiss what accountability & power he did have or feel like he had over what had happened in his life. I said something like: "You're right, I don't want to discount what responsibility you have. I'm also aware that being white, I don't have to deal with external racism in addition to whatever my internal struggles might be." I was trying to be empathic, but in reality, I don't know

how my comments were received or experienced by him. When he said: "I've been black my whole life" I can see racism in my comment about the profiling. As if here I was this white woman trying to bring something into the light that was so obviously already a part of his experience.

Alice begins the passage with her observation that her client is self-blaming and her interpretation that this may have to do with his experience of internalized racism. Alice struggles to broach race in a way that addresses his accountability and power while also acknowledging his oppression. She is concerned that her comments may have seemed racist in the eyes of her Black client.

The passages above illustrate the varying ways participants expressed their concerns about how their clients perceived them. These concerns were described as both a fear of being seen as ignorant and a fear of appearing racist.

Summary

The three main themes that emerged from the qualitative data in this study exploring how White clinicians engage in dialogue about race and racial difference in cross-racial therapy with Black clients are: *broaching the subject of race, power dynamics and white privilege*, and *race and the therapeutic alliance*. These themes and the supporting quotes suggest that White clinicians make a variety of choices as to how and when to broach the subject of race in therapy with Black clients. These differences include whether to broach the subject of race early in the relationship or whether to allow the topic to emerge later in the therapy, choices to talk about one's race as a White clinician and whether to take responsibility for broaching the subject of race in the therapy. The findings also suggest that some participants adjusted how they talked about race in the therapy in order to avoid

discomfort in the therapy relationship and some struggled with concerns about appearing ignorant or racist in their work with their Black clients. The implications of these findings are discussed in the next chapter. The following chapter also contains a further discussion of the interconnectivity of the four themes and an outline of study bias and limitations.

CHAPTER V

Discussion

The current study examines when, how, and why White clinicians discuss race when working with Black clients. This chapter discusses the findings from a survey of open-ended comments solicited from 12 White clinicians who have conducted therapy with Black clients.

The results from the current study suggest that White clinicians make a variety of choices regarding talking about race in therapy with Black clients. While all clinicians surveyed felt it is important to talk about race in therapy, the findings show important differences in the choices participants made as to how, when and why to talk about race in therapy with Black clients. These clinical decisions reflect a range of practices and beliefs including whether to take responsibility for broaching the subject of race, when in the process of therapy to broach the subject of race, and whether to talk about one's own race in the therapy. In addition, participants report wanting to avoid discomfort related to talking about race and not wanting to be seen as ignorant or racist. This range of responses reflects a significant disparity in clinical practice and raises concerns about quality of clinical treatment for Black clients working with White clinicians.

Research suggests that there is a correlation between therapeutic alliance and treatment outcome and that it is the client's perception of positive therapeutic alliance that most accurately determines successful treatment outcomes and retention (Horvath, 2005). Bedi, Davis and Williams (2005) suggest that clients attribute the responsibility for fostering a

positive relationship to the therapist and that therapeutic technique is perceived as important to the development of the alliance. Some research suggests that clinicians who demonstrate cultural responsiveness are perceived by clients-of-color as more credible and competent (Knox et. al, 2003). Therefore, it is possible that failure to address issues of race and ethnicity can perpetuate cultural bias by imposing a dominant cultural perspective on minoritized clients.

Furthermore, research supports the idea that exploration of race in cross-racial therapy should include self-disclosure by the therapist. Burkard, Knox, Groen, Perez and Hess (2006) look at the effects of White therapists' use of self-disclosure in cross-racial therapy. Their research suggests that it is important for White therapists working with clients-of-color to validate clients' experiences by acknowledging the role of racism/oppression in clients' lives. In addition, their research suggests that self-disclosure by White therapists about their own racist/oppressive beliefs can strengthen the therapeutic relationship. Thus, in building positive relationships with clients-of-color, the authors assert that White therapists need to be open to discussing racial and cultural concerns, validate clients' experiences of discrimination, and demonstrate willingness to self-disclose their own experiences and reactions in such discussions (Burkard et al., 2006). Therefore, White therapists who are able to be open with clients-of-color about their own perceptions and attitudes and communicate sensitivity to racial concerns may help build effective cross-racial therapy alliances, potentially improving the efficacy of the therapeutic work.

