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What are the factors that influence whether a clinician discusses race in the crossracial therapeutic encounter?

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CHAPTER I

INTRODUCTION

Currently, there is an ever-expanding body of literature on cross-cultural therapy. However, culture encompasses a range of social identities including such differences as race, ethnicity, religion, sexual orientation, and gender. While cultural difference continues to be explored and has even developed into its own field of clinical work and study, there are elements of culture that deserve specified attention, race being one of them.

Race is still a topic met with much sensitivity and even resistance in public discourse today. How racial difference plays out in the therapeutic relationship is still relatively uncertain. While there are a number of texts dedicated to working cross-racially, many of them use case studies to illustrate the issues that arise in the interracial therapeutic dyad. Additional literature offers suggestions and considerations about cross-racial therapy and elements to facilitate its success. However, there is a dearth of research that specifically researches concrete strategies that are empirically supported to facilitate a successful cross-racial working relationship. One strategy that has been discussed somewhat in the literature is engaging in discussions about racial difference when working cross-racially in the clinical encounter.

This study will attempt to gather quantitative data about clinicians that may shed light on factors that influence a clinician's decision to discuss or not to discuss race when working with a client of a different race. The specific research question posed is: What

are the factors that influence whether a clinician discusses race in the cross-racial therapeutic encounter? It was hypothesized that clinician characteristics such as race, years of experience, and graduate training influence a clinician's decision to discuss racial difference in the cross-racial therapeutic encounter. Social work clinicians working with clients of a different race were the focus of the study. A tailored survey was used to gather data for this study.

In this survey, attention was given to the specific factors that affect whether a clinician addresses racial differences in the cross-racial clinical encounter, focusing on graduate and professional training, the specific therapeutic factors that may influence whether a clinician engages in conversations about race, and the perceived effects of discussing or not discussing racial difference.

The following chapter will look at the various terms used in cross cultural work such as culture, ethnicity, and race in order to clarify their meanings. The movement to examine cross-cultural work will also be detailed as it provides a context for today's research on work across difference. Previous research in the area of cross-racial work will also be reviewed, including studies on the therapeutic alliance, ethnic matching, racial identity development, and discussing racial difference in cross-racial therapy.

This research is important to the field because of the growing cultural diversity in the United States. According to U.S. Census projections, Caucasians will no longer maintain a majority in the U.S. population by the year 2020 (United States Census Bureau [USCB], 2000). Given the complexity of race and racism as both a social and personal experience, whether or not a clinician directly addresses race in the clinical encounter may impact the effectiveness and cultural competence of treatment. The information

gathered through this process will contribute to the discussion about cross-racial therapy

and illuminate one aspect of working with individuals of a different race.

CHAPTER II

LITERATURE REVIEW

This research aims to gather information about the factors that influence a clinicians' decision to address or not to address racial and ethnic differences when working cross-racially in the clinical encounter. Clinicians' process of engaging in dialogue about racial difference with their clients is the principal focus of this research. In addition, specific clinician characteristics, such as race, years in clinical practice, and graduate and professional training are compared to assess their influence on clinicians' approaches to working with racially diverse clients.

This literature review will first outline the historical context of the multicultural cultural competence movement in counseling and psychology. Secondly, the therapeutic alliance will be reviewed in relation to therapy outcomes and client retention in treatment. Then, the literature on the therapeutic alliance in the cross-racial therapeutic dyad will be examined with attention given to the issues of client-clinician matching and elements that impact clients' perception of the working alliance. Finally, this literature review will look at the research that specifically addresses cross-racial clinical work and discussing race in the cross-racial clinical encounter.

Definition of Terms

Race, Ethnicity, and Culture

The terms race, ethnicity, and culture are often used interchangeably due to the frequent inability among researchers to reach a consensus on defining these terms

(Betancourt & Lopez, 1993; Casas, 2005; Helms, 1990a; Miller & Garran, 2008; Phinney, 1996; Quintana, 2007). However, for the purpose of this thesis, it is important to tease out where their meanings intersect and where they are different.

Race is often thought of as a way to categorize individuals based on group biological factors and physical similarities such as skin color and facial features (Phinney, 1996). However, citing the American Anthropological Association, Miller & Garran (2008) write that, "race is not a legitimate biological or genetic construct; rather, it is an ideology used to justify the domination of one identifiable group of people by another" (p. 15). This statement refers to race as a social construction. Along the same lines, Helms (1990a) points out the importance of seeing race in the social context as a fluid phenomenon. Helms also notes the difference between racial categorization and racial identity development, which she defines as, "a sense of group of collective identity based on one's *perception* that he or she shares a common racial heritage with a particular racial group" (p. 3).

Phinney (1996) defines ethnicity as "broad groupings of Americans on the basis of both race and culture of origin" (p. 919). Therefore, race is considered an element of ethnicity. Ethnic affiliation is also both determined by cultural background and acts as an element of culture (Betancourt & Lopez, 1993).

It should be noted that the United States Census Bureau (2000) differentiates between race and ethnicity. For the 2000 Census, four groups were identified as racial categories: American Indian or Alaskan Native, Asian or Pacific Islander, Black, and White. In addition, two ethnic categories were designated: of Hispanic origin and Not of

Hispanic origin. Therefore, ethnic origin is identified as a distinct concept from race (USCB, 2000).

The concept of culture is more ubiquitous in public discourse, which may be a result of its all-encompassing meaning. The 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" (p. 61).

For the purposes of this paper, race will be used in reference to one element of an individual's identity that is shaped both by the individual process of racial identity formation as well as the social meaning given to racial categories. Culture, as it refers to cultural competence will include a wider range of social identities (e.g., race, ethnicity, socioeconomic status, sexual preference, religion, language, etc.) and areas of influence in an individual's experience or worldview.

Cultural Competence

The National Association of Social Work (NASW) National Committee on Racial and Ethnic Diversity defines cultural competence as,

> the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997).

The NASW Code of Ethics (1997) Section 1.05, Cultural Competence and Social Diversity, highlights three elements of culturally competent clinical practice including awareness and understanding of culture, a knowledge base pertinent to the clients served,

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and continuing education about social diversity and oppression with respect to the various aspects of social identity.

In 2001, the NASW expanded on this section of the Code of Ethics to create Standards for Cultural Competence in Social Work Practice (NASW, 2001). The Committee lists ten more detailed standards toward the achievement of cultural competent clinical practice. In addition to the guidelines outlined in the NASW Code of Ethics, the Standards for Cultural Competence in Social Work Practice addresses self-awareness of personal social identities, the acquisition of knowledge to the development of skills, and highlights macro issues that affect culturally competent practice.

Historical context

The growing awareness of multicultural issues within counseling and psychology has its origins in the expansion of the general public's consciousness during the Civil Rights Era. Specifically, passage of the Civil Rights Act in 1964 expanded access to education and employment for groups that were historically marginalized, including ethnic minority groups in the United States (Arredondo & Perez, 2006). Membership in professional organizations also became more diverse, shedding new light on issues of importance to people of color. 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). Subsequent groups that formed during the 1970s and early 1980s include the Asian American Psychological Association, the National Hispanic Psychological Association, and the Society of Indian Psychologists (Arredondo & Perez, 2006).

During the 1970s and 80s there was also increased research and discussion about working with an ethnically diverse clientele. At the 1973 Vail Conference of Graduate Educators in Psychology, participants raised the issue of needing specific counseling competencies when working with culturally diverse clients (Ridley & Kleiner, 2003).

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 (Ridley & Kleiner, 2003). 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. Thirdly, this model highlights the importance of a clinician's skill set, or the development and application of culturally appropriate intervention strategies and techniques. Many subsequent standards and research have been based on Sue et al.'s (1982) model of multicultural counseling competencies.

A decade following Sue et al.'s (1982) model of multicultural counseling competencies (MCCs), Sue, Arredondo, and McDavis (1992) issued a call to the counseling profession for the implementation of multicultural counseling competency standards in counseling practice, training and education. Sue et al.'s (1992) document 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 1990s, discussion ensued about the definition of MCCs, assessment guidelines, and ways to implement multicultural

counseling competencies into educational and training curricula (Ridley & Kleiner, 2003). In addition, multicultural counseling became a well-developed area of research and theory throughout the counseling professions (Worthington Soth-McNett, and Moreno, 2007). Not only has multicultural counseling competence emerged as a movement in its own right, it has become incorporated into mainstream psychological and counseling standards.

The therapeutic alliance

A discussion of the therapeutic alliance is relevant to this research because it is considered in much of the literature to be a core element of every therapeutic relationship regardless of theoretical orientation (Burkard, Juarez-Huffaker, and Ajmere, 2003; Horvath, 2006). The last 25 years has seen an abundance of research about the therapeutic alliance, also referred to as the working or helping alliance. Constantine (2007) defines the therapeutic working 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). In distinguishing the therapeutic alliance from the therapeutic relationship, Horvath (2001) also focuses on the collaborative relationship between therapist and client, highlighting both the affective bond as well as the cognitive elements such as treatment tasks and goals.

Horvath (2005) tracks the historical context of the therapeutic alliance going as far back as Freud, who felt that a strong therapeutic relationship endowed the therapist with added authority and gave credibility to the analyst's interpretations. Early analytical writers viewed the therapeutic relationship as facilitative rather than having any curative

properties in its own right. In the 1950s, Carl Rogers proposed that the therapeutic alliance was in and of itself healing (Horvath, 2006). With the exception of behavior theorists who focused more on techniques and skill-building rather than the therapeutic relationship, there is little disagreement over the importance of the therapeutic alliance.

Horvath (2005) reviews the research of the past 25 years, which has looked at two general areas of the alliance, the first being the relationship between the therapeutic alliance and treatment outcomes. In looking at the data, Horvath (2005) reports that the results have been rather consistent, indicating a moderate correlation between therapeutic alliance and treatment outcome. This information is revealing in that it rightfully places importance on the relationship established between client and therapist. Be the relationship facilitative of healing or itself having curative properties, the significance of its impact on treatment outcomes is consistently substantiated by the research.

The second general area of investigation about the therapeutic alliance has compared assessments of the client-therapist relationship from different vantage points including client, therapist, and third party observer. This research suggests that clients' perception of a positive therapeutic alliance more accurately determines successful treatment outcome and retention when compared with the opinions of therapists or third party observers (Horvath, 2005). Bachelor (1995) conducts a qualitative analysis of clients' perception of the therapeutic alliance, noting the low rate of agreement between client, clinician and third party views of therapeutic alliance.

In their research, Bedi, Davis, and Williams (2005) attempt to identify specific factors that determine the quality of the therapeutic alliance as indicated by clients. Interestingly, their research reveals that the clients surveyed lay a great deal of

responsibility on the therapist for fostering a positive therapeutic relationship. Bedi et al. (2005) find that therapeutic technique is perceived as important to the development of the therapeutic alliance, which varies from past studies that link therapeutic technique to treatment outcome rather than therapeutic alliance.

Ackerman and Hilsenroth (2003) review the research on the therapeutic alliance and identify therapist's personal characteristics as well as in-session treatment techniques viewed to have an impact on the therapeutic alliance. The personal attributes of therapists deemed to positively impact the formation of a strong therapeutic alliance include those individual qualities that facilitate an environment of trust and respect as well as communicating a sense of clinical competency and confidence in the therapist's clinical ability. Specifically, these qualities include being flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, friendly, open, and warm. While theoretical orientation was noted to have little impact on therapist's positive working alliances, the techniques used in the therapeutic process were reported to go hand-in-hand with clinicians' personal attributes. The techniques shown to positively influence the formation of a strong working alliance include facilitating exploration, depth, and reflection, being supportive, noting past therapeutic success, accurate interpretation, facilitating the expression of affect, an active, affirming, and understanding stance, and attending to the client's experience. The personal characteristics and treatment techniques used to facilitate a positive therapeutic alliance cut across theoretical orientation but have an undeniable effect on the success of therapeutic treatment.

Race in the therapeutic setting

Cross-cultural therapy is often thought to be its own category of research within psychology and counseling due to the specific issues that may arise when client and clinician identify differently on a variety of social factors (e.g., race, gender, sexual orientation, etc.). Critiques have been leveled against psychodynamic theory as being largely based on standards of mental health for White male clients (Perez Foster, 1996; Perez Foster, 1998; Suchet, 2004; Sue & Sue, 2003). Suchet (2004) notes the scarcity of racial analysis within psychodynamic therapy and calls on the field to develop a "multidimensional model of subjectivity" by taking into account social identities such as race, ethnicity and class. She cites Helms and Cook (1999) who, "argue that race and culture critically influence every aspect of the therapeutic process" (p. 435). Tatum (1997) makes a similar statement, pointing out that, "…in a race-conscious society, racial group membership has psychological implications." (p. 94).

Ganzer and Ornstein (2002) present an overview on the relational therapeutic model as a culturally sensitive framework for working cross-culturally as it incorporates the "social context" into the therapeutic process. The authors also stress the importance of clinicians' increasing their awareness about their own racial and/or ethnic identity as it invariably interacts with the client's social identities.

RoseMarie Perez Foster (1998) introduces the phenomenon of the "clinician's cultural countertransference":

> Comprising both cognitive and affective elements within the therapist, what I term the clinician's cultural countertransference is a complex and interacting set of: culturally derived personal life values; academically based theoretical/practice beliefs; emotionally driven biases about ethnic groups; and feelings about their own ethnic self identity" (p. 256).

These elements that each clinician brings into the therapeutic relationship have the potential to influence the therapeutic alliance, process, and treatment outcomes. Certain aspects of a clinician's cultural countertransference develop in American culture, which places value on particular views about the self. Furthermore, a clinician's academic training is likely to also establish notions of mental health and pathology that may be culturally-bound. Active awareness about how one's own cultural countertransference is present in the clinical encounter is important to protect against ruptures in the therapeutic alliance, impasses in treatment, and even premature termination (Perez Foster, 1998).

The therapeutic alliance in the cross-racial therapeutic dyad

When looking at cross-cultural therapeutic dyads, a branch of research has focused on the impact of ethnic matching on the therapeutic alliance and indirectly on retention and treatment outcomes. Ethnic matching occurs when clients and clinicians are matched based on ethnic and/or racial similarities (Farsimadan, Draghi-Lorenz and Ellis, 2007). Proponents of ethnic matching contend that therapists are more likely to have a shared background with their ethnically similar clients, allowing therapists to better understand certain issues presented in therapy. Those who support cross-ethnic therapy focus more on the commonalities of the human experience and argue that culturally competent clinicians can work effectively with ethnically different clients. Proponents of cross-cultural therapy also maintain that matching on every cultural aspect (e.g., ethnicity, race, religion, sexuality, socioeconomic status, etc.) is improbable and the focus should be on developing skills when working with clients who are racially or ethnically different.

The research on treatment retention and outcome of ethnically matched and unmatched dyads has produced varying results. Gray-Little and Kaplan (2000) review research on therapeutic treatment for ethnic minorities and report that a shared cultural background can facilitate the formation and maintenance of the therapeutic alliance. Farsimadan et al.'s (2007) research looked at the process and outcome of therapy in ethnically similar and dissimilar therapeutic dyads and makes the case that ethnic matching has a notable impact on therapeutic process. It should be noted that in Farsimadan et al.'s study, those clients who were ethnically matched expressed a preference for an ethnically similar therapists, which may contribute to the strength of the findings. Much of the research that Farsimadan et al. reviews links ethnic matching to treatment outcomes by way of the therapeutic alliance.

Wintersteen, Mensigner, and Diamond (2005) look at both gender and racial differences and their impact on the therapeutic alliance and treatment retention in work with adolescents. The results indicate that race does not appear to be a deciding factor in developing the early therapeutic alliance after two sessions. In contrast, therapist interviews showed a belief by clinicians that racial matching would in fact have a positive impact on clients' assessment of the working alliance. While race did not appear to significantly impact the strength of the therapeutic alliance, the research results did show matching to affect treatment retention. In particular, Caucasian therapists treating clients of color had notably lower retention rates than the other therapeutic dyads in the study.

The research on ethnic matching, the therapeutic alliance, and treatment outcomes is inconclusive about the extent to which ethnic matching impacts the working alliance and treatment outcomes. However, the demographic reality of today's helping profession,

which is largely made of up White clinicians, compared with the growing diversity of the general public may make the findings somewhat irrelevant (U.S. Department of Health and Human Services, 2001). Despite the inconsistent results of the research on ethnic matching, information can be gleamed to improve the quality of the therapeutic working alliance in cross-cultural therapeutic dyads.

Racial identity development and the therapeutic alliance

Another element proposed to impact the therapeutic alliance in cross-racial therapeutic dyads is racial identity development. Racial identity is defined as "the quality of an individual's identification with a specific racial group in which he or she perceives a 'common racial heritage' (Helms, 1990a). In other words, racial identity refers to the psychological meaning that an individual ascribes to her or his race (Burkard, et al., 2003).

Helms' (1990b) proposed a model for both Black racial identity development as well as White racial identity development. Much of the research on cross-cultural therapeutic dyads, including the literature covered in this review, looks at White clinicians working with clients of color. Therefore, Helms' model of White racial identity development will be outlined here in more detail.

Helms' initial model of White racial identity development was created in 1984, expanded in 1990, and updated by Helms and Piper in 1994. Helms (1990b, 1995) proposes six ego statuses that reflect an individual's attitudes, belief, and behaviors. In what is considered the least evolved ego status, Contact, an individual shows lack of awareness about race and racism, particularly the privilege inherent in one's own Whiteness. Disintegration is marked by an internal conflict and acknowledgement of race

and racism. Those individuals characterized by the Reintegration ego status recognize their Whiteness and subscribe to the belief system of White racial superiority. In Psuedo-Independence, this belief system is abandoned and a positive view of racial identity for White people and people of color is reformulated. In Immersion-Emersion, a person may immerse him/herself in the development of a non-racist identity. Finally, in the most advanced ego status, Autonomy, a non-racist outlook is internalized as well as a positive White racial identity.

Because racial identity reflects an individual's attitudes, affects, and behaviors (Helms, 1995), it is thought to influence the therapeutic alliance, particularly in cross-cultural counseling where there are more likely to be differences in individual worldviews (Burkard, Juarez-Huffaker, & Ajmere, 2003; Burkard, Ponterotto, Reynolds, & Alfonso, 2003; Carter, 1990; Gushue & Constantine, 2007).

Carter's (1990) research differentiates between the race perspective and the racial identity perspective. Proponents of the race perspective view the racial makeup and presentation of the client and clinician as influential in the counseling relationship. The race perspective also believes that societal stereotypes about race play out in the cross-racial therapeutic dyad. In the racial identity perspective, regardless of the client or counselor's race, the respective levels of racial identity that each holds and how they interact is what is thought to primarily affect the therapeutic interaction (Carter, 1990).

Burkard, Ponterotto, Reynolds, and Alfonso (1999) looked at white counselor trainees' racial identity status and their perceptions of working alliances. Supporting the racial identity perspective, the results of their study suggested a moderate but significant correlation between White racial identity attitudes and participant rating of the working

alliance in matched and unmatched therapeutic dyads. In other words, the more advanced the White racial identity of the White counselor trainee, the more positive the effect on the working alliance regardless of the client's race.

Gushue and Constantine (2007) study the impact of White racial identity attitudes of psychology trainees, looking at the connection between color-blind racial attitudes and White racial identity attitudes. The authors note the tendency of some White mental health practitioners to embrace a color-blind racial attitude, which they define as "a conscious or unconscious minimization, denial, or distortion of race and racism" (pp. 321). For some, this attitude stems from a conscious or unconscious desire to protect White privilege while for others it may be an attempt to rise above racial bigotry and focus on similarities rather than differences. Gushue and Constantine (2007) note that color blindness plays into the less overt form of racism that prevails today in which race and racism is minimized or even denied. While individuals of any racial makeup can adopt a color-blind worldview, the authors point out that it is more likely for White practitioners to do so and the focus of their study is on White psychology trainees.

Gushue and Constantine (2007) found that psychology trainees who denied the prevalence of racism today were also rated as having less developed levels of White racial identity attitudes. Conversely, those who recognized the existence of contemporary racism were also considered to have more advanced levels of White racial identity attitudes. These findings are relevant to this study because for many practitioners avoiding discussions about race and racial differences may originate from a desire to focus on similarities or to treat everyone the same. Gushue and Constantine (2007) stress the importance of clinicians and training programs to focus on clinician racial identity

development given the negative consequences related to color blind racial attitudes and lower levels of White racial identity attitudes when working interracially as well as intraracially.

Constantine (2007) looks at colorblindness and other racial microaggressions and the perception of the African American clients when working with White therapists. The study looks at perceived racial microaggressions in the cross-racial therapeutic relationship, the working alliance, therapist general and multicultural counseling competencies, and client satisfaction. A racial microaggression is defined as "subtle and commonplace exchanges that somehow convey insulting or demeaning messages to people of color" (p. 2). One such example is the belief that as socially aware clinicians, we are protected from the racial biases that exist in society at large and that we are some how excluded from acting in racist ways (Perez Foster, 1998).

Constantine's (2007) findings indicate that both conscious and subconscious forms of racial aggression perceived by African American clients negatively impact the therapeutic alliance. Furthermore, the research also notes a correlation between the clinicians' cultural competency as perceived by the client and its impact on the therapeutic alliance.