Day-Vines et al., (2007) look at how counselors broach racial, ethnic, and cultural differences in the counseling process and relate broaching style to the clinician's process of racial identity development. The authors propose a continuum of broaching behaviors

including avoidant, isolating, continuing/incongruent, integrated/congruent and infusing (2007). The findings from the current study demonstrate that addressing race in cross-racial therapy can take many forms and may inconsistently include self-disclosure by the White therapist about their own racial identity, perceptions and attitudes. The results of this study support the current literature on broaching behavior in cross-racial therapy and demonstrate a range of broaching behaviors consistent with the broaching continuum proposed by Day-Vines et al. (2007). The findings are discussed in the context of the literature reviewed and in light of the outline of broaching behaviors proposed by Day-Vines (2007). Following this are considerations for practice, a review of study strengths and limitations, and recommendations for future research.

Broaching Behaviors and How They Impact Therapy

The Avoidant Broaching Style.

The first stage of the broaching continuum proposed by Day-Vines (2007), the *avoidant* broaching style, is characterized as one in which the therapist gives little attention to race due to a color-blind stance in which differences are minimized. DiAngelo (2012) suggests that there are patterns of behavior that Whites frequently demonstrate. These include Whites wanting to prove to people of color that they are not racist and the expectation that people-of-color should teach whites about racism. DiAngelo (2012) explains that these patterns reinforce several dimensions of racism including the idea that racism is something that happens to people of color but has nothing to do with White individuals and that, as a result, White individuals cannot be held responsible for racism. These common White positions—that they are not racist and that people of color must teach whites about racism—reflect a framework that denies that racism is a relationship in which both groups are

involved. DiAngelo (2012) points out that this framework requires nothing of Whites in terms of responsibility or action and as a result, reinforces unequal power relations. In addition, these behaviors don't recognize the historical or institutional dimensions of racism and in turn result in reinforcing racism (Miller & Garran, 2008).

The White patterns of behavior described above are reflected in the findings of the current study. The eleven participants of the current study who talked about race in therapy with their Black clients stated that talking about race had a positive impact on the therapeutic alliance. However, three of these clinicians avoided talking about their own race in the therapy. Jenny writes that the topic of race comes up "in the middle of therapy" and observes that, "talking freely about race" happens more often "after a relationship has been established." She does not talk about her position as a White woman therapist, but instead allows the topic of her race to arise through comments about her made by the client that generally indicate that she is "not like other White people." Although Jenny addresses race in therapy with her Black client, she does so without broaching the subject of her own racial experiences and privilege as a White woman. Instead she attempts to build an alliance by being "less White" than other Whites or through a color-blind stance in which she attempts to be seen as more alike than different from her client.

Similarly, Nora does not broach the subject of race with her client. When her client addresses race directly with Nora, Nora explains that she would like to empathize with her client and hopes her client might be able to help her learn about her experience as an African American so that Nora can be effective as a therapist. Rather than talking about her experience of race and privilege as a White woman, Nora looks to her client to "help me learn what it was I needed to know to help her work on the issues she was having in her life."

Likewise, Kevin explained that he broaches race in therapy with Black clients because he believes race is “an important aspect...for any Black person in this country”. Kevin does not address his Whiteness or White privilege here, but rather brings up race in order for his Black clients to explore their experience of being Black. In these examples, the power dynamics in the therapeutic relationship remain unaddressed despite the fact that race has been broached and discussed in the therapy. Further, the dominant norm of an unmarked, unraced whiteness is reinforced. In other words, the client has a race that is significant to their experience but the white therapist does not have a race, or at least a race that is seen as significant to their experience.

This study shows a range of broaching behaviors and abilities among White therapists. The *avoidant* broaching style proposed by Day-Vines, (2007), in which the therapist takes a color-blind stance and differences are minimized, is supported by the current study and reflects White patterns of behavior which deny White responsibility for understanding White racial identity and White privilege.

The Isolating Broaching Style.