Sue et al. (2007) also look at "racial microaggressions," and examine the implications for clinical practice. Their work reveals that white clinicians are vulnerable to acting, consciously or subconsciously, in racist ways when working with clients of color. The authors indicate that a therapist's position of power relative to her/his client may increase the likelihood that microaggressions that occur within the therapeutic dyad will go unnoticed by the clinician. Sue et al. (2007) note that, "the power of racial

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microaggressions lies in their invisibility to the perpetrator and, oftentimes, the recipient (D. W. Sue, 2005)" (p. 275).

Racial identity and broaching race in the clinical encounter

Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake, and Douglass (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 define broaching as, "the counselor's ability to consider how sociopolitical factors such as race influence the client's counseling concerns" (p. 401). Related to this is broaching behavior, which refers to, "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 these definitions is the clinician's responsibility to be consistently aware of how race influences the client as well as to provide the client with opportunities to explore the role of race on their experience. The authors emphasize the importance of considering race as compared to other aspects of a client's social identity due to its controversial and taboo nature.

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 counselor gives little attention to race due to lack of awareness or a color-blind stance in which differences are minimized. The isolating broaching style addresses race superficially or out of obligation. Counselors with an isolating broaching style may feel hesitant to discuss race out of fear that it will be offensive or a belief that race is a taboo subject of

discussion. A continuing or incongruent broaching style looks at broaching as a skill. While these clinicians may consider how sociopolitical factors affect clients personally, limitations persist on how race is explored, stemming from a lack of understanding and openness. Integrated/congruent counselors have a well established awareness of diverse racial, ethnic, and cultural norms and its impact on a client's presenting concerns. In addition, these clinicians look at broaching as an incorporated aspect of their professional identity. The final, and most advanced broaching style, called infusion, extends the broaching behavior beyond the clinician's professional identity to a greater commitment to social justice.

Day-Vines et al. (2007) make a connection between a counselor's broaching style and their racial identity functioning, hypothesizing that both broaching behavior and racial identity functioning fall along a similar continuum. The authors adopt Helms' (1990a) definition of racial identity, which "pertains to the degree and quality of identification that individuals maintain toward individuals with whom they share a common racial designation" (p. 85).

Looking at Helms' (1995) White Racial Identity Development (WRID) model, Day-Vines et al. match the avoidant broaching style with the contact status level of WRID in which individuals are unaware of their own racial identity as well as racism as a reality for people of color. The authors associate disintegration with both the avoiding and isolating broaching style. In disintegration, the counselor experiences conflict in their beliefs about race and racism. This internal discord can be reflected in both the avoiding and isolating styles in which clinicians may avoid discussions about race out of their own discomfort or instead broach the subject out of guilt or shame over the conflict.

The reintegration phase of WRID is also associated with both avoiding and isolating broaching behaviors. In reintegration, a white person returns to his/her initial stereotypic thinking and therefore may altogether avoid broaching race or may only superficially discuss it without an openness to deeper exploration of the issue. In the pseudo-independence phase of WRID, a therapist may begin to develop a continuing/incongruent broaching style as s/he is attempting to adopt a nonracist attitude yet understanding remains on an intellectual level.

The immersion/emersion phase correlates with the integrated/congruent broaching style. The clinician is aware of how race impacts a client and has a deepened awareness of his/her white racial identity. Finally, in the autonomy stage, which is congruent with the infusing broaching style, the clinician has successfully incorporated awareness and broaching as integral to his/her professional and personal identity. The clinician values diversity and demonstrates an openness and willingness to discussing its implication for the client and therapeutic process.

The authors assert that those counselors who are more advanced in their own racial identity development are more likely to foster open and trusting therapeutic relationships with their clients that welcome a diversity of racial, ethnic, and cultural backgrounds and experiences. Another important aspect highlighted throughout this article is the element of therapist responsibility, and particularly the white therapist, not only to develop an understanding of his/her own racial identity but also to provide opportunities for the client's exploration of race and its personal impact.

Discussing race in the clinical encounter

When taking into account the social context in which both the client and clinician live, the likelihood that the interracial therapeutic interaction will raise issues of race for client, clinician, or both is great. Surveying clinicians about the factors that influence a decision to discuss or not to discuss race attempts to gain insight about how race plays out in the therapeutic relationship. The social barriers and resistance to acknowledging racism in the larger social setting may impact a clinician's approach, both consciously and subconsciously, to initiating dialogue about such a charged and personal issue (Daniel, 2000).

Daniel (2000) identifies the social barriers to discussing issues of race and racism and the resistance on the part of white clinicians within the context of the therapeutic relationship. However, she stresses the importance of allowing space in the therapeutic process for verbalizing racism as it impacts the African American female client: "…race is related to the experience of trauma, not only as a source of trauma, but as a force shaping its acknowledgement and its outcomes" (p. 133).

Thompson and Jenal (1994) outline the universalistic approach of some clinicians to focus on those experiences shared by all humankind. However, the authors argue that while universalism may serve as a solid knowledge base for counseling, therapists should not rely solely on those skills when racial and cultural issues arise in therapy. Their research indicated that when Black clients worked with counselors in one quasi-counseling session avoiding race-specific talk, the most frequent client response was characterized as an exasperated-type interaction. In this type of exchange, researchers observed a breakdown in communication as well as frustration and unease on the part of

the client. Other client responses were characterized as smooth type, with no notable disruptions in the exchange; constricted type, in which the client-clinician conversation is marked by silences and breaks in communication; and disjunctive-type interaction, in which the counselors disrupted the flow of the discourse.

Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) looked at the experiences of African American and European American therapists addressing race in cross-racial psychotherapy dyads. Notably, the results showed that African American therapists typically felt comfortable discussing race with their European American clients while European American clinicians were more likely to feel discomfort talking about race with their African American clients. Both African American and European American therapists reported that discussions between them and their racial-different clients had a positive effect on the therapeutic process. For those therapists who recalled instances of avoiding discussions about race with particular clients, they 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 a negative consequence.

Knox et al. (2003) also inquire about the clinicians' past experience, both personal and educational, and highlight that African American therapists were more likely to have experiences with diverse people throughout their lives, both positive and negative. In contrast, the European American therapists reported learning more about racial difference through academia rather than personal experiences. Related to these findings is the higher frequency with which the African American therapists worked with diverse clients compared to the European American therapists.

Thompson and Alexander (2006) report on the responses of African American clients when matched with European American and African American clinicians. In addition, the authors also assess the effect of clinician-initiated discussions about racial differences by European American therapists in the first session. The authors point out that a clinician-initiated discussion about racial difference early in the therapeutic process is likely to communicate therapist awareness of the impact of race on the client's life as well as an openness to discuss race. The results of Thompson and Alexander's study suggest that there exists a moderate influence of a therapist's race on client measures of clinicians' understanding of treatment strategies and therapeutic usefulness. Their research did not show improved ratings for those European American therapists who did initiate discussions about race in the first session. In light of these findings, the authors encourage additional research about other factors involved in discussions about race such as timing, rationale, and the development of a supportive environment for talking about race and racial difference.

Cardemil and Battle (2003) discuss the practical implementation of multicultural counseling by supporting an open dialogue with clients about race and ethnicity. The authors outline reasons therapists may not discuss race with their clients including fear of raising such an emotionally charged issue, concerns about saying something offensive, not knowing when and how to address race, and waiting for clients to initiate discussions about race. However, there may be unforeseen consequences to not discussing race and racial difference when clients and clinicians. As Cardemil and Battle (2003) point out, "Not acknowledging racial/ethnic differences could send an implicit message to the client

that the therapist is uncomfortable discussing certain topics or does not view them as important – a message that is likely to hinder the therapy process" (pp. 282).

Cardemil and Battle (2003) make recommendations for clinicians when talking about race and ethnicity with clients. The first recommendation is to question clients about how they identify rather than assume an individual's racial or ethnic identity by appearance. The authors also ask therapists to refrain from assigning stereotypic assumptions of racial groups to an individual and recognize the variance present within a racial or ethnic group. It is also suggested that a therapist consider how racial difference affect the therapeutic relationship and therefore the therapeutic process. This recommendation speaks specifically to therapists' recognition that they themselves, in addition to their clients, are racial beings and how the two racial identities interact in therapy. A developed awareness of interpersonal and societal power dynamics, privilege, and racism is also advised. The authors encourage clinicians to err on the side of discussing race rather than taking a more conservative or passive approach. Finally, Cardemil and Battle urge therapists to keep learning about race, ethnicity, not only through concrete information but also through introspection that each individual is a racial being living in a racialized society.

In the literature on addressing racial or cultural difference in therapy researchers rarely discuss times when addressing difference is not useful or facilitative of the therapeutic process. However, La Roche and Maxie (2003) do ask that clinicians consider certain issues related to addressing cultural differences in the psychotherapy. These include the patient's level of distress and presenting problem as well as the larger cultural context within which therapy is taking place. In addition, the authors suggest weighing

the client's cultural history and racial identity as well as the relationship between cultural differences and the other issues present in the therapeutic relationship.

Miller and Garran (2008) also point to the complex and variable criteria for bringing up the issues of race and racism. "Clinicians should be willing and able to broach the topic, but they should understand that there is no formula about when and how to do this effectively" (pp. 244). Looking to the general context of the therapeutic relationship and process, Miller and Garran (2008) suggest considering such factors as the client's presenting problem, treatment goals, and the therapeutic alliance.

Maxie, Arnold, and Stephenson (2006) investigate whether clinicians and clients discuss ethnic and racial differences as well as the factors surrounding that conversation like who initiates the discussion and reasons for discussing racial and ethnic differences. The authors also examine clinicians' perceptions about their skill and comfort when talking about racial difference with their clients as well as clinician characteristics (theoretical orientation, experience with diverse clients, and certain demographic variable) that may affect whether a clinician does or does not address racial and ethnic differences.

Of 808 APA-licensed psychologists, over 80% of respondents reported discussing ethnic/racial differences with at least one client in the previous two years. 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 ethnic/racial difference, therapists pointed to "a cultural component to 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 ethnic/racial difference, a majority of participants felt addressing racial difference was like addressing other sensitive issues in therapy. The overwhelming majority of clinicians surveyed identified feeling either very comfortable or somewhat comfortable discussing difference. Almost all respondents described themselves as somewhat skilled or very skilled at addressing difference. Most therapists felt that addressing ethnic/racial difference is facilitative, to varying degrees, of the therapeutic process.

Conclusion

Due to the increasing diversity in the United States (USCB, 2000), the utilization of cross-racial therapy will only increase in frequency in the future. As the literature suggests, there are a range of aspects unique to cross-racial and cross-cultural work that influence the efficacy and value of therapy for clients of all races. These include the salience of race for client and clinician, the interplay of racial identities, and the social climate among other factors.

Some researchers (Cardemil & Battle, 2003; Day-Vines et al., 2007; Knox et al., 2003; La Roche & Maxie, 2003; Miller & Garran, 2008) contend that discussing race and racial difference with clients is one concrete approach that supports the therapeutic process and fosters communication in the cross-racial therapeutic dyad. In an effort to gain further insight from clinicians about the process of discussing race with racially diverse clients, this examination of the factors that influence a clinician's decision to discuss or not to discuss race focuses specifically on the elements of the therapeutic process, as well as clinician characteristics, that may carry weight when therapists decide to address race or racial difference in the cross-racial therapeutic relationship.

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CHAPTER III

METHODOLOGY

This study was a quantitative, quasi-experimental investigation that explored cross-racial therapy in which the clinician and client are of a different race from one another. The purpose of this study was to examine what factors influence whether clinicians discuss racial differences when working cross-racially in the clinical encounter. Specifically, this research gathered information about clinician characteristics and elements of the therapeutic relationship that may influence a clinician's choice to initiate or refrain from discussions of race. In addition, clinicians' perceptions of the consequence of discussing or not discussing race are assessed. The research question asked: What factors influence a clinician's decision to discuss racial difference in the cross-racial clinical encounter?

This researcher hypothesized that therapist characteristics such as race, graduate training, and years in clinical practice influences whether a clinician does or does not address racial difference in the cross-racial therapeutic dyad. Furthermore, this researcher hypothesized that the perceived effect of discussing racial difference in the clinical encounter is generally positive while the effect of not discussing racial difference is generally negative.

Research design

This study was conducted through a fixed method design in that the observational context remained constant throughout the duration of the study (Research Methods, June

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5, 2007). This study was both relational and descriptive. A descriptive study aims to give a snapshot from a certain perspective in order to clarify the nature of a specified phenomena (Research Methods, June 14, 2007), while a relational study aims to observe a certain phenomena rather than manipulate it. Anastas (1999) defines relational research as, "research designed to describe regularities or patterns in how a predefined phenomenon relates to other predefined phenomena" (p. 148). Relationship research, as its name suggests, concerns itself more with the association among and between variables as they happen in everyday life rather than through manipulation by the researcher (Research Methods, June 19, 2007). Theory is then used to clarify and understand the connection highlighted through the study findings.

A relational-descriptive research design best fits the research question because not only does it attempt to look at cross-racial therapy from the perspective of the clinician, but also examines the correlation between clinician characteristics in relation to their observations.

Sample

The purpose of this study was to gather information from clinical social workers about those factors that influence their decision to discuss or not to discuss race with clients who are racially different from them. Therefore, the primary inclusion criteria for candidates to participate in this research study were individuals who obtained their masters degree in social work and who have worked in a clinical setting. Also, participants must have worked with clients of a different race and be willing to reflect and comment on their experience. Exclusion criteria included clinicians from other fields in mental health (e.g., Marriage and Family Therapists, Psychologists, Psychiatrists, etc.),

students who have not yet graduated from their MSW programs, as well as those clinicians who have not worked with clients of a different race. The survey did not exclude participants based on race or ethnicity, age range, or agency affiliation. On the contrary, diversity of race, level of experience, geography, and agency was welcomed.

The primary means of recruitment for this survey was by word of mouth and through the snowball method. Upon receiving final approval from the Smith College School for Social Work Human Subjects Review Committee, the survey was circulated to professional and personal contacts known by the researcher who were working in the field of mental health. The recruitment email briefly described the purpose of the survey and the inclusion criteria for participation. Potential participants were then led to an introductory cover letter that outlined the study in greater detail, including the potential benefits and risks of participation, the ethical standards and safeguards used to protect confidentiality, and the researcher's contact information for questions and comments.

Additional participants were recruited through a snowball method and asked to forward the email and survey to individuals who met the inclusion criteria. In addition, the survey was posted on Facebook, an online networking website that includes various forums for social workers.

All recruitment material was electronic and, therefore, the majority of recruitment occurred via email with minimal recruitment taking place verbally through direct contacts. An introductory letter preceded the survey and individuals were asked to complete the survey only if they met the outlined criteria. Therefore, participants were not formally screened prior to gaining access to the survey. Those participants who indicated that they did not meet the participation criteria (e.g., not yet graduated from an

MSW program) were ineligible and had answers removed from the survey so as to protect the reliability of the data. For this research, 56 participants entered the study and 47 participants completed all surveys questions.

<center>*Data collection*</center>

Data collected for this study took place through Survey Monkey, a web-based service to create survey instruments and electronically collect responses. Information was collected solely through the online survey and not through personal contact.

Using a survey as a means of data collection has both strengths and limitations. A major advantage of a survey is the anonymity that can be guaranteed to participants. Given that Survey Monkey does not collect identifying information from research participants, personal contact and identification of research participants is not possible, which can guarantee anonymity.

Survey access online can be both a strength and weakness. A primary limitation of any electronic questionnaire is that it excludes individuals who do not have access to email or the Internet. However, an online survey is also a strength in that those who do have online access are able to easily access the survey through the email link provided. Dissemination through word of mouth to a large number of potential participants is also fast and easy over the Internet.

The survey used to obtain the research data was created by the researcher. This was an advantage in that survey questions were tailored for the specific purpose of collecting data specific to this phenomenon. However, a limitation is that this type of instrument had not been previously tested for effectiveness (Anastas, 1999).

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The survey questions were divided into four major sections. In the first section, participants were asked to disclose demographic as well as other characteristics. For example, participants were asked the time period in which they graduated from their masters in social work program, their years of clinical experience, and about their clients who identify as being of a different race from them.

In the next section, survey respondents were asked to reflect on their graduate and professional training. Specifically, participants were asked about their graduate coursework, practicum experience, and supervision about working with racially diverse clients. This section also surveyed clinicians about their level of participation in professional workshops in relation to working with clients who were racially different from themselves. Finally, participants were asked about their level of awareness related to their own racial identity, possible stereotypic beliefs and their own perceived level of skill and confidence when working with clients of different races.

In section three, participants were first asked to comment on their approach to working with clients of a different race. This question was the only open-ended question in the survey, allowing for some limited qualitative data. Clinicians were also asked to identify with whom they discuss racial difference in the clinical encounter. The survey then asked participants to consider the importance of specific factors in their decision to discuss or to not discuss racial difference. These factors included the length of the clinical relationship, the client's diagnosis or presenting problem, the strength of the therapeutic alliance, and the clinician's comfort level in relation to discussing race. Participants were asked to rate the importance of these factors on a 6-point Likert scale ranging from Very Important to Very Unimportant.

The fourth and final section asked clinicians to reflect on their perceived effect of discussing or not discussing racial difference in the clinical encounter. Participants were then asked to consider the effect of racial difference on the formation of the therapeutic alliance, treatment success, and clients staying in treatment. Answers were given on a 5-point Likert scale, ranging from the effect being Very Positive to Very Negative.

Ethics and Safeguards

The introductory letter served as the method of obtaining informed consent for participants in this study. The cover letter included information about the study, inclusion and exclusion criteria, the risks and benefits of survey participation and safeguards used to maintain confidentiality. Participants were also informed that upon completing the survey, they would not be able to withdraw from the survey as there would be no way to identify their individual survey responses. Finally, individuals were notified that by entering the survey they were consenting to participate in the survey.

All communication with survey participants took place through the internet and email. Survey Monkey does not collect any individual information from participants, making identification of subjects unfeasible.

The principal risk for participating in this study was seen as minimal, however it was possible that individuals could experience complex and difficult emotions while reflecting on their clinical work. This risk was outlined to participants in the recruitment letter, as was the voluntary nature of participation in the research. No monetary or concrete benefit was provided to research subjects.

There were a number of potential benefits of participating in this research project. For example, clinicians had the opportunity to share their experience working with

racially different clients as well as adding to the limited research currently available about addressing race in the clinical encounter. Finally, collecting data about the experience of clinicians working across racial difference may also help increase understanding about one aspect of cross-racial therapy.

Any future presentations will be prepared so that participants cannot be identified. The quantitative data gathered from the questionnaire will be presented in aggregate. Qualitative data and illustrative vignettes will be disguised so as to protect the identity of participants.

Completed surveys were stored online through Survey Monkey, which is a password protected website. When printed out for data analysis, surveys were subsequently stored in a locked file cabinet. The data provided will be stored in a locked file for a minimum of three years as required by Federal regulations. After that time the information will be destroyed or continued to be secured in a locked cabinet as long as needed.

Data Analysis

Descriptive statistics were used to describe the sample population itself (Anastas, 1999). The survey data was processed initially through Survey Monkey, the online instrument used to collect the responses. Survey Monkey provided frequency reports which were then confirmed by Smith's statistical consultant using a Statistical Package for the Social Sciences (SPSS) software.

Inferential statistics were then used to describe how variables relate to each other, such as correlations, strengths of association and tests of difference (Research Methods, July 26, 2007). In order to ascertain whether there was a difference between the mean

score of two or more groups, t-tests and Oneway Anovas were used. In other words, these tools were used to examine whether the mean score of one group (such as White clinicians) is different, from a statistical perspective, from the mean score of another group (such as clinicians of Color). When there were two groups being compared, a t-test was used and when there were more than 2 groups, a Oneway Anova test was used (Coding and Statistical Analysis Handbook, 2007).

When a Oneway Anova test was used, the initial test indicated whether the means were different, but it does not tell us which specific groups were different from each other. It was therefore necessary to run a post hoc test which attempts to identify which specific groups were different from each other. In these cases, a Bonferroni test was run in order to ascertain the differences between groups. The results of this data analysis, along with remaining survey findings, will be presented in the following chapter.

CHAPTER IV

FINDINGS

This study looked at the factors that affect a clinician's decision to discuss or not discuss racial differences when working cross-racially in the clinical encounter. The primary hypothesis was that clinician characteristics such as race, years in clinical practice, and graduate and professional training would impact a clinical social worker's decision to discuss race with their racially different clients. This study also attempted to gain insight into those elements of the therapeutic process that would have greater or lesser influence on a clinician's decision to discuss or not to discuss racial differences.

The major findings of the study are divided into three different groupings of the participants' responses. First, participant characteristics will be discussed. Then the descriptive statistics from the survey responses will be outlined. Finally, the correlations and associations between clinician characteristics will be detailed.

Participant characteristics

Fifty-six clinical social workers participated in the study. Of the 56 respondents, the majority, or 37 individuals (68.5%), identified as being Caucasian; 6 identified as Latino/a (11.1%); 4 identified as African-American (7.4%); 4 identified as Asian (7.4%); 3 as Multiracial (5.6%); 1 as Native American (1.9%); and 1 as Middle Eastern (1.9%). Due to the smaller numbers in those identifying as being Latino, African-American, Asian, Multiracial, Native American, and Middle Eastern, these categories will be combined and compared with those clinicians who identified as being Caucasian. The

limitations of grouping the diverse group of participants who do not identify as Caucasian will be discussed in the following chapter.