The *isolating* broaching style proposed by Day-Vines et al. suggests that some White therapists address race superficially or out of obligation. According to this theory, White therapists with an isolating broaching style may hesitate to discuss race out of fear that it will be offensive or a belief that race is a taboo subject. Findings of the current study support the notion that the isolating broaching style may be a common broaching behavior among some White therapists. Examples of the isolating broaching style from the data include Elizabeth, who suggests that her Black clients may have been uncomfortable with discussions of race and Alice, who speaks about trying to be empathic, yet feels she was seen as “missing the

point". Linda states that she was not sure if it was her "job to centralize race in the conversation". She was unsure if she should decide what is central to her client given her position of privilege and worries about the possibility of "an enactment" if she were to broach the subject of race. These clinicians struggle with talking about race in therapy with their Black clients. They attempt to protect themselves and their clients from feelings of discomfort and hope to avoid being perceived by their clients as racist or ignorant. These participants are able to reflect on some of their concerns as they respond to the survey questions, yet in the therapy with their Black clients they are unable to take responsibility for exploring race and racism.

Cardemil and Battle (2003) discuss supporting an open dialogue with clients about race and ethnicity and outline reasons therapists may choose not to discuss race with their clients. These reasons include fear of raising emotionally charged issues, concerns about saying something offensive, not knowing when and how to address race, and waiting for clients to initiate discussions about race. The authors suggest that not acknowledging racial differences could send an implicit message to the client that the therapist is uncomfortable discussing race or does not view issues of race as important.

The idea that trust must develop before broaching the subject of race and that there is a "natural" time to talk about race was a theme that emerged in the findings. George states that he brought up race when it was "naturally part of the conversation". At a certain point in the therapy, George felt it was natural to talk about race, but he does not explain how it is evident to him when race should become a part of the conversation, nor does George indicate whether his client shares his perception. Jenny voices the idea that the relationship must be established before "talking freely about race happens." Likewise, Jenny emphasizes the importance of

establishing trust in the relationship, but does not indicate who determines if and when that trust is established.

Day-Vines et al. (2007) point out that some clients may harbor apprehensions about addressing issues of race in therapy because of concerns that the therapeutic alliance may not represent a safe environment within which to disclose racial issues. They note that many people of color may recognize that their survival depends upon their socially conditioned ability to racially compartmentalize their lives. They state:

This accommodation of Whiteness, whereby clients avoid issues of race unless prompted to do so, results from concerns about the power differential between the counselor and the client in which the counselor wields the balance of power (Sue & Sue, 2003).

If clinicians avoid discussing race for fear that broaching the subject may be offensive or is taboo, clinicians close down opportunities to explore issues of race in the therapy. Similarly, waiting for “trust to develop” or a “natural time” to address race has the potential to perpetuate a power differential between the therapist and the client in which the White therapist has the power to decide when it is time to talk about race. Alternatively, as supported by the literature and validated here, those therapists who broach the subject of race early in the therapy and are able to address their own experiences of race and White privilege are more likely to foster open and trusting therapeutic relationships with their clients.

The Integrated/Congruent Broaching Style and The Infusing Broaching Style.

Day-Vines et al. describe the most advanced of their proposed continuum of broaching styles to be the *integrated/congruent* style and the *infusing* broaching style.

Integrated/congruent counselors are described as having a well-established awareness of

diverse racial, ethnic, and cultural norms and their impact on clients' presenting concerns. *Infusing*, the most advanced broaching style the authors present, extends the broaching behavior beyond the clinician's professional identity to a greater personal commitment to social justice.

Three of the twelve participants appear to operate at the *integrated/congruent* style of broaching. These participants report that they consider broaching the subject of race early in the therapy to be their 'responsibility.' Holly explains that she feels the need to broach the subject of race in order to "take responsibility" for the "power differential" in the therapy relationship. By taking responsibility for addressing the power differential in the relationship, Holly feels she helps to "create a space to talk about race," resulting in "a deepening" of the relationship. Cassandra reports broaching race in the intake session. She and her client discuss race in the relationship as well as in the "context of the overall culture". Likewise, Marc broaches the subject of race within the first several sessions, specifically focusing on his own White identity. Marc writes about his concern that his client might be confused or uncomfortable if he brings up their racial identities. Yet, despite his discomfort, Marc pursues a conversation about race and addresses the power dynamics in the relationship. "I was bringing up the issue of both her race and mine in order to acknowledge the power differential and privilege/oppression dynamics inherent in our relationship". He focuses on the ways in which his White identity influences his thinking and behavior and how these dynamics play out in the therapy.