Participants represented a range of experience with 14 clinicians (25.9%) working in clinical practice for up to 5 years; 10 clinicians (18.5%) working in clinical practice between 6 and 10 years; 13 clinicians (24.1%) working in clinical practice 11 to 20 years; 12 clinicians (22.2%) working in clinical practice for 21 to 30 years; and 4 clinicians responded that they have worked in clinical practice for 31 or more years. In a related question, 20 respondents (37.0 %) graduated from a Masters in Social Work program in 2000 or after; 15 respondents (27.8%) graduated between 1990 and 1999; 10 respondents (18.5%) graduated between 1980 and 1989; and 8 respondents (14.8%) graduated between 1970 and 1979.

When asked about the approximate percentage of clients in the last year who have identified as being of a different race from the clinician, responses were evenly spread out with 11 people (20.4%) working with 0% to 20% of their caseload being racially different clients, 11 people (20.4%) working with 20% to 40% of racially different clients; 11 people (20.4%) responding that 40% to 60% of their clients are racially different; 13 respondents indicating that 60% to 80% of their clients are racially different from them; and 7 clinicians responded that 80% to 100% of their clients are racially different from them.

Descriptive statistics

Graduate and professional training

When asked to review their graduate and professional training, respondents tended to indicate that their graduate training included classes on multicultural

counseling. Seventy percent of respondents either strongly agreed (38.9%) or somewhat agreed (31.5%) with the statement: "During my MSW program, I took classes on multicultural counseling." Over 60% of respondents strongly agreed with the statement "During my MSW practicum/internship, I had experiences working with racially diverse clients." Another 27.8% of respondents indicated that they somewhat agreed with the statement, which means that approximately 90% of the clinical social workers who responded to this survey worked with racially diverse clients in their MSW training. When asked about adequate supervision and training working with racially diverse clients, the number dropped somewhat, with only 16.7% indicating that they strongly agreed and 48.1% indicating that they somewhat agreed with the statement. In reference to these statements, one clinician commented, "In both of my practicum placements, there was a large percentage of supervisors/trainers who were people of color. This helped tremendously in my training."

In response to the more general assessment of MSW education and training for working with racially diverse clients, 22% of participants strongly agreed, 40.7% of participants somewhat agreed, and 20.4% of respondents felt neutral about the statement: "My MSW adequately prepared me to work with clients of different races." In reference to professional training about working with a racially diverse clientele, over 85% of all respondents indicated that they have taken workshops or trainings about cross-racial clinical work as a professional. In the comment box following these statements, one participant remarked, "I have been doing multicultural work since the 1960s. I have learned by experience."

Racial identity

Some interesting findings emerge when the clinician respondents were surveyed about elements of their racial identity, something that is shown to affect client perceptions of cultural competence and has an influence on the cross-racial therapeutic relationship. When questioned about the statement, "I am aware of my racial identity and how it impacts my interactions with persons of a different identity," all respondents agreed, with over 64% indicating that they strongly agreed and 33% participants indicating that they somewhat agreed with the statement. The results were similar when asked the degree to which clinicians agreed or disagreed with the statement, "I am aware of prejudices or stereotypic beliefs learned from childhood and how it impacts my work with persons of a different racial identity." Again, 64% strongly agreed with this statement while 31% somewhat agreed and 1 participant indicated that s/he felt neutral about the statement. Finally, clinicians were asked to respond to the statement, "I feel skilled and comfortable working clients of different races." Over 92% agreed with this statement, with approximately 40% of the participants designating that they strongly agreed and over 50% somewhat agreeing. Seven percent of participants felt neutral about the statement. One participant commented, "I have tried to continue to be aware of my prejudices and work from the perspective that this is a long learning process." The limitations of these findings will be discussed in the following chapter.

Cross-racial dyad

When asked, "How do you decide with which clients you should discuss racial differences?" respondents were given five statements from which to choose. They were asked not to pick more than two that best describe their approach. The most common

response by 19 participants was to the statement, "I only discuss racial difference after the client raises the issue." Another 16 clinicians identified with the statement, "I discuss racial difference after a client identifies him/herself as being racially different from me." A somewhat common response by 13 clinicians was to the statement, "I discuss race with every client, regardless of how they present." Another somewhat common response by ten respondents was to the statement, "I discuss racial difference with those clients who appear different from me." Finally, the least common response indicated by four clinicians was to the statement, "I rarely, if ever, discuss the issue of racial difference with my clients."

Factors in the therapeutic process

Clinicians were asked to indicate, on a 6-point Likert scale ranging from Very Important to Very Unimportant, the level of influence of certain therapeutic factors on their decision to initiate discussions about racial difference with their racially-different clients. Clinicians considered two factors as being "Very Important" influences on their decision to initiate conversations about racial difference: if the goal of treatment is related to race and if the client makes a racist comment. Twenty four clinicians (49%) characterized "If the goal of treatment is related to race," as a very important influence on their decision. Notably, the next most popular choice was from seven clinicians (14.3%) who considered the relationship between the goal of treatment and race as unimportant. Participants generally considered "If the client makes a racist comment" as having a strong influence, with 23 participants (47.9%) considering it very important, 12 clinicians (25.0%) characterizing it as important, and another 9 clinicians (18.8%) considering it somewhat important.

Those factors that were generally considered to have an "Important" influence on a social work clinician's decision to initiate discussions about race were the strength of the therapeutic alliance, the client's diagnosis or presenting problem, and when the clinical work does not seem to be going well. The strength of the therapeutic alliance was thought to be important by 23 respondents (47.9%), very important by 9 clinicians (18.8%), and somewhat important by another 10 clinicians (20.8%), accounting for the vast majority of survey participants.

The length of the clinical relationship was felt to be somewhat important by 24 clinicians (50%) as was addressing race as a routine part of the intake process. The only issue considered by more clinicians to be an unimportant influence on their decision to discuss race was if the client had not raised the issue in a given period of time. Eleven participants (22.9%) considered this issue to be somewhat unimportant, and an additional 8 clinicians (16.7%) deemed it an unimportant influence.

The social work clinicians were then surveyed about the therapeutic factors that contributed to their decision not to discuss race with their racially-different clients. No one factor stood out as being a very important influence in the respondents' decision not to discuss racial differences with their clients. However, certain elements were considered to be important in affecting their decision. A lack of a therapeutic alliance was identified as carrying the most weight when clinicians do not discuss race with their clients. Of the 49 total participants who responded to this set of questions, 16 clinicians (34%) considered a lack of a therapeutic alliance as an important influence while another 16 clinicians (34%) characterized it as somewhat important. Similar numbers emerge when clinicians considered the severity of the diagnosis, which 16 clinicians (32.7%)

characterized as important and another 13 clinicians (26.5%) felt was somewhat important.

When race was not related to the presenting problem, the majority of respondents felt that it influenced their decision not to discuss race with their racially-different clients. This factor was identified as being an important influence for 13 respondents (26.5%) and somewhat important for another 13 respondents (26.5%). There were more evenly dispersed answers when participants looked at the influence of a short clinical relationship and a preference to focus to focus on similarities rather than differences. A short clinical relationship was felt to be somewhat important for 15 clinicians (31.3%), important for 8 clinicians (16.7%), somewhat unimportant for 10 clinicians (20.8%), and unimportant for 7 clinicians (14.6%).

The factor that clinicians felt to have the least impact on their decision to discuss race with their clients was their own discomfort as a clinician to discuss race. Eleven participants (22.9%) characterized their discomfort as being unimportant. An additional nine clinicians (18.8%) felt their discomfort was a somewhat unimportant influence and seven clinicians (14.6%) considered it a very unimportant influence. However, ten clinicians (20.8%) did identify it as a somewhat important influence and another four clinicians (8.3%) characterized their discomfort as an important influence on their decision not to discuss race.

Perceived effects

In the final matrix of questions, participants were asked to consider the general effect of discussing race, of not discussing race, and of racial difference on three elements of the therapeutic relationship: the therapeutic alliance, treatment success, and treatment

retention. The responses were given on a 5-point Likert scale ranging from a very positive impact to a very negative impact. In the instances in which they did discuss race with their clients, 32 clinicians (68.1%) considered the effect to be generally positive. Another 13 clinicians (27.7%) considered the effect to be generally very positive and 2 respondents (4.3%) felt there was no impact. Not one respondent found the general impact of discussing race to be negative. In those instances in which clinicians did not discuss racial difference with their clients, 21 (44.7%) clinicians indicated that there was no impact while 13 clinicians (27.7%) perceived a somewhat negative impact. Another 8 clinicians felt there to be a somewhat positive impact in the instances in which they did not discuss racial differences.

The responses to the questions about the general impact of racial difference on the therapeutic alliance, treatment success, and treatment retention, the answers were more dispersed. However, clinicians considered racial difference to generally have no impact or a somewhat positive impact on these aspects of treatment. In the comment box offered for optional comments following this set of questions a number of participants noted the difficulty making generalizations about their cross-racial relationships as one case may be impacted in an entirely different way from another. One clinician wrote, "I believe there is an impact but I can't make one general statement of the direction of its impact."

Qualitative data

A qualitative question was included in the survey to complement the quantitative data. Participants were asked to reflect on their general approach to working cross-culturally. Of the 56 clinicians who entered the survey, 43 participants responded to this question. A few major and some minor themes emerged from the answers to this

question. A theme was considered major if it appeared in 10 or more of all responses (approximately 25%) while a minor theme was considered if it appeared in 4 or more (10%) of the answers.

Three major themes emerged in the participants' responses to the question, "What is your general approach to working cross-culturally?" One major theme to emerge from the responses was the approach of bringing up, or addressing, cultural differences in the clinical setting. Seventeen participants talked about bringing up, acknowledging, or addressing race and cultural when working cross-culturally. For example, one clinician stated, "I bring into the room the fact that we are of different races or cultures in the session." There was variance among these responses in that some clinicians specifically noted discussing difference early in the therapeutic work. One participant wrote, "I open the topic of difference in the first interview and ask whether the clients are initially feeling comfortable or somewhat less than comfortable with me, indicating that they are entirely free to be frank about this with no penalty." Others only initiated conversations about race and/or culture when something problematic arose. For example, one respondent commented, "When my questions or comments don't seem to be well received or understood, I acknowledge the difference in cultures. I might inquire about the impact of client's culture on the issue at hand."

Another major theme that emerged from the responses was clinicians' inclination to investigate how race relates to the client's presenting problem. One participant wrote, "My approach is to treat the issue [race] as part of what brings someone into treatment, or what makes treatment with me easier/harder, and what that person's race (and culture) have to do with their presenting problem or with their treatment seeking…" Like this

participant, a number of respondents considered the impact of both culture and race. Another clinician wrote, "I bring up the issues of 'race' when it appears appropriate or I can see a connection with my patient's presenting problem."

The third major theme present was clinicians' asking specific questions about their client's culture, customs, and background in order to better understand their clients. Of the twelve respondents who cited asking their client's questions about their culture, one clinician wrote, "My rule of thumb is to inquire about a patient's social and family customs, especially as I sense that they are further from mine and my knowledge." Another respondent commented, "I ask for clarification of ethnic/cultural issues. I am willing to learn from clients about things I don't know regarding their ethnicity/culture."

A minor theme emerged in these responses that clinicians also tried not to make any assumptions and instead inquired about their client's culture. For example, one social worker wrote, "Don't assume anything. Always ask and see what their cultural beliefs are." Related to this point of view are the responses a few participants who highlighted the importance of treating the client as an individual. One clinician commented, "I think everyone's experience of their race is so different…You have to draw on your client's individual experience of what it means to be from their particular back ground and how it impacts them." Other comments worth noting are the importance of doing one's "own work," to learn about different cultures, attend trainings, and understand one's own culture and racial identity.

Inferential statistics

Inferential statistics were used to compare differences between the answers of respondents in two or more groupings. For this, the participants' characteristics were

grouped into three different categories so as to compare their answers: time period of graduate training, years of clinical experience, and clinician race.

Time period of graduate training

In order to compare the experiences of participants who graduated from their Master in Social Work programs during different time periods, Oneway Anovas were run in order to see if there were significant differences. Respondents were divided into six categories based on the time period of their graduate training: before 1960, 1961 to 1970, 1971 to 1980, 1981 to 1990, 1991 to 2000, and 2000 and after. A significant difference was found when comparing the responses to whether participants took classes on multicultural counseling (F(3,49)=3.604, p=.020). A Bonferroni post-hoc test indicated the significant difference was between those who graduated in the 1970's (m=3.13) and those who graduated in the 1980's (m=1.40). This suggests that those who graduated in the 1970s did not agree as strongly with the statement, "During my MSW program, I took classes on multicultural counseling."

There was also a significant difference by graduation period (F(3,49)=4.403, p=.008) when asked about clinicians' experience in their MSW internships with racially diverse clients. A Bonferroni post-hoc test indicated the significant difference was between those who graduated in the 1970's (m=2.50) and those who graduated in the 1980's (m=1.30), in the 1990's (m=1.47), and in 2000 or later (m=1.30). In other words, the mean response of those who graduated in the 1970's was significantly different than all three other groups, which indicates that graduates from the 1970s agree significantly less when compared with graduates from all other groups to the statement: "During my MSW practicum/internship, I had experiences working with racially diverse clients."

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No significant difference emerged when participants were asked about the adequacy of supervision and training on working with diverse clients. However, there was also a significant difference by graduation period ($F_{(3, 49)}=3.698$, $p=.018$) when asked the level to which they agreed with the statement "My MSW program adequately prepared me to work with clients of different races." A Bonferroni post-hoc test indicated the significant difference was between those who graduated in the 1970's (m=3.50) compared with those who graduated in the 1980's (m=2.00), in the 1990's (m=2.20), and in 2000 or later (m=2.20). Again, the mean response of those who graduated in the 1970's was significantly different than all three other groups indicating that graduates from the 1970s felt much less confident about the degree to which their graduate programs prepared them for working with a diverse clientele.

Clinicians' years in clinical practice

In order to compare the responses of clinicians by their number of years in clinical practice, clinicians were grouped in five categories: Clinicians working in clinical practice for 0 to 5 years, for 6 to 10 years, for 11 to 20 years, for 21 to 30 years, and for 31 or more years. Due to the small number (n = 3) of clinicians who identified as having practiced 31 or more years, their data was removed from the analysis. Oneway Anovas were run to determine if there was a notable difference in the responses of the remaining four groups.

There was a significant difference by years in clinical practice ($F_{(3,45)}=3.243$, $p=.031$) when asked about the level to which participants agreed with the statement, "As a professional, I have taken workshops/trainings that specifically address working with racially diverse clients." A Bonferroni post-hoc test indicated the significant difference

was between those who had been in practice 0-5 years (m=2.21) and those who were in practice between 21 and 30 years (m=1.25), suggesting that that newer clinicians agreed less strongly with the statement than did clinicians with 21 or more years of clinical experience. There was no significant difference found by years in clinical practice when looking at any of the other variables.

Clinicians' race

The final group for comparison was between White clinicians and clinicians of color. Due to the small number of clinicians in each racial category other than Caucasian, clinicians were divided between White clinicians and those from all other racial categories. T-tests were run to determine if there was a difference in the mean response. No significant differences were found when comparing the answers of these groups when participants were asked about their racial identity awareness and its impact, their awareness of prejudices and stereotypic beliefs, and their level of skill and competence when working with racially different clients.

T-tests were also run to compare the groups' responses to the question that asked clinicians about the therapeutic factors that affect whether or not they discuss race with their clients. For each of these, respondents who indicated "Not applicable," had their responses removed so they did not affect the mean.

There was a significant difference by the race of the clinician (t(41.253)=-2.543, p=.015, 2-tailed). The clinicians of color had a lower mean (m=1.8) than the Caucasian clinicians (m=2.37). Since a lower mean indicates greater importance, this data suggests that the clinicians of color said that the "length of the therapeutic relationship" was more important than the Caucasian clinicians. There was no significant difference in the other

variables that affected whether a clinician initiated a conversation about race with their racially different clients.

When asked about the factors that influence a decision not to discuss race with their clients, there was also a significant difference found by the race of the clinician $(t(41)=-2.250, p=.030, 2\text{-tailed})$ regarding the importance of a short clinical relationship on their decision not to discuss race. The clinicians of Color again had a lower mean $(m=2.69)$ than the Caucasian clinicians $(m=3.57)$, which indicates that clinicians of Color felt a short clinical relationship carried more importance than White clinicians. There was no significant difference in any of the other variables.

The implication of these findings, and the strengths and limitations of this data will be discussed in the following chapter.

CHAPTER V

DISCUSSION

Current findings and previous literature

This study attempted to gain insight into both clinician characteristics and

therapeutic elements that influence a clinician's decision to discuss or not to discuss race

in the cross-racial therapeutic dyad. Currently, there is a dearth of studies that specifically

look at the factors that influence clinicians' decision to discuss or not to discuss racial

differences. One notable exception is research done by Maxie et al. (2006) that addresses

the general question of whether therapists address ethnic and racial differences in cross-

cultural psychotherapy. As part of their study, participants were also surveyed about the

reasons for addressing racial and ethnic difference with their clients. The most frequent

reason for bringing up racial difference related to times when respondent's presenting

problem related to race. This is similar to the results of this study in which 49% of

respondents felt that when the client's presenting problem relates to race, it was more

likely that they would initiate discussions about race.

Maxie et al.'s study (2006) also asked therapists about their level of comfort and

skill addressing racial difference. Almost all clinicians reported a general level of comfort

and skill addressing racial difference. Again, there is consistency between the results of

Maxie et al.'s study and the findings of the current study in which approximately 40% of

participants strongly agreed and over 50% somewhat agreed with the statement, "I feel

skilled and comfortable working clients of different races."

However, these findings are not consistent with the qualitative study by Knox et al. (2003) in which European American therapists generally acknowledged discomfort when addressing race with their racially-different clients. The results of Knox et al.'s study are more in line with this researcher's hypothesis that clinicians, particularly White Clinicians, feel some level of discomfort and ambiguity as to how to address racial difference in cross-racial work. It is possible that the qualitative method used in that research allowed clinicians to reveal instances in which they felt discomfort rather than needing to make a general statement about their comfort and skill level.

Additional articles that address the issues of cross-racial therapy on a theoretical level include Cardemil and Battle (2003) who ask clinicians to get comfortable with conversations about race and ethnicity in psychotherapy and offer concrete suggestions about how to initiate such a dialogue with clients. For example, Day-Vines et al. (2007) relate broaching the subjects of race, ethnicity, and culture in counseling practice with a clinician's level of racial identity development, and stress the importance of discussing cultural differences. In addition, La Roche and Maxie (2003) offer ten considerations for clinicians when addressing cultural differences in psychotherapy that illustrate the complex issues involved when working across difference in the therapeutic relationship. Similarly, in their chapter on clinical implications, Miller and Garran (2008) address the myriad factors, including the acuity of the client's presenting problem, the strength of the therapeutic alliance, and treatment goals that may be helpful to consider when engaging in cross-racial therapy. Finally, Vasquez (2007) considers the relationship between cultural differences and the therapeutic alliance and concludes that the formation of a therapeutic alliance with ethnic minority clients may require special considerations.

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Such studies help inform the findings of the current research by highlighting the importance of considering dialogues about racial difference as a concrete way to facilitate the cross-racial therapeutic dyad. Furthermore, they offer support for critical thought and investigation about the issues that can help and hinder an effective cross-racial working relationship. The literature on working across difference in therapy also signals that racial and ethnic differences matter. However, it is less clear how to effectively support and facilitate a successful cross-racial therapeutic experience. Given the sensitivity with which race is often handled in public discourse, it is imperative that the counseling field, beginning with graduate training programs, openly address and critically examine the elements that help and hinder the therapeutic process for cross-racial work.

Graduate training

Other interesting findings that emerged include a confirmation that graduate training programs have improved their offering of classes on multicultural counseling and provide training experiences with a diverse clientele. Over 60% of respondents agreed, on some level, that their graduate program adequately trained them to work with a racially diverse clientele. The inferential data provides more details about this set of answers. Those clinicians who graduated in the 1970s responded significantly differently from all other groups. They did not feel as confidently that their graduate programs adequately prepared them to work with a diverse clientele when compared with clinicians who graduated during 1980s to the present. This group of participants who graduated from their masters in social work programs during the 1970s also did not agree as strongly with the statement, "During my MSW practicum/internship, I worked with racially different clients," as did the clinicians who graduated in subsequent decades. The

inferential data did not highlight any other significant differences in the remaining survey responses.

Clinicians' race

In terms of differences in the responses of clinicians by racial category, the length of the clinical relationship was the only therapeutic factor that noted a significant difference between clinicians of Color and White clinicians. Clinicians of Color deemed the length of the therapeutic relationship more important than White Clinicians. Similarly, clinicians of Color felt that a short therapeutic relationship carried more importance when choosing not to discuss racial difference than did the White respondents. There are no other studies to explain the possible reasons for a significant difference to emerge about this therapeutic factor, which may indicate a need for further inquiry to examine the reasons why the length of the therapeutic relationship carries more weight for clinicians of Color when compared with White clinicians.

<center>*Strengths and limitations of the study*</center>

There are a number of limitations and strengths of this study. A primary limitation is that this study relied only on self-report for data about clinicians experience working across racial difference in the therapeutic encounter. In addition, the predefined questions and the quantitative nature of study may not have fully captured the complex and nuanced nature of cross-racial work.