These clinicians describe their intention and their ability to address race, oppression, and power dynamics in the therapy encounter with their Black clients. Not only do these participants have an awareness of racial, ethnic, and cultural issues and their impact on

clients' presenting concerns, they also take responsibility for initiating addressing these concerns with their clients. They do not wait for the subject to come up "naturally" as did other participants. Instead they broach the subject of race out of a responsibility as clinicians and as White people to create the opening to talk about race and power dynamics in the therapy.

Infusion, the most advanced broaching style the authors present extends the broaching behavior beyond the clinician's professional identity to a greater personal commitment to social justice. Only one of the participants appeared to reach a level of broaching behavior that might be characterized as *infusion*. This clinician describes his intention and ability to address race, oppression and power dynamics with his Black client. Marc writes about his development as an individual committed to social justice:

Growing up in a working-class community played a large role in my development as an individual committed to social justice as I continued to witness the suffering enacted on working-class and working-class poor folks by an economic and political system designed to perpetuate wealth, privilege, and safety for the rich and upper-middle class.

One theme that stands out in Marc's comment is how the personal experience of oppression plays a role in the development of a greater personal commitment to social justice. Marc goes on to cite his social work training as being significant in "helping me develop a greater awareness of my racial identity." He then mentions personal relationships with professors and the influence authors have had in shaping his views on racial politics and his "ability to initiate and discuss race openly with all of my clients, including black clients." Marc's comments suggest that both personal experiences that enable them to relate and

professional training are necessary for White therapists to develop the capacity to talk about race in the therapeutic encounter in a way that consistently and continually invites clients to explore race, racism, and issues of power and control within and outside of the therapeutic relationship. These findings suggest that White clinicians for whom issues of oppression are both personally and professionally significant may be more prepared to develop an effective broaching style in cross-racial therapy with Black clients.

Conclusion

Given the power dynamics in therapeutic relationships between White clinicians and Black clients, this study indicates that it is the responsibility of the clinician to provide the client with opportunities to explore race and racism as it exists in the therapy relationship and in both the client's and the clinician's life experiences. Day-Vines (2007) describes broaching behavior as a "consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (p. 402). Although all of the participants in this study voice some degree of discomfort regarding talking about race with their Black clients, some forge ahead to broach the subject nonetheless, and still others go further and talk about their own Whiteness, white privilege and the power dynamics inherent in the therapy relationship.

Research suggests that in order to build positive relationships with Black clients, White therapists need to be open to discussing racial and cultural concerns, validate clients' experiences of racism, and demonstrate willingness to self-disclose their own experiences and reactions in such discussions (Burkard et al., 2006). Literature on cross-racial therapy suggests that taking responsibility, not only for broaching the subject of race in therapy, but for extending the broaching behavior beyond the clinician's professional identity to a greater

personal commitment to social justice is central to effective broaching behavior (Day-Vines et al., 2007; Miller et al., 2008). White therapists who are able to broach the subject of race in an ongoing and consistent manner and be open with clients about their own perceptions and attitudes may be able to build more effective cross-racial therapeutic alliances, potentially improving treatment outcomes with Black clients.

Given the range of broaching behaviors made evident by this study and other research, an important consideration for practice is education and training for White clinicians. Training should focus on helping advance the clinical skills as well as the racial identity development of White clinicians in order to help improve the capacity of White clinicians to work effectively with Black clients.