An example of where more qualitative data might have illuminated the complexity of cross-racial work is when participants were asked to consider their own level of racial identity awareness. The level to which participants felt confidently about their own level of racial identity development, its impact on their clients, and their skill

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and comfort level working with racially-different clients was surprising. When questioned about the statement, "I am aware of my racial identity and how it impacts my interactions with persons of a different identity," all respondents agreed, with over 64% indicating that they strongly agreed and 33% participants indicating that they somewhat agreed with the statement. The results were similar when asked the degree to which clinicians agreed or disagreed with the statement, "I am aware of prejudices or stereotypic beliefs learned from childhood and how it impacts my work with persons of a different racial identity." Again, 64% strongly agreed with this statement while 31% somewhat agreed and 1 participant indicated that s/he felt neutral about the statement.

Asking therapists about their awareness may limit the validity of the findings because therapists have a purely subjective opinion of their own awareness. The survey did not attempt to measure clinicians awareness using a standardized tool. Furthermore, the survey failed to actually question therapists about the frequency of their discussions about race, which may have highlighted inconsistencies between the therapists' self-perception and their practice with racially different clients. Future studies would be better served to include more than one measurement when surveying clinicians about their racial identity awareness as self-report is inherently biased and may not reveal the clinicians' subconscious influences.

Another set of questions that may have benefitted from more individualized examples were the questions in the survey that asked participants to provide a general sense of their perceived effect of racial differences on the therapeutic alliance, treatment success, and treatment retention. This question was met with resistance by certain participants. In the optional comment box, a number of therapists noted the unique and

individual nature of cross-racial work in which generalizing would not accurately portray their varied experiences. More qualitative data may have been helpful in highlighting the complexities of cross-racial practice.

Sample

Of the 56 social work clinicians who entered the survey, 37 individuals self-identified as Caucasian, which accounts for almost 70% of all respondents. This is a limitation in that the other racial and ethnic categories had to be combined to form one group representing clinicians of Color. Given the varying experiences that exist even within one racial group, it weakens the findings to compare Caucasians with clinicians from such a varied group of races. Perhaps a larger study that better represented clinicians from ethnic minority groups would provide a more solid basis for comparison of the perceptions and approaches between clinicians of different races.

While the racial diversity of the study participants was somewhat lacking, the clinicians represented a wide range of clinical experience and were evenly distributed across graduate time periods. This range of experience and graduate training is useful for comparison purposes and makes the findings more generalizable.

This survey attempted to gain too broad a range of information, which may have diluted the findings somewhat. Future research would benefit from concentration on a more specific population of clinicians or clients. Possible ways of focusing the category would be to survey only White clinicians working with clients of color or, conversely, only clinicians of Color working with White clients. While these findings are less generalizable to the clinical population as a whole, they would likely provide more reliable data.

Design

The use of a survey for this research has both strengths and limitations. A customized survey was created for this survey, which allowed the researcher to inquire specifically about the phenomenon of interest (Anastas, 1999). However, a limitation of a survey that has not been standardized is the question of its validity and reliability.

A major advantage of an online survey is that anonymity can be practically guaranteed. This level of security may allow participants to comment more freely or honestly about their experiences with race. Given the lack of face-to-face communication, clinicians may have felt better about revealing their approach on a subject that is emotionally charged and sensitive.

While self-report is considered an advantage because it allows for anonymity, it is also a disadvantage in that self-report is a person's subjective accounting of their own awareness and may be biased toward what the respondent believes to be the "correct" answer. There may even be some subconscious bias in the data that might be avoided by using a standardized questionnaire, allowing for more validity.

Due to the highly individual nature of cross-racial therapeutic dyads, future researchers may wish to consider formulating a qualitative study to delve deeper into the complexities of working cross-racially. A more mixed-method approach could ask certain questions with predefined answers. This would allow for follow up with qualitative questions that ask participants to elaborate on an exception or a specific example that my illustrate more of the complexities of the cross-racial relationship.

Implications for practice and policy

Some of the findings of this study have implications for social work practice and policy. For example, the most common response to the question, "How do you decide with which clients you should discuss racial differences?" was by indicating that clinicians only discuss racial difference after the client raises the issue. This issue is increasingly discussed in literature on cross-cultural therapy. Cardemil and Battle (2003) note that,

> Others may choose to wait until their clients raise the topic before engaging in such a conversation. Unfortunately, this approach neglects the possibility that many clients will themselves not broach issues related to race and ethnicity for various reasons (e.g., their own discomfort with the topic, being unsure of therapist perspective or bias) (pp. 278).

This opinion encourages clinicians to take the initiative when working cross-racially, given the resistance clients may also have in bringing up the topic of race.

However, in response to the qualitative question, one clinician commented, "What has changed in my practice is that I don't always bring up racial difference any longer. I noticed that for a while it seemed to be more of my agenda than theirs." This participant raises a valid concern that is likely shared by other clinicians when grappling with the decision to initiate racial difference with clients. Future researchers may wish to examine the perspectives of clients when clinicians initiate conversations about race.

Recommendations for future research

While the field of cross-cultural therapy is ever-expanding, the literature that looks at the impact of cross-*racial* therapy and the efficacy of certain therapeutic elements is still relatively small. Given the skill and comfort with which most of the clinicians in this study feel about their work with racially diverse clients, additional

research on both clinicians' perspectives about working cross-racially as well as their approach to practice may shed light on the concrete techniques that facilitate the cross-racial working relationship. Furthermore, research that incorporates a standardized measure to corroborate or contest clinicians' perceptions of their comfort and skill levels might also illuminate inconsistencies in clinicians' self-concept allowing for further discussion. Given the importance of racial identity development for clinicians, it would also be useful to study graduate training programs in detail and examine if and how racial identity development is incorporated into the curriculum.

The research shows (Bachelor, 1995; Horvath, 2005) that clients more accurately assess the nature of the therapeutic alliance when compared to treatment success than do clinicians or third-party observers. Therefore, research that incorporates the voice of clients, particularly individuals from marginalized or underserved populations, will likely offer more tools that are effective with clients. Given that people of color are more likely to terminate therapy prematurely (Constantine, 2007; Day-Vines et al., 2007; Maramba & Hall, 2002), surveying clients of color about the elements that may carry more or less weight in determining treatment success would be clinically useful for clinicians of all races.

It is clear to this researcher that continued exploratory research about cross-racial work is still necessary to illuminate the unique aspects of this therapeutic relationship. A focused sample of clinicians or clients from a specific racial group would give added weight to the findings and an open, qualitative study would allow for the complexity to emerge that is inherent in therapeutic work. This seems particularly true in work that

involves racial difference due to the both conscious and subconscious meanings individuals and society ascribe to those differences.

Conclusion

As the United States becomes increasingly more diverse, it becomes imperative that the counseling professions address the elements in cross-racial therapy that help and hinder the therapeutic process for clients of all races and ethnicities. Due to the emotionally-charged and often sensitive nature of race, assisting clinicians of all levels of experience with approaches and tools to facilitate cross-racial therapy will become not only valuable but necessary.

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Appendix A

Human Subjects Review Application:

What are the factors that influence whether a clinician discusses race in the cross-racial

therapeutic encounter?

Project purpose and design

The purpose of this study is to explore how clinicians address racial differences in the clinical encounter. This research aims to gather information about clinicians' experience working with clients of a different racial background, specifically looking at clinicians' process of engagement with their clients of a different race. Particular attention will be paid to examining the factors that influence a therapist's willingness to initiate conversations about race in the clinical encounter. Possible influences include clinician's race, years in practice, graduate education, and professional training. This researcher hypothesizes that clinicians generally do not discuss racial differences in the cross-racial encounter nor are clinicians necessarily aware of the consequences of not addressing racial difference when working with a client of a difference race. Furthermore, this researcher hypothesizes that therapist characteristics such as race, graduate training, and years in clinical practice will influence whether a clinician does or does not address racial difference in the cross-racial therapeutic dyad.

This study intends to survey clinical practitioners who have received a masters degree in social work and who have worked with clients of a different race. This study will be conducted online through Survey Monkey. Using an online survey will be both a limitation and a strength as it will limit access to those who are not computer literate or do not have access to a computer; however, for those who are connected to online

networks it will be an easy way to complete an anonymous survey. The data collection

will include both pre-defined questions that ask clinicians about their perceptions and

engagement process when working with clients of different races. The study will also

provide comment boxes throughout the survey so that clinicians may elaborate on a given

question, and the responses to these questions will provide some limited qualitative data.

First, the survey will ask participants to reveal information such as race, years in

clinical practice, and the time frame of graduate school graduation. This information will

allow survey results to be grouped for comparison in these categories to ascertain if any

notable differences exist in the responses when grouped based on race, years in practice,

and graduate training. The research questions will then attempt to gather information

about participants' professional training and experience working with individuals across

racial difference. Research questions will subsequently focus on a clinician's process of

engagement if and when racial difference is discussed in the therapeutic encounter.

Finally, the survey questions will ask participants to reflect on some possible effects of

discussing or not discussing racial difference in the clinical encounter. These areas

include the impact on the therapeutic alliance, therapeutic process, as well as treatment

retention when working cross-racially. A complete list of survey questions is included in

Appendix D.

This research aims to identify any patterns in how therapists approach a complex

and delicate topic. Particular interest will be paid to comparing the responses and optional

commentary of white clinicians with those of clinicians of color. This survey will also

evaluate differences in the questionnaire responses between clinicians trained in recent

years, when cultural competence may have had a more prominent role in MSW curricula,

to those who graduated from MSW programs in past decades. Additional years of experience may also affect clinicians' general sense of ease at raising complex topics in the therapeutic dyad, which may impact discussions on race.

The information gathered through the survey will be used in partial fulfillment of the requirement for the master of social work degree at Smith College School for Social Work. The information will also be presented to members of the Smith College SSW student body and may be used in other educational activities or publications.

This research is important to the field because of the growing cultural diversity in the United States. According to U.S. Census projections, Caucasians will no longer maintain a majority in the U.S. population by the year 2020. It is likely that the field of social work will continue to be dominated by white clinicians for some time, and thus the frequency of cross-racial counseling is likely to increase. Given the complexity of race and racism as both a social and personal experience, whether or not a clinician directly addresses race in the clinical encounter may impact the effectiveness and cultural competence of treatment.

While there are numerous texts dedicated to working cross-racially, many of them use case studies to illustrate the issues that arise in the interracial therapeutic relationship. This study will attempt to gather quantitative data about a larger number of clinicians that may shed light on patterns of engagement in certain groupings of clinicians. The information gathered in this process will contribute to the discussion about cross-racial therapy and illuminate one aspect of working with individuals of a different race.

The characteristics of the participants

The purpose of this study is to gather information from clinical social workers about the process of engagement when discussing race with clients who are racially different from the clinician. Therefore, the primary criteria for candidates to participate in this research study are individuals who have obtained their masters degree in social work and who are working in a clinical setting. Also, participants must have worked with clients of a different race and be willing to reflect and comment on their experience. The survey does not exclude participants based on race or ethnicity, age range, or agency affiliation. On the contrary, diversity of race, level of experience, geography, and agency is welcomed. At a minimum, 45 to 50 clinicians who meet the outlined criteria are expected to participate.