Considerations for Practice

The findings of the current study suggest that White clinicians make a variety of choices regarding talking about race in therapy with Black clients. These clinical decisions reflect a range of practices and beliefs about conducting cross-racial therapy, some of which may result in limited therapeutic alliance and negatively impact treatment outcomes. Day-Vines et al., (2007) assert that those therapists who are more advanced in their own racial identity development are more likely to foster open and trusting therapeutic relationships with their clients. Current research suggests that in building positive relationships with clients-of-color, White therapists need to become competent at discussing racial and cultural concerns and be willing to self-disclose their own experiences and reactions in such discussions (Burkard et al., 2006). White therapists who are able to communicate their sensitivity to racial concerns and be open with clients about their own perceptions and attitudes may help build effective cross-racial therapy alliances, potentially improving the efficacy of the therapy

(Burkard et al., 2006). Given the range of broaching behaviors made evident by this study and previous research, an important consideration for practice is that education for White clinicians should include curriculum development and training that advances the clinical skills of White therapists in the area of cross-racial therapy. In addition, clinical education should include training that helps to advance the racial identity development of White clinicians-in-training. Such training may help to improve the capacity of White therapists to work effectively with clients-of-color.

Study Strengths and Limitations

The research question and study design were successful in collecting some White therapists' reflexive thoughts about how they talk about race in therapy with their Black clients. In addition, a successful aspect of the study is the degree to which the data and findings remain close to the participant's voices and emphasize the meaning that participants made of their experiences.

The major limitations of this study come through in the sample bias, including a small sample size, self-selection, and lack of sample diversity. All study participants are self-selected for the survey, which may indicate increased self-reflection on the part of participants about how they address issues of race, racism and racial difference in cross-racial therapy with Black clients. The snowball sampling technique employed in this study may have limited the diversity of experiences and backgrounds of the individuals in the sample. It is possible that a more random sampling technique could have resulted in a sample of participants from more diverse socioeconomic backgrounds. The study is regionally discrete with half of the participants from New England and half from the North West. Although this study collected information about participants' credentials, it did not investigate details about areas of

expertise. All of these biases in the sample are concerning because the sample may not be an accurate representation of the population of White clinicians in the United States.

My social location as a researcher has a bearing on the study biases, including my background, education, racial identity and my values as a social worker in training. I am a White, heterosexual, able bodied, middle class, non-religious Christian-raised, gender-normative woman who has a previous Masters in Education. I value talking about race and racial identity in my therapeutic work and I seek to develop my own understanding of the intersectionality of oppression- the connection between different identities and different kinds of oppression (Miller & Garran, 2007). In data analysis, my opinions, emotions and values could have caused me to look for and report on responses that resonate with my beliefs or to put greater emphasis on responses that reflect or strongly conflict with my own values.

Recommendations for Future Research

Future research could continue in a number of directions. It would be useful to focus on better understanding which didactic, clinical, and supervisory preparation activities help trainees improve upon their ability to broach the subjects of race, racism, White privilege and related topics during the therapy process. Researchers may want to further study the continuum of broaching behaviors presented by Day-Vines (2007). This might entail research into the relationship between White racial identity development and broaching behavior. In addition, researchers may want to study the operationalization of the continuum of broaching behaviors presented by Day-Vines (2007). This could involve research related to training clinicians in broaching behaviors and studying the impact of the training on subsequent broaching behavior, therapeutic alliance and treatment outcomes. Given that the current study did not differentiate between clinical disciplines, it might also be useful for future research to

focus on whether broaching behavior changes based on one's particular clinical discipline. Finally, it would be beneficial to study the experience of talking about race in therapy from the client's perspective. Specifically, further research should look at the client's perceptions and reactions to talking about race in therapy, as well as how the client rates the therapeutic alliance according to the broaching style of the therapist.

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Appendix A

Informed Consent Form

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....
Title of Study: Talking About Race: How Do White Clinicians Engage in Dialogue About Race in Cross-racial Therapy with Black Clients?

Investigator(s): Elizabeth Hare, Smith School for Social Work Masters Program

.....
Introduction

You are being asked to participate in a research study exploring how White clinicians engage in dialogue about race in cross-racial therapeutic dyads with Black clients. You were selected as a possible participant because you are a clinician who may identify as White and may have worked with Black clients. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

There is a growing amount of evidence in the literature that suggests that addressing race in cross-racial therapy can have a significant impact on the therapeutic alliance, the treatment process, and the treatment outcome. The purpose of this study is to investigate how White clinicians engage in dialogue about race in their clinical work with Black clients. This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to reflect on your experience working with Black clients. Specifically, you will respond to three yes/no questions and seven open-ended questions on a confidential survey on Survey Monkey regarding your work in therapy with Black clients. Initially, you will sign and mail the Informed Consent form to the researcher and will then receive an email with a link to the survey. You will have 30 days to consider, answer, and submit your survey responses via Survey Monkey. Given the variety of each participants' experiences there is no way to determine exactly how long the survey will take to complete, however, it is expected that participants will be able to complete the survey in one hour or less. Nevertheless, it is the hope that each participant will consider each open-ended question and respond in depth.

Risks/Discomforts of Being in this Study

The risk for participating in this study is likely to be minimal. However, it is possible that individuals may experience complex and difficult emotions while reflecting on their clinical work or may feel uncomfortable disclosing or sharing their experiences in regards to race, racism, and Black clients.

Benefits of Being in the Study

There are a number of potential benefits of participating in this research. Clinicians will have the opportunity to reflect on and write about their experiences working with Black clients. Participants may find that this experience facilitates greater insight into their clinical work. In addition, the participation of clinicians who have worked with Black clients can add to the limited research currently available regarding how White clinicians might most effectively address race in the clinical encounter. Collecting data about the experience of

clinicians working across racial difference may help increase understanding about cross-racial therapy.

Confidentiality

Your participation will be kept confidential. The following steps will be taken to protect confidentiality:

- The survey will not require you to reveal identifying information such as your name.
- You will be cautioned before taking the survey not to reveal any identifying information that may be associated with a client as a means to protect third party identities.
- Any identifying information related to the participant in this study will be removed from the survey.
- Confidentiality will be further maintained through the use of codes to identify participants.
- Individuals involved in reviewing surveys or other information associated with the study will sign and adhere to a confidentiality agreement prior to conducting work related to the study. This agreement will be written as a contract.
- Research advisors will have access to data from the study only after it is clear that all identifying information has been removed and excluded from this data.
- In publishing or presenting the data publically, identifying information will be removed. In the case of quotations that may reveal identifying information, they will be paraphrased and changed to preserve confidentiality.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according

to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 3rd, 2015. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study at any time, please feel free to contact me, Liz Hare at lhare@smith.edu or by telephone at (413) 626-7905. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your

rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep

.....

Name of Participant (print):

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

Appendix B

Interview Instrument

Survey Monkey survey questions:

1. What are your credentials (degree and license) as a clinician?
2. This study seeks to understand how White clinicians think about their work with Black clients. Therefore, in order to participate in this research you must identify as White. Do you identify your race as White?
3. As a mental health clinician, have you conducted therapy with one or more clients who identify as Black or African American?
4. Please think about instances when you conducted individual therapy with Black clients. Did you discuss race in therapy with any of these clients?
5. Please describe a time when you discussed race in therapy with a Black client by responding to the following questions:
 - a. When during the therapy did the subject of race come up? (e.g. first session, second session, last session, etc.)
 - b. How did the subject of race come up and who initiated this discussion?
 - c. During this discussion about race, what do you think your client's concerns were?
 - d. Was your race discussed and, if so, please describe how your race was brought into the conversation.
 - e. Was your client's race discussed and, if so, please describe how your client's race was brought into the conversation.
6. Considering your experience talking about race with Black clients, please discuss how you think talking about race has affected the therapy relationship between yourself and your Black client/s?
7. When you initiate discussions of race with clients, what motivates you to do so?
8. Have there been times when you chose not to address race with your Black clients? Why did you choose not to address race at these times? Please discuss any positive and negative consequences you observed as a result of not discussing race.
9. What was influential in the development of your thinking regarding talking about race in cross-racial therapy? Please consider your education, clinical supervision, upbringing, friends, family relationships, learning from clients and other factors that may have influenced you.
10. Please discuss your reasons for not talking about race with Black clients.

Appendix C

Human Subjects Review Committee Letter of Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994
January 30, 2015

Elizabeth Hare

Dear Liz,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read "Elaine Kersten". The signature is written in a cursive style with a prominent initial "E".

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Robin DiAngelo, Research Advisor