The recruitment process

This survey will be circulated to LCSW clinicians and MSW contacts of the researcher. In addition, the survey will be posted on Facebook, an online networking website that has various forums for social workers as well as in the forum section of *The New Social Worker Online,* an online resource for social work students and professionals.

Additional participants will be recruited through a snowball method. In other words, interested participants will be asked to forward the email and survey to clinical social workers who may also be interested in participating in the research. A drawback to the method of snowball recruitment is that diversity cannot be guaranteed. However, every effort will be made to seek out diverse contacts for participation. For example, initial contacts will include student members of Smith's Council for Students of Color as well as a group of clinical social workers of color known by the researcher. In addition,

the researcher has outreached to contacts at both the National Association of Social Work and the California Chapter for additional contacts and listservs that will increase the likelihood of a diverse sample of survey participants.

All recruitment material is electronic and, therefore, the majority of recruitment will occur via email with minimal recruitment occurring verbally through contacts. The recruitment letter is included in this application in Appendix C.

Individuals will be asked to complete the survey only if they meet the outlined criteria, which will be listed in the recruitment letter. Therefore, participants will not be formally screened by the researcher before having access to the survey. Those participants who identify in their qualitative responses that they do not meet the participation criteria (e.g., not yet graduated from an MSW program) will have their answers removed from the survey so as to protect the reliability of the data.

The nature of participation

Participants will be asked to reflect on their experience working with clients from a different racial background and answer a series of questions. The survey questions will ask participants about their graduate and professional training as well as their experience working across racial difference. Participants will also be asked share about their internal processes when working with clients of a different race. Demographic information will also be collected in order to compare the experiences of participants of different racial backgrounds, levels of experience, and graduate programs.

Information will be collected solely through the online survey and not through personal contact. The survey questions do not collect identifying information and therefore personal contact is not possible. Each question will have a box for comments in

the case that participants would like to elaborate on their survey responses. Participation will require a commitment of approximately 5 to 15 minutes, exclusive of qualitative commentary by participants. The data will be processed through Survey Monkey, the online instrument used to collect the data. Analysis of the online submissions will also happen through Survey Monkey as well as with the assistance of Marjorie Postal, Smith's research consultant.

Risks of participation

The principal risk for participating in the study is likely to be minimal; however it is possible that individuals may experience complex and difficult emotions while reflecting on their clinical work. This risk is outlined to participants in the recruitment letter as is the voluntary nature of participation in the research is also highlighted. It is also stressed that all identifying information will be kept confidential.

Benefits of participation

There are a number of potential benefits of participating in this research project. Clinicians will have the opportunity to share about their experience working with racially different clients. The participation of clinicians who have worked with racially diverse clients can add to limited research currently available about addressing race in the clinical encounter. Finally, collecting data about the experience of clinicians working across racial difference may also help increase understanding about one aspect of cross-racial therapy. No monetary or concrete benefit will be provided to research subjects.

Informed consent procedures

All communication with survey participants will occur through the internet and email. Therefore, individuals will be notified that by completing the survey they are

consenting to participate in the survey. Survey Monkey does not collect any individual information from participants, making identification of subjects unfeasible.

Any future presentations will be prepared so that participants cannot be identified. The quantitative data gathered from the questionnaire will be presented in aggregate. Qualitative data and illustrative vignettes will be disguised so as to protect the identity of participants. The data provided will be stored in a locked file for a minimum of three years as required by Federal regulations. After that time the information will be destroyed or continued to be secured in a locked cabinet as long as needed. The introduction letter (Appendix C) outlines the precautions taken to safeguard confidentiality and identifiable information.

Appendix B

Human Subjects Review Committee Approval Letter

February 15, 2008

Ann Goett

Dear Ann,

Your revised materials have been reviewed and your materials are in excellent shape. We are happy to give final approval to your very interesting study.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent 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.

Good luck with your study and with the recruitment. Recruitment is at least half the battle and does demand a lot of work.

Best regards,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Alan Schroffel, Research Advisor

Appendix C

Informed Consent Letter

Dear Survey Participant:

My name is Ann Goett. I am a Smith College School for Social Work student and I am conducting a survey of social work clinicians to learn more about the ways therapists address racial difference in the therapeutic dyad. This study is being conducted in partial fulfillment of the requirements for the master of social work degree at Smith College School for Social Work.

You are being asked to participate in this study if (a) you obtained a master in social work (MSW) degree from an accredited social work graduate program, and (b) you have worked with adult clients of a different race in a therapeutic setting. As a subject in this study you are being asked to participate in an anonymous online survey. The online questionnaire should take approximately 5-15 minutes to complete, exclusive of any comments you choose to make. Additional comments about your personal experience will take more time but both you and the research will likely benefit from your reflections.

Your participation is voluntary. You will receive no financial benefit for your participation in the study. However, you may benefit from knowing that you have contributed to the knowledge of understanding if and how clinicians approach issues of racial difference in the therapeutic dyad. It is my hope that this study will help social workers and other clinicians have a better understanding of one aspect of cross-racial therapy.

A potential risk of participating in this study is the possibility that you might feel some discomfort while reflecting on and sharing about your experience.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Unless you choose to identify yourself in the survey, your survey responses will be completely anonymous. The data provided will be stored in a locked file for a minimum of three years. Your anonymous data may be used in other educational activities or publications, as well as in preparation for my master's thesis.

This study is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study by exiting the online survey at any time. However, once you have completed the survey, you will no longer be able to withdraw from this study as your responses are anonymous and there would be no way to identify your particular survey.

If you have questions about this survey, please contact me by email at xxxx@smith.edu. You may also contact the Chair of the Human Subject Review Committee at (413) 585-xxxx.

By entering this survey, you are indicating that you have read and understand the above information and that you have had an opportunity to ask questions about the survey, your participation, and your rights and that you agree to participate in the survey.

Thank you for considering participation in my study.

Sincerely,

Ann Goett
MSW Candidate

Appendix D

Survey Questions

Demographic and Background Information

1.   How do you self-identify your racial and/or ethnic background?

        □ African American
        □ Asian
        □ Caucasian
        □ First Nations/Native American
        □ Latino/a
        □ Middle Eastern
        □ Multiracial (please specify in comment box)
        □ Racial/ethnic identity not listed above (please specify)

2.   During what time period did you graduate from your Masters in Social Work program?

        □ Before 1960
        □ 1960 – 1969
        □ 1970 – 1979
        □ 1980 – 1989
        □ 1990 – 1999
        □ 2000 or after

3.   How many years have you been working in clinical practice?

        □ 0 – 5 years
        □ 6 – 10 years
        □ 11 – 20 years
        □ 21 – 30 years
        □ 31 or more years

4.   In your clinical experience have you worked with a client who identifies as of a different racial/ethnic group from how you identify*?

        *Note: For clinicians who identify as multiracial, please reflect on your work with clients with whom you do not identify racially.

        □ Yes
        □ No

        Comments:

5.   How many years have you worked with clients of a different race or ethnicity?

      □ 0 – 5 years
      □ 6 – 10 years
      □ 11 – 20 years
      □ 21 – 30 years
      □ 31 or more years

6.   In your last year of clinical practice, approximately what percentage of your clients identified as being of a different race or ethnicity than you?

      □ 0% - 20%
      □ 20% - 40%
      □ 40% - 60%
      □ 60% - 80%
      □ 80% - 100%

      Comments:

7.   In a typical month, approximately how many clients of a different race/ethnicity have you worked with?

      □ 0 – 5 clients
      □ 6 – 10 clients
      □ 11 – 15 clients
      □ 16 – 20 clients
      □ more than 20 clients

Graduate School and Professional Training

1.   Please reflect on your graduate school and professional training and experience working with clients of a different racial or ethnic makeup.

Answers on a 5-point Likert scale:

Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree

      a. During my MSW program, I took classes on multicultural counseling.
      b. During my MSW practicum/internship, I had experiences working with racially diverse clients.
      c. During my MSW practicum/internship, I had adequate supervision and training about working with racially diverse clients.
      d. My MSW program adequately prepared me to work with clients of different races/ethnicities.

e. As a professional, I have taken workshops/trainings that specifically address working with racially or ethnically diverse clients.
f. I am aware of my racial identity and how it impacts my interactions with persons of a different racial identity.
g. I am aware of prejudices or stereotypic beliefs learned from childhood and how it impacts my work with persons of a different racial identity.
h. I feel skilled and competent working with clients of different races.

Comments:

Process of Engagement

1. Please describe your general approach to working with clients of different races in the clinical encounter. (If you do not have a general approach to cross-racial therapy, please comment or explain.)

Comment box:

2. How do you decide with which clients you should discuss racial differences? (Please choose up to two statements that best describe your approach.)

    □ I discuss racial difference with those clients who appear different from me.
    □ I discuss racial difference after the client identifies him/herself as being racial different from me.
    □ I discuss race with every client, regardless of how they present.
    □ I only discuss racial difference after the client raises the issue.
    □ I rarely, if ever, discuss the issue of racial difference with my clients.

    Comments:

3. Please consider the importance of the following factors on your decision to initiate conversations about racial difference with your clients.

    *Note: If you do not usually initiate conversations about racial difference with your clients, please choose N/A.

Answers on a 6-point Likert scale:

Very Important	Important	Somewhat Important	Somewhat unimportant	Unimportant	Very Unimportant	N/A

a. Length of clinical relationship
b. Client's diagnosis or presenting problem
c. Goal of treatment is related to race
d. If the client makes a racist comment

     e.   Client has not raised the issue of race for a given period of time
     f.   Strength of therapeutic alliance
     g.   Routine part of intake process
     h.   The clinical work does not seem to be going well.

4.   Please consider the importance of the following factors when you choose NOT to discuss racial difference in the clinical encounter.

Answers on a 6-point Likert scale:

Very Important	Important	Somewhat Important	Somewhat unimportant	Unimportant	Very Unimportant	N/A

     a.   Short length of clinical relationship
     b.   Severity of diagnosis or presenting problem
     c.   Race is not related to the goals of treatment
     d.   Lack of therapeutic alliance formed
     e.   Client has not brought up racial difference
     f.   My discomfort as a clinician to discuss race
     g.   Preference to focus on similarities rather than differences

    Comments:

Perceived Effect

1.   Please reflect on the effect of racial/ethnic difference on various aspects of the therapeutic process.

Answers on a 5-point Likert scale:

Very positive	Somewhat positive	There is no impact	Somewhat negative	Very negative	NA

     a.   In the instances in which I do discuss the racial difference with my clients, I perceive the general effect on the therapeutic alliance to be…
     b.   In the instances when I do not discuss the racial difference with my clients, I perceive the general effect on the therapeutic alliance to be…
     c.   In my experience the effect of the racial difference on the formation of the therapeutic alliance is generally…
     d.   In my experience the effect of racial difference on treatment success is generally…
     e.   In my experience the effect of racial difference on clients staying in treatment is generally…

    Comments: