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**“IN OUR OWN WORDS”: THE PHENOMENOLOGICAL
EXPLORATION INTO THE AFRICAN AMERICAN EXPERIENCE OF
RELATIONAL THERAPY WITH WHITE THERAPISTS**

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ABSTRACT

The consideration of one's cultural context is a critical component of systemic therapy. Marriage and family therapy literature underscores this importance with a wealth of information on working with various diverse family systems. The literature has not adequately reflected the voices of the African American client. The purpose of this study was to understand the African American experience in relational therapy with White clinicians. Phenomenological methodology was employed via semi-structured interviews with eleven participants across the United States. The findings revealed three themes (*lived experiences of African Americans, lack of culturally responsive clinical practice, and what works in therapy*). The data also culminated in a formula that demonstrates the failure to practice through a culturally responsive lens. Inversely, a second, corrective, formula was proposed to attend to the cultural context of the client. There was agreement on what made treatment a positive experience which clustered around the character of the therapist, the therapist's regard and respect for the client, and the level of skill demonstrated as part of the therapeutic work. Clinical recommendations include a more systemic approach to training therapists. Training from both a social justice and a self of the therapist lens is important as it allows clinicians to understand their impact. In systems theory, clinicians become a part of the client system to create a context in which change can occur (Becvar & Becvar, 2013). If a clinician does not understand themselves within the context of social justice dynamics, they risk subjecting their clients to the same injustices in therapy as they face consistently in their day to day lives. To ensure effective, culturally responsive clinicians in training, other levels of the system need to engage beyond administrative, fiduciary, and gatekeeper duties.

“IN OUR OWN WORDS”: THE PHENOMENOLOGICAL EXPLORATION INTO THE
AFRICAN AMERICAN EXPERIENCE OF RELATIONAL THERAPY WITH WHITE
THERAPISTS

BY

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Dissertation

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in
Marriage and Family Therapy

Syracuse University
December 2017

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Dedication

I dedicate this work to Dr. Diane Estrada. You were the gift I didn't know I needed. I simply could not have finished without you. Thank you for every reminder, nudge, hug and redirection.

Table of Contents

| | |
|---|-----|
| Abstract | i |
| Title Page | ii |
| Copyright Notice..... | iii |
| Acknowledgements..... | iv |
| Dedication | v |
| Table of Contents..... | vi |
| Chapter One: Introduction | 1 |
| My Experience with White America | 1 |
| Historical Perspective | 3 |
| Carla..... | 6 |
| Anne Moody | 7 |
| Description of the Problem | 9 |
| Purpose of the Study | 10 |
| Operational Definitions..... | 11 |
| Chapter Two: Literature Review | 16 |
| African American Belief System | 17 |
| Group Needs over Individual Needs and Social Black Identity | 17 |
| Differences across Age Groups | 18 |
| Black Identity..... | 20 |
| Racial Group Identity..... | 20 |
| Social Status, Moral Development and Identity | 21 |
| Black Identity and Invisibility | 24 |

| | |
|---|----|
| Rage in the African American Community | 26 |
| Support Systems and Well-Being | 30 |
| Coping with Racism and Discrimination | 30 |
| Stigma Management vs. Black Identity | 32 |
| Self-Esteem and Coping | 34 |
| Cultural Mistrust | 35 |
| Therapist Bias and Awareness of Privilege | 39 |
| Theory and Research on Clinician Stereotypes and Bias | 40 |
| Client-Therapist Ethnic Match and Preferred Styles of Treatment | 42 |
| International Consideration of Culturally Specific Needs | 48 |
| Presenting Problems in Therapy | 49 |
| Theoretical Framework | 51 |
| Story Telling in the African American Community | 51 |
| Multicultural Perspective | 52 |
| Narrative Therapy | 53 |
| Research Question | 54 |
| Chapter Three: Methodology | 55 |
| Phenomenology..... | 55 |
| History..... | 56 |
| Fundamentals of Phenomenology..... | 58 |
| Epoche..... | 58 |
| Self of the Researcher | 59 |
| Role of the Researcher and the Participant | 63 |

| | |
|--|----|
| Sampling | 63 |
| Data Collection | 66 |
| Trustworthiness..... | 66 |
| Data Analysis | 69 |
| Participants..... | 71 |
| Kathy..... | 72 |
| Debbie..... | 72 |
| Fredrick..... | 73 |
| Juanita..... | 73 |
| Melinda..... | 73 |
| Erica..... | 74 |
| Marsha..... | 74 |
| Viola..... | 74 |
| Francis..... | 75 |
| Coreen..... | 75 |
| Dorothy..... | 76 |
| Chapter Four: Findings | 77 |
| Themes..... | 77 |
| Theme One: Lived Experiences of African Americans..... | 78 |
| Differences in daily life experiences..... | 78 |
| The impacts of White privilege..... | 81 |
| The impacts of marginalization | 82 |
| Discretion for self-preservation | 87 |

| | |
|--|-----|
| Theme Two: Lack of Culturally Responsive Clinical Practice | 89 |
| Therapy with White clinicians | 89 |
| Unpacking the infraction..... | 93 |
| Defining culturally responsive clinical practice | 96 |
| Theme Three: What Works in Therapy | 97 |
| Cultural awareness | 98 |
| General clinical skills..... | 105 |
| Therapist qualities..... | 108 |
| Additional Perspective | 111 |
| Summary | 112 |
| Chapter Five: Discussion | 114 |
| Lived Experiences of African Americans..... | 115 |
| Lack of Culturally Responsive Clinical Practice | 119 |
| What Works in Therapy..... | 121 |
| Limitations of the Research | 123 |
| Clinical Implications and Recommendations | 124 |
| Future Research | 127 |
| Conclusion | 129 |
| Appendix A- Consent Form..... | 131 |
| Appendix B- Recruitment Email | 134 |
| Appendix C- Recruitment Letter | 135 |
| Appendix D- Newspaper Advertisement..... | 137 |
| Appendix E- Demographic Questions | 138 |

| | |
|--------------------------------------|-----|
| Appendix F- Interview Questions..... | 139 |
| References..... | 140 |
| Curriculum Vitae | 164 |

Chapter One

Introduction

My Experience with White America

My interest in the study of the African American perspective of therapy stems from the lessons I have learned. I was born and reared in Baton Rouge, LA. My mother, a native of Woodville, MS and my father, a native of Tunica, LA raised my younger brother, sister, and me with stereotypically Black, southern traditional values. Connection with family was imperative, education was critical, and hard work was the only way to get anywhere in life. We always put God first by attending weekly services and becoming active members of the congregation. There were also values that maintained socially painful norms. The man is the head of the household, children are to be seen and not heard. Women were expected to be submissive but were also expected to be strong enough to care for everyone around them and to keep the family together regardless of whether there was a man present or not.

As a child growing up in the South, I quickly recognized the differences between African Americans and the larger White majority. It seemed, through my very young eyes, that they were more financially secure. I thought all White people had a small fortune hidden away. I thought their children were unruly and spoiled as I watched them throw tantrums in stores where I would not dare make such a display for fear of the wrath of my mother. They spoke differently; their version of southern accents seemed strange, foreign.

My experience with White people through most of my primary education was limited as I attended an all-Black, private Catholic school from 1st through 8th grade. It was not until I went to a public high school that I had any significant experiences with White people. While my

perspective broadened during those years, I cannot say that it changed significantly, but rather became more complex.

I have spent the last several years examining my own biases around therapy and the Black community and I have questioned my own assumptions about why we as a community do not seek out therapeutic services as readily as our White counterparts (Constantine, Donnelly, & Myers, 2002). Based on my own upbringing and experiences, I have assumed that we as a community are resistant because of the stigma attached to attending therapy (Li-Repac, 1980). The general consensus I have heard about therapy in my community is “I’m not crazy, what do I need to go to counseling for?”

I have also noticed my own distrust of White clinicians as a microcosm of the White community in general. I learned both overtly and covertly that I should not trust White people. I learned to notice the invisible lines that separated our communities. I learned that their intentions were never for my benefit. I recall direct statements about how White people would always view me as less than them and that I should never trust them with any intimate knowledge, hence the old adage “Don’t air out your dirty laundry.” Because I generalized these lessons, I applied the same mistrust to those who are supposed to be helpful, to those who are supposed to be healers. I applied the same mistrust to White clinicians.

Much of my experience growing up followed “the Village model” in that I was reared by more than my parents and I had resources within my many parent figures who “counseled” me. Also, having been reared in a religious community, there was an expectation that the pastor of your congregation was there to help you through personal counseling issues which might otherwise be treated by a clinician in an office (Allen, Dawson, & Brown, 1989). I began to recognize my own upbringing was rooted in my ancestry. The way I spoke, the way I carried

myself, the way I worshipped, the food I ate, who I considered my support, and who I learned to trust or distrust were all rooted in my ancestry. Similarly, the idea of therapy for the African American client is complex in that there is an historical context that must be considered.

Historical Perspective. When a therapist escorts an African American client into his or her therapeutic setting, there must be an awareness of how large their doorway must be in order to allow, metaphorically that is, for all they bring with them. Imagine the African American client who walks across the threshold to participate in individual, couple or family therapy. When that person crosses the threshold, along with them come the spirits of their ancestry eager to tell their stories. Maybe they will speak of their tribes of origin, their language, their customs, their values, the gods and goddesses they served before christianity (intentionally not capitalized) was forced into their value systems by their enslavers. They might want to speak of the middle passage into slavery where many of them never completed the voyage either due to dehumanizing conditions of filth and disease or due to their refusal to be enslaved; which resulted in a number of suicides throughout the voyages from the bosom of the Motherland to the plantations of the states. Perhaps they would speak of having their native tongues beaten out of them until they were forgotten. Maybe they would want to speak of either being raped and impregnated with the seed of their masters or of feeling powerless to protect their wives as their masters yanked them from their beds to violate them as if they were objects rather than their soul mates. They want to speak about the alleged freedoms they fought for; the abolition of slavery, the right to vote, the right to own their own property, the right to earn wages by some other means than sharecropping. Imagine their infuriated retorts about the lunacy of the notion that humans can own one another.

Perhaps the ancestral spirits want to speak about how time and perseverance has changed so many things and yet so many things have remained the same. Maybe they want to speak about the mindset that continues even in the more recent times; the mindset that deems it acceptable to hang, lynch or otherwise murder at will with no remorse or even fear of consequence. They want to speak about being beaten by clubs, bitten by dogs, and marching in protest with the understanding that their march might end in their death. They want to speak about their need to fight for their lives and their freedom (for what is life without freedom?) by any means necessary (X, 1992).

Maybe the ancestral African American spirits want to speak about how the world today still has so much to learn about what they have been trying to teach us all along. They want to speak of our need to understand the concept of love, not just the love of those we know. Perhaps they will insist on everyone knowing how much they loved their children, their parents, their sisters and brothers, their family, their tribe, their nation, all things known to them. But they may also want to speak of the need to love the people of the world, the need to love the earth and the gifts she shares with us. They want the people of the world to act out of love instead of fear. They want us to know that when one only addresses the act rather than the motive behind the act, one risks the lessons of life never truly being learned, thereby dooming us all to repeat this pattern time and time again.

Imagine perhaps that the ancestral spirits want the therapist to know that when one of us becomes the client embarking on a therapeutic relationship, we have strengths, passions, dreams, desires, and pains that all stem from the history they are so eager to pass onto us all. They beg us to listen, to question, to honor, to sit with the complexity of it all, to “remind” the client of the answer because the reality is they have already whispered this history into our souls. But

sometimes our souls need to be reminded of what we already know so that we can survive and heal ourselves. Maybe they want therapists to remember that our position is not that of healer but one who facilitates those processes that re-awaken the client's own ability to heal themselves. Perhaps they want us to remember that, as clinicians, we are not here to play God but to merely be a conduit for others to access their better selves.

Honoring this request may appear to be a daunting task for clinicians; however, the literature suggests that there are ways to consider the personal circumstances, differences, and values of African American clients (Pinderhughes, 1989; Mayo, 2004; Hardy & Laszloffy, 1995). There is also a wealth of literature on the best ways to train clinicians on working with diverse populations; specifically, African Americans (e.g., Bean, Perry, Bedell, 2001; Ho, 1987; Sue & Sue, 2015).

Research suggests differences in the ways in which African Americans relate in the world, the therapeutic styles we find preferable, and basic strengths in our community (Broman, Neighbors, & Jackson, 1989; Helms, 1995; Helms & Carter, 1990). The basis for these variances and our ways of being are deep rooted but not well-known in the field of mental health. Specifically, there is little in-depth research in the field of marriage and family therapy about the historical context that adds to the complexity of working with African American clients (Bean, & Crane, 1996; Hunter, 1997; Hardy & Laszloffy, 1992).

This section has detailed historical perspectives from the African American community in the United States dating back to the dehumanizing and murderous events during the civil rights movement and relating that context to more recent struggles in the community. These perspectives are then used to reveal the complexity of the African American client who seeks therapy.

Carla's Story. Authors Thomas and Schwarzbaum, (2008) used the self-reported "Life Stories" of clients to provide clinicians with various perspectives into the complexity of cultural dynamics within minority populations. Carla, one of their clients, details the "obstacles of being Black, poor, and raised in a single parent home" (p. 244). At the time of contributing her autobiography, she was 48 years old, a divorced mother with a dual college degree who remembers feeling as a child that the "only thing White people could not take from me was my color" (Thomas & Schwarzbaum, 2008, p. 244). She eloquently describes examples of feeling the difference between her own experience and that of her White counterparts.

I knew there was a difference by the time I turned 7 in the second grade. The White children dressed better, and they even had better lunches. White children seemed to have better homes, every necessity any human could want, including me. This had me asking myself questions about my Black identity and how come I could not give this evil, bad color back. How come I could not trade me in for a White version that got respect, that did not go hungry, that did not want for a pretty dress? (Thomas & Schwarzbaum, 2008, p. 244)

Even at a young age, she was aware of her socioeconomic status and connected this to her race. If she were White, life presumably would have been much better, filled with so many more basic necessities and luxuries.

While attending an educational program for low-income students, her teacher used Carla and her race as a motivator for the White students in the class with no consideration of how this impacted her.

One of the significant life events that happened to me while in this school was, besides my teacher being White, I became one of her prized students to use in class to the other

White students as ‘the poor Black student who was able to come to school on scholarship’; she would tell them, ‘If she can make it, you people should make it that much more.’ The teacher used to tell me that I was Black; she must have figured I did not know that. Then she would say that I would never learn how to type because my hands were like a dwarf’s-too short to reach the keyboard. The reality of the situation is that culturally I was not White, but I was not an idiot, either. The teacher always used the three Black students as her escape to try to make the White students succeed. (Thomas & Schwarzbaum, 2008, p. 250)

The experiences Carla describe, speak to the many ways in which issues of mistrust, self-doubt, and low self-esteem are connected to her experience with the White community.

Anne Moody. Civil rights activist, Anne Moody, (1968), wrote an autobiography entitled *Coming of Age in Mississippi*. She describes, in painful detail, her experiences of growing up in Centreville, MS prior to and during the Civil Rights Movement. Like so many poor Blacks in the rural south, Anne, then called Essie Mae, worked in the homes of White families as housekeeper, errand girl, or babysitter to earn money to help feed her family. She began working at the age of nine. While she had some positive experiences with White employers, she also endured many experiences meant to break her spirit and fit her snugly into the place of someone less than human, someone Black:

I walked up to the front porch and discovered that the screen door was locked. ‘Who is it?’ Mrs. Burke called as she heard me knocking. ‘It’s me Essie,’ I answered. ‘Use the back door, Essie, it’s open!’ she yelled to me. The tone of her voice told me that she was again trying to subdue me. I went to the back door that morning. But the next morning, I walked up on the front porch again and knocked at the front door. I knocked for what

seemed like ten minutes and she still didn't answer. I didn't stop knocking though.

Finally, Mrs. Crosby (Mrs. Burke's mother) came to the door and let me in. When I walked in, I noticed that as usual, Mrs. Burke was occupying her favorite chair in her living room...I knew she heard me knocking. 'That's all right,' I thought. I will knock at the front door tomorrow morning again and the day after that too.' (Moody, 1968, p. 122)

Anne refused to be "broken" and throughout her story, one notices the strength she displayed in the face of an undefeated enemy; the enemy that is hatred, bigotry, and ignorance. Still there were times that even in her strength, she recognized the dangers of simply being Black in the south:

Mrs. Burke entered the kitchen... 'Essie, did you hear about that fourteen-year-old boy who was killed in Greenwood?' she asked me, sitting down in one of the chairs opposite me. 'No, I didn't hear that,' I answered... 'Do you know why he was killed?' she asked and I didn't answer. 'He was killed because he got out of his place with a White woman. A boy from Mississippi would know better than that. This boy was from Chicago. Negroes up North have no respect for people. They think they can get away with anything. He just came to Mississippi and put a whole lot of notions in the boys' heads here and stirred up a lot of trouble,' she said passionately. 'How old are you, Essie?' she asked me after a pause. 'Fourteen. I will soon be fifteen though,' I said. 'See, that boy was just fourteen too. It's a shame he had to die so soon.' I went home shaking like a leaf on a tree. For the first time out of all her trying, Mrs. Burke had made me feel like rotten garbage. Many times she had tried to instill fear within me and subdue me and had given up. But when she talked about Emmett Till there was something in her voice that sent chills and fear all over me. Before Emmett Till's murder, I had known the fear of hunger,

hell, and the Devil. But now there was a new fear known to me—the fear of being killed just because I was black. (Moody, 1968, p. 132)

Sometimes it's easier to respond to fear by living in it. Anne's response was to live through it, to fight in spite of it. Her experiences led her to voraciously pursue equal rights. She demonstrated throughout Mississippi and quickly became known as a rebel. The experiences she describes are more about her personal experience through the civil rights movement than her perspective of White people in general.

The personal accounts of both Anne and Carla demonstrate elements of pride, perseverance, and strength, as well as fears, shame, and loss. Clients can and will speak to these elements that are woven into the fabric of their individual experiences. Clinicians, however, are responsible for ensuring that they pay attention to the stories African American clients do not address, i.e., the history that the ancestral spirits beg us to hear.

Description of the Problem

The literature provides a wealth of information on various aspects of diversity in the more global field of mental health. Research on ethnic matching between therapist and client has been well documented (Terrell & Terrell, 1984; Blank, Tetrick, Brinkley, Smith, Doheny, 1994; Williams & Soydan, 2005; Okonji, Ososkie, Pulos, 1996; Russell, Fujino, Sue, Cheung, Snowden, 1996). However, marriage and family therapy seems behind the curve in regard to race in spite of concerted efforts to address issues of diversity and/or special populations (Boyd-Franklin, 2003; Bean et al., 2001). Turner, Wieling, & Allen (2004) address this issue as they propose that the field of mental health in the United States is still overwhelmingly guided by the melting pot concept; the notion that the distinctions of different racial backgrounds is becoming more seamless and indeed invisible because of the blending of races. While there are elements of

truth to this notion, perhaps this view is popular because it is far easier to embrace similarity than the reality and painful truth of our differences. There remain several gaps in the literature on treatment with African American families. Specifically, there is an absence of literature on African American perspective of their experience of relational therapy with White clinicians.

Purpose of the Study

I have asked African Americans who have been in relational therapy with White clinicians to share their experience with me in order to gain a better understanding of their experience of marriage and family therapy with those clinicians. The use of the phrase “African American Experience” both in the title and body of this study is meant to be inclusive of all participant experiences regardless of their adaptive identity (Briggs, Bank, Fixsen, Briggs, Kothari, & Burkett, 2014) or their respective stage of Black identity development (Neville & Cross, 2017). Furthermore, some individuals may identify themselves in other ways (e.g., Jamaican, Black). I respectfully use the term African American with the hopes that it includes all identities and does not offend anyone.

Using qualitative research methodology to study an under-represented population, I will hopefully add to the body of knowledge already used in working with African American families. My hope is that this study will also provide an in-depth understanding of this phenomenon will be based on an intimate exchange between the interviewer and the participant. The results of this study may also be used to understand the humanity of our community. In other words, as therapists, we must confront, address, and learn those issues that are troubling, those that are painful, and those that are difficult to overcome. In doing so, we can bear witness (Weingarten, 2000) to families healing themselves, we can become a part of that healing, and we

can better understand our responsibility not only to ourselves and those dear to us but also to those who are farthest from our consideration.

There are a number of themes that emerge in the literature on working with African American clients. Chapter two presents research related to working with African American clients. I will address each study individually, offering the scope of the research and its findings. This more explicit explanation will hopefully lay the foundation for what I believe creates the necessary balance for successfully treating the African American client; i.e., the clinician having a solid grasp of the literature while seeking to understand the perspective of the client from his or her cultural lens.

Operational Definitions

White Privilege: White privilege refers to a series of advantages that come to White Americans in their daily lives because, typically, they have been free of the labeling, stereotyping, and discrimination, past and present, that people of color experience. If there are racial groups that face discrimination, there must be a group (or groups) that benefit from such a social arrangement, by this reasoning. (p. 1403) White privilege has also been described by experts as invisible, structural, and systemic (Dei, Karumanchery, and Karumanchery-Luik, 2004).

Marginalization: Schaefer (2008) defines marginalization as:

the singling out of a specific group on the basis of some social demographic characteristic that is negatively viewed by a dominant group or class who, through institutionalized and informal practices, exclude the unwanted from social, economic, and political realms of the larger society. (p. 871)

Research participants described experiences of marginalization through *microaggressions*, *stereotyping*, *overt acts of racism*, and *systemic erasures*, which are defined below.

Microaggressions: Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, and Esquilin, 2007 describe microaggressions as common daily encounters with people of a majority group that communicate denigrating messages to people of a particular minority group. Because microaggressions can occur in many contexts, i.e., gender, sexual orientation, racial, etc., the authors are specific in their referencing racial microaggressions.

Racial microaggression: “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group (Sue et al., 2010, p. 273)

There are three forms of microaggressions: microassault, microinsult, and microinvalidation (Sue & Sue, 2010; Sue et al, 2007).

Microassault: conscious explicit racial, gender, or sexual oriented bias characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions (Sue & Sue, 2010; Miller & Garren, 2008; Nelson, 2006). Microassaults typically occur under circumstances where the perpetrator feels a degree of safety, anonymity or a loss of inhibitions (Sue et al., 2007; Sue & Sue, 2010).

Microinsult: unconscious, subtle snubs conveying hidden insulting messages in the forms of rudeness, stereotyping, and insensitivity (Sue & Sue, 2010). These messages are meant to demean a person’s racial, gender, sexual orientation, heritage, or identity (p. 31).

Microinvalidations:

Sue & Sue (2010) define microinvalidations as communications or environmental cues that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality

of certain groups, such as people of color, women, and LGBT's. In many ways, microinvalidations may potentially represent the most damaging form of microaggressions because they directly and insidiously deny the racial, gender, or sexual-orientation reality of these groups (p. 37).

Stereotyping: A belief or generalization about a group of individuals (Allen, 2011; Kanahara, 2006).

Systemic erasure: The word “erasure” is appearing more frequently in scholarly literature particularly with regard to those population of people on the margin (Edelman, 2016; Garren, 2017; & Tillapaugh, 2016). The overall premise conveys the diminished view, value, or relevance of a subjugated group. For the purposes of this study, systemic erasure is defined as the effect of racial biases, racism, and marginalization. Systemic erasures occur when a verbal or non-verbal exchange between a privileged and subjugated person diminishes the value of that subjugated person. Systemic erasures are also created when an event or a systemic policy and/or procedure renders the subjugated person invisible, or sends the message that one is not good enough to be considered equal to the White majority.

Institutional racism: Institutional racism or systemic racism describes forms of racism, which are structured into political and social institutions. It occurs when organizations, institutions or governments discriminate, either deliberately or indirectly, against certain groups of people to limit their rights.

This form of racism reflects the cultural assumptions of the dominant group, so that the practices of that group are seen as the norm to which other cultural practices should conform. It regularly and systematically advantages some ethnic and cultural groups and disadvantages and marginalises others.

Institutional racism is often the most difficult to recognise and counter, particularly when it is perpetrated by institutions and governments who do not view themselves as racist. When present in a range of social contexts, this form of racism reinforces the disadvantage already experienced by some members of the community. For example, racism experienced by students at school may result in early school dropout and lower educational outcomes. Together with discrimination in employment, this may lead to fewer employment opportunities and higher levels of unemployment for these students when they leave school. In turn, lower income levels combined with discrimination in the provision of goods and services restrict access to housing, health care and life opportunities generally. In this way, institutional racism may be particularly damaging for minority groups and further restrict their access to services and participation in society. (NSW Department of Education, 2015).

Racial discrimination: The legal definition of racial discrimination provided by the U. S Equal Employment Opportunity Commission (n.d.), includes the following:

Race discrimination involves treating someone (an applicant or employee) unfavorably because he/she is of a certain race or because of personal characteristics associated with race (such as hair texture, skin color, or certain facial features). Color discrimination involves treating someone unfavorably because of skin color complexion.

Title VII of the Civil Rights Act of 1964 protects individuals against employment discrimination on the basis of race and color as well as national origin, sex, or religion. It is unlawful to discriminate against any employee or applicant for employment because of race or color in regard to hiring, termination, promotion,

compensation, job training, or any other term, condition, or privilege of employment.

Title VII also prohibits employment decisions based on stereotypes and assumptions about abilities, traits, or the performance of individuals of certain racial groups.

Title VII prohibits both intentional discrimination and neutral job policies that disproportionately exclude minorities and that are not job related.

Tokenism: In Leong's *Encyclopedia of Counseling*, Delgado-Romero and Wells (2008)

define Tokenism as:

Tokenism involves the symbolic involvement of a person in an organization due only to a specified or salient characteristic (e.g., gender, race/ethnicity, disability, age). It refers to a policy or practice of limited inclusion of members of a minority, underrepresented, or disadvantaged group. The presence of people placed in the role of token often leads to a misleading outward appearance of inclusive practices. The term token is derived from the Old English word taken, which means "to show." Thus tokenism exists because inclusion of the person or group is required or expected, not because of inherent value. (p. 1349)

Chapter two will expand on several dimensions of working with African American families including the African American belief system, the phenomenon of rage and cultural mistrust, and biases related to working with clinicians and clientele. Chapter two concludes with the research questions related to this study. Chapter three will describe the methodology used in this study.

Chapter Two

Literature Review

This study will attempt to gain an understanding the African American experience of relational therapy with White clinicians. As a clinician dedicated to the systemic treatment of marginalized populations, my epistemology dictates that one should not rely solely on the client to educate you on the ways he/she is different from the rest of the world, i.e., their experience; nor is it appropriate to rely solely on what literature and research teaches us about various populations. Rather clinicians should seek a balance by examining research and exploring the unique perspective of each client. This chapter addresses part of this balance by exploring the research on working with the African American clientele.

There have been a number of issues related to working with African American clientele in a therapeutic setting that have been the basis of extensive research studies. Still researchers and therapists call for further research in order to add an increased understanding of a population that still, in many ways, requires demystification. This chapter first explores the African American system of beliefs and values, racial group identity, coping strategies and styles, and self-esteem and well-being to lay the foundation for better understanding those dynamics that contribute to presenting issues in therapy. Next, the literature review will expand on those themes that research has identified in working with the African American population such as issues of cultural mistrust in the clinical setting and the importance of ethnic and racial matching in a clinical setting. This chapter will then review literature detailing the implications of cultural, ethnic, or racial matching between clinician and client in therapy. Finally, this chapter will conclude by reviewing existing literature on presenting problems in therapy. It addresses special populations where possible and adds to the foundation of why studying differences in presenting

issues for therapy with African American clients and European American clients is a necessary addition to marriage and family therapy and culturally responsive therapy in general.

The African American community operates with certain values such as the importance of religious practice and/or affiliation, the importance of social and/or community support, the importance of positive self-regard and a sense of cultural and racial identity (Gurin, Miller, & Gurin, 1980; Gurin, Hatchett & Jackson, 1989; Cross & Strauss, 1998; Leach & Moreland, 2001). The following sections address these dynamics from a theoretical perspective.

African American Belief System

Group needs over individual needs and social black identity. Throughout history African Americans have relied on each other to survive. As a result of this reliance, the needs of the family took precedence over individual needs. Watson (1998) addresses this belief in her chapter on African American sibling relationships. Individual family members are charged with the responsibility of contributing to the well-being of the extended family. Mayo (2004) adds that African American families believe in supporting that person in the family who is likely to be most successful. The success this person achieves ensures the success of the family and its legacy. Specifically in a society riddled with educational and economic barriers, it has been necessary for families to rely on the collective efforts of extended family members to insure their survival. While African American families share a common legacy, their belief systems are also influenced by differing contextual variables, such as social class.

Allen, Thornton, and Watkins (1992) studied the influence of social status position and education on the African American belief system. The authors divide the concept of the racial belief system into five different constructs. The first construct is entitled closeness to mass groups, which is defined as an emotional connection to one's racial group. The second construct

is called closeness to elites which reflects African Americans identification with civic and political leaders. The third and fourth constructs have to do with African Americans who believe in positive and/or negative stereotypical ideals of one's own racial group. The final construct, Black autonomy refers to the belief that African Americans should establish political and social infrastructures that reflect the cultural values and interests of its own community rather than the larger White society. The authors interviewed 2,107 participants representing a cross section of African Americans across the United States. Allen et al (1992) found that while African Americans in general share a racial consciousness, their beliefs are not monolithic and vary according to class. For example, the researchers found that lower income impacts how African Americans perceive negative stereotypes of the community in that lower income earning African Americans are more likely to identify with the elite.

Differences across age groups. Allen and Bagozzi (2001) studied the differences in African American belief systems across age groups. The authors divided their concept of the African American belief system into five constructs that are similar to Allen et al's (1992) concept of racial belief system. These concepts are: 1) positive stereotypical beliefs about African Americans, 2) negative stereotypical beliefs about African Americans, 3) closeness to Black masses, 4) closeness to Black elites, and 5) self-esteem. Black masses refer to ordinary citizens whereas Black elites refer to Black political leaders (Allen et al., 1989). The authors divided their participants based on three distinct time periods pre-civil rights (participants age 55 to 90), civil rights (participant age 35 to 54), and post-civil rights (participant age 17 to 34) (Allen & Bagozzi, 2001).

The authors predicted that both the generation reaching maturity during the human rights movement and post-civil rights age groups would have a stronger sense of a racial belief system

and a stronger sense of self than those of the pre-civil rights generation. They found that in all age groups, those with a stronger African American belief system had a stronger sense of well-being and a greater propensity toward cohesiveness. The results also indicated that of the five constructs upon which the African American belief system is based, self-esteem was the highest predictor of well-being in African Americans.

Hughes and his colleagues (2015) test predictions of two opposing theoretical views, social identity theory (Ellemers & Haslam, 2012) and internalized racism perspective. The researchers summarize social identity theory by saying it “explains how group identification promotes a positive self-esteem and, by extensions, mastery and positive psychological well-being” (Hughes, Kiecolt, Keith, David, 2015, p. 30). Internalized racism perspective is the belief that individuals accept and incorporate negative stereotypes about themselves as members of a minority group (Hughes et al., 2015). The overall research question was how does racial identity impact self attitudes and well-being among African Americans? Similar to social identity theory (SIT) (Ellemers & Haslam, 2012), the researchers hypothesized that as African Americans closely identify with their group, their evaluation of their group will be positive. Two other hypotheses are that in the African American community, closer group identification and favorable ingroup evaluation will related to greater self esteem, greater mastery, fewer depressive symptoms. Inversely, their last hypothesis is that group identification and evaluation will interact negatively if internalized racism is present. In other words, internalized racism and closeness to the African American group is related to lower self esteem, lower mastery, and more depressive symptoms.

Findings indicate all hypotheses were supported which suggests that both SIT and internalized racism perspective are needed to more fully understand the interaction between racial identity and self attitudes (Hughes et al., 2015).

This section identifies several themes related to the African American belief system. Findings indicate the value of the group is greater than the individual; the belief system a person holds is impacted by his or her income; and a stronger belief system contributes a higher sense of well-being and a greater sense of cohesiveness with other African Americans. These findings begin to identify common threads important in the African American community and are critical to this proposal because they begin to create a foundation for a successful therapeutic process, i.e., a balance between the clinician understanding the literature while attempting to understand the cultural worldview of the African American client.

Black Identity

Black identity is an important recurring theme in research literature. Understanding the components of this theme supports the necessary balance for successful therapy with African American clients and is therefore vital to the proposed study.

Racial group identity. Positive racial group identification is another value within the African American community and is therefore important to consider when exploring Black identity. Gurin and co-authors (1980) define racial group identification as a “sense of belonging to a status group; the feelings associated with being part of a status group; the sharing of similar feelings and interests with others who have similar characteristics” (p.148). Cross and Strauss (1998) speak to the misconception that the stigma associated with being Black is, in fact, a part of Black identity when they state, “in moving toward a more balanced depiction of Black identity dynamics, the role of stigma in the everyday experiences of Black people has not been lost on

theorists, rather issues of stigma, pride, cultural resources as well as vulnerability are depicted as different aspects of the same phenomena, that is, Black identity” (Cross & Strauss, 1998; p. 268).

Social status, moral development, and identity. Broman and co-authors (1989) studied social status determinants of racial group identification among Black adults. Similar to Gurin et. al. (1980), Broman et. al. define racial group identification as “the feeling of closeness to similar others in ideas, feelings and thoughts” (p.148). The authors used data from 2,107 participants of the National Survey of Black Americans, the first nationally represented cross-section of adult Black American population in the continental U.S., to measure how close they felt to other African Americans with a myriad of descriptors such as “poor, religious, young, middle class, working class, older, elected officials, and professional Black people” (Broman et al, 1989, p. 149). Results indicated that older, less educated, rural and southern Blacks were likely to feel closer to other Blacks; and college students from both the North and South were more likely to identify with Blacks than their counterparts from the West. Interestingly, the authors suggest that as income increased, racial identification decreased. Porter and Washington (1979) are credited with developing a theoretical perspective entitled relative deprivation, which may explain the latter finding from Broman et al. (1989). Relative deprivation is the belief that Blacks compare themselves to Whites, feel deprived and, as a result, exhibit a militant like identification with other Black Americans (Porter & Washington, 1979). This definition suggests those African Americans who do not experience a sense of deprivation may be less likely to identify with other African Americans.

Leach and Moreland (2001), using the Kohlberg (1976, 1981) model of moral reasoning and the Helms (Helms, 1995; Helms & Parham, 1985) model of Black identity development, explored the relationship between moral development and Black identity development among

African American university students. The authors proposed that (1) moral development and identity development are linked and (2) are partly determined by emotional responses.

Kohlberg (1969, 1976, 1981) defined three levels of moral development which encompass six stages. The stages include preconventional morality, conventional morality, and post conventional morality. Preconventional morality, Stages 1 and 2, suggests one's moral decisions are based on society rules or an external component which dictates appropriate behavior. Conventional morality, Stages 3 and 4, represent an assimilation of an attitude shared by the community as a whole, i.e., in this case, the African American community. Postconventional morality, Stages 5 and 6, speaks to a level of development that has already internalized community attitudes and beliefs and is now able to separate current community values from a more altruistic sense of what one's own values are (Leach & Moreland, 2001).

The Helms (1985) model of Black identity development focuses on four of five statuses which are included in the Black Racial Identity Attitude Scale. The first of four statuses defined is pre-encounter where one accepts the worldview of the dominant White culture while rejecting the worldview of one's own Black culture. The second status is encounter, in which the experience one has, challenged previous ideas of identity, thus allowing for expanding the interpretation of identity. The third status is immersion-emersion where one begins to reject the majority White cultural worldview and simultaneously begins to develop a sense of Black pride. The fourth status, internalization, reflects the value for one's own culture while accepting diversity or differing worldviews.

Leach and Moreland (2001) compare similarities in both models. Preconventional morality and pre-encounter racial identity are viewed as developmentally external components. However, they view Stage 2 of preconventional morality and encounter racial identity as the

burgeoning awareness of one's sense of individual identity (Leach & Moreland, 2001). Likewise, conventional morality and immersion-emersion racial identity reflect the embracing of one's community and a shared sense of identity. Postconventional morality and internalization racial identity reflect a stronger sense of self and a simultaneous respect for individual differences.

The authors propose that (1) moral development and identity development are linked and (2) are partly determined by emotional responses. One hundred ninety-seven undergraduate and graduate students completed the RIAS-B, Racial Identity Attitude Scale for Blacks and the DIT, the Defining Issues Text, which assesses moral reasoning using six moral dilemmas or vignettes based on a Black, White or non-specified central character.

Results of the Leach and Moreland study indicate a significant relationship between Black racial identity and moral development in that students with a more developed sense of Black racial identity were better able to make moral choices. In addition, higher levels of emotionality from students indicated they were in either the pre-encounter or the encounter stage of Black racial identity. Participants who idealized White cultural worldview or who idealized Black cultural worldview were more likely to make decisions based on a highly emotional and reactive position rather than from a more centered position. This study implies that Black identity is an important component in moral development. Those individuals who have internalized their sense of identity and can embrace areas of diversity are more likely to approach the world from a position of what the state of the world should represent rather than what it does represent. The study also suggests the importance of African Americans owning their Blackness as a positive component of their identity (Leach & Moreland, 2001). The Leach and Moreland study addressed an important consideration which may impact the results of my proposed research. They suggest that participants in my study are likely to view their past experience with

European American clinicians based on both where they are in their own Black identity development and their moral reasoning.

Black identity and invisibility. Franklin (1999) developed a model which he labeled the Invisibility Syndrome to describe racial identity development in African American men. He defines this syndrome as: “an inner struggle with the feeling that one’s talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism” (p. 761) and explains that repeated exposure to debilitating racial experiences lead to one feeling invisible. While this model contains several elements, its central component is understanding the psychological and emotional stress African American men experience “as they attempt to evolve an identity within the larger socioeconomic, political, and cultural entity we consider ‘society’ – whose practice of racism manipulates the rules of conformity and inclusion for them” (Franklin, 1999, p. 764). This stress ultimately contributes to a predominantly negative sense of self which Pierce (1988, 1992) considers an assault to the self-esteem of African American people. Franklin suggests that visibility occurs when one learns to discern a behavior as racist and still acts in a manner that is consistent with one’s sense of self (Franklin, 1999).

Franklin (1999) compares his model with Black or racial identity development. He agrees with other definitions of Black identity as he suggests the achievement of the African American identity is influenced by attaining personal comfort with oneself not only in spite of racism but, in part, because of it. He argues that the main differences between the invisibility syndrome and racial identity development have to do primarily with the scope and intent of the two models. He further offers that “the invisibility paradigm is broader...than the racial identity model because it allows for interpretation of greater domains of human experiences that make up one’s personal identity, as impacted by encounters of racism” (p. 782).

Wyatt (1999) published an article expanding on Franklin's (1999) theory of invisibility in the African American male. She expounds on how invisibility impacts families, addresses clinical implications, and offers interventions to address the issue.

One of the clinical implications she addresses is the possibility that some African Americans may intentionally choose therapeutic relationships outside of their own race "in an attempt to minimize the limitations that being a person of color imposes" (p.804). Wyatt suggests these situations are most suitable for an ethnic immersion process in therapy. She defines ethnic immersion as:

...the process of learning about history, cultural values, and beliefs that are ethnic-group specific; identifying the role that culture and ethnic identity have in life; and increasing one's awareness of the value that ethnic-group affiliation and collectivist attitudes can have on personal growth, self-esteem, and ethnic pride (p. 805).

She also suggests that allies are essential when going through this process in therapy, i.e., a family member or friend with whom the client can process his/her emotions, reactions, and revelations which are sparked as a result of therapy.

Boyd-Franklin (2003) addresses the phenomenon of invisibility in the African American woman. She suggests the media, history, racism and sexism all contribute to this invisibility as they serve to portray African American women in the most pejorative light imaginable. African American women are perceived in terms of their physical attributes, affect, and their demoralized values. These perceptions serve as powerful contributors to invisibility as they strategically force attention to that which is detestable and therefore irrelevant.

This section defines Black identity as an important value within the African American community. Black identity is a form of racial group identity, a sense of belonging to a group of

people with whom one shares similar characteristics (Gurin et al., 1980). Those shared characteristics create the basis for a shared set of beliefs and values. Research indicates that there are several factors which impact a sense of Black identity including income, education, and self-esteem (Broman et al., 1989; Cross and Strauss, 1998; Leach & Moreland, 2001; Kohlberg, 1969, 1976, 1981). Research also suggests that the racial identity of men, women, and families are all impacted by negative treatment because of race (Franklin, 1993; Wyatt, 1999; Boyd-Franklin, 2003). Franklin (1993) introduced a phenomenon of Invisibility experienced by African Americans who feel they are not valued or recognized for their abilities. This section has identified the concept of Black identity and elements central to identity development for African Americans. Understanding the components of this theme helps to create a stronger knowledge base for clinicians working with African American clients and is therefore vital to the proposed study.

Rage in the African American Community

African Americans clients have often been perceived as angry, aggressive, or hostile by White clinicians. This perception has led to clients being feared, misunderstood, and misdiagnosed in therapeutic settings (Russell et al., 1996). The following information about rage in the African American community is vital to this research in that it offers insight into an observed reaction of African Americans while providing a context that explains why these reactions might occur. This proposal seeks to understand the experiences of African American clients and this section addresses a phenomenon that speaks to a common experience of the African American community and an uninformed perception of White society and consequently by many White clinicians.

Several authors have contributed powerfully to literature on the issue of rage within the African American community. This section focuses on specific works by Willis, Hardy, and Laszloffy. There are several similarities that appear in their publications worthy of noting. Willis (1995) wrote about rage within the African American community and its connection to “critical mass” (p. 105). He defines critical mass as:

the point at which individuals have experienced a maximum amount of stress before they succumb to psychological pressure. At that point they lose their ability to think clearly and act rationally; that is, they reach their breaking point. The breaking point for the African-American is reached after experiencing an overwhelming negativity in the family, culture, and society. It is the point when all the hurt, pain, anger, and rage are focused in a single moment in time. (p. 106)

He addresses the importance of understanding the historical context that contributes to rage in the community and he identifies slavery as the precedent to African Americans feeling a sense of powerlessness to respond to acts of injustice imposed upon them (Willis, 1995). Hardy and Laszloffy (1995) also speak to this powerlessness when they write:

Under the institution of slavery, African people were stripped of their names, culture, and language. They were forced to labor their entire lives without the benefit of legitimate compensation or reward. They were denied basic human rights, such as the right to learn to read and write, vote, choose where to live, how to worship, and with whom to engage in sexual relations. Above all, slaves were forced to endure these hardships in silence. No opportunities for protestation existed...because they were regarded as chattel; slaves were forced to endure their subjugation and degradation with absolute complicity. (p. 59)

Grier and Cobbs (1980) explain the intricacies of rage and then elaborate on how anger and rage contribute to African Americans reaching the point of critical mass. Willis (1995), Hardy and Laszloffy (1995) agree that suppressing anger leads to rage, which can ultimately result in an explosive retaliation ignited by what might appear to be the most miniscule trigger event.

Hardy and Laszloffy (1995) also address the issue of rage in the African American community and they expand on the concept by identifying therapeutic interventions to address rage. They first distinguish the difference between anger and rage in terms of the variables of time and intensity. They describe anger as a less intense reaction, prone to a quick emotional release that ultimately causes a reduction in tension. Rage, however, is a “much more sustained and intense emotion...it tends to develop more gradually and over a protracted period of time” (p. 58). In a later publication, Hardy and Laszloffy (2005) again address the difference between anger and rage when they state:

While anger emerges in the immediacy of the moment, rage builds over time. It is the product of numerous experiences with devaluation, erosion/disruption of community, and the dehumanization of loss that accumulate over time. These are the experiences that sow the seeds of rage. (p. 103)

The authors suggest a sociocultural approach to working African American clients where rage is a clinical concern. They identify four steps in this approach: “a) identifying rage and its connection to the presenting problem; b) validating rage; c) identifying other related emotions; and d) developing constructive ways of channeling rage” (Hardy & Laszloffy, 2005, p.60). A case example is provided to demonstrate how a clinician successfully addresses the issue of rage in therapy.

The authors offered a more complex explanation of rage as a way to defend against deeper, more vulnerable emotions (Hardy & Laszloffy, 2005). Society has validated the expression of anger and rage in a variety of ways. These emotions have become preferred expressions over any form of vulnerability. This tendency is especially true in the African American community. We have a painful legacy combined with a societal norm that reinforces the myth “only the strong survive.” As a result, our tendency might be to shield against further injury by seeming so fierce that no one dare touch the pain that lies just beneath the surface.

Ashley (2014) provided a case study of a client that supports other research about the stereotypes projected onto African Americans, and in this case, African American women. She presented a client who had been sexually traumatized as a child and who had a recent work experience that triggered her experience of that trauma. A significant dynamic in this client’s experience was her suppressing the anger she experienced because of her trauma and to avoid being wrongfully labeled the angry Black woman. The author stressed the importance of treating the presented trauma. She expanded her clinical purview to include the historical context of African Americans and the myth of the angry Black woman. Years of treatment with the sole clinical view of depression, trauma, and failure to establish and maintain health intimate relationships were unsuccessful. Including the context of history and stereotypes resulted in a successful outcome in therapy.

Researchers agree that rage is a by-product of prolonged suppressed anger and the result of multiple experiences of African Americans being subjugated in our society. The literature explains the source of anger, hostility and aggression that African American clientele might feel. This phenomenon is relevant to the proposed study in two ways; 1) rage has significant historical relevance for African American clients and clinicians should be prepared to address this

phenomenon in therapy and 2) this experience may be relevant to participants of the proposed study.

Support Systems and Well-Being

This section explores the importance of support systems and well-being in the African American community. African Americans rely on each other to successfully navigate the daily demands in a society that largely views the community through a pejorative lens (Herrnstein & Murray, 1994). Often based on a historically tribal or communal way of living, support systems in the African American community are complex and a vital component of one's sense of well-being. George and Bearon (1980) define the term "well-being" as "a diverse group of indicators used to measure various aspects of life quality" (p.442).

Chatters, Hardison, Riley, and Taylor (2001) studied the impact of kin and non-kin support resources on the subjective well-being of African Americans. The researchers used the National Survey of Black Americans (NSBA) data set to address questions examining the impact of several measures of support from family, friends, church members, fictive kin, and neighbors on individual assessments of happiness and life satisfaction. Results indicated demographic factors, health, religious service attendance, and various sources of informal social support, i.e., family and friends, all contribute to one's individual sense of well-being.

Coping with Racism and Discrimination

Coping with the deleterious effects of racial discrimination is a reality in the African American community. Many in the community experience some form of discrimination on a consistent basis. Successfully managing these effects is an important component to surviving, and thriving in the community.

Utsey, Ponterotto, Reynolds, and Cancelli, (2000) state, “given racism is an invidious and omnipresent stressor in the lives of many African Americans, research aimed at delineating those coping behaviors that effectively ameliorate its potentially harmful psychological and somatic consequences is warranted” (p. 72). The authors consequently examine coping strategies used by African Americans in managing the stressful effects of racism (Utsey et al., 2000). They define stress as, “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19).

Utsey et al. (2000) define coping as the process by which “an individual attempts to manage, through cognitive and behavioral efforts, external or internal demands that are assessed as exceeding one’s resources” (p. 73).

Results of the study indicated differences in coping strategies used by African American men and women in their encounters with racial discrimination in that women used seeking social support significantly more than men. The authors found that African American women preferred strategies that avoided stressful issues as their primary coping strategy in instance of racial discrimination. Another finding was that those African Americans who experienced higher instances of cultural racism and who used social support to cope less often were more likely to experience race related stress. The authors also suggest that the higher the use of avoidance the lower ones self-esteem and reported life satisfaction (Utsey et al., 2000).

Research shows racial discrimination impacts the mental and physical well-being of African Americans (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Huynh, 2012; Gomez, Miranda, & Polanco, 2011). However, more research is emerging linking the negative impact of racial discrimination and racial microaggressions, (RMAS), with suicidal ideation (O’Keefe,

Wingate, Cole, Hollingsworth, Tucker, 2015). The researchers studied the relationship between experiences with racial microaggressions, symptoms of depression, and suicidal risk (O’Keefe et al., 2015).

The following measures were administered to four hundred and five participants: demographic questions, the racial microaggressions scale (Torres-Harding, Andrade, & Diaz, 2012), the Center for Epidemiologic Studies depression scale (Radloff, 1977) and the hopelessness depression symptom questionnaire-suicidality subscale (Metalsky & Joiner, 1997). Findings confirmed a relationship between RMAS, depression, and suicide risk, i.e., “experiencing more RMAS leads to more symptoms of depression, which in turn leads to more reported suicidal ideation” (p. 570-572).

Stigma management vs. Black identity. Blackmon and Thomas (2015) studied reactions to the shooting death of Trayvon Martin. Further, they questioned if “Black racial identity cluster profiles were predictive of participants’ emotional reactions, specifically self-reported anger and anxiety (i.e., “sense of safety” (p. 284). Using the Multidimensional Inventory of Black Identity, (MIBI) (Sellers, Rowley, Chavous, Shelton, & Smith, 1997), and racial identity profile clusters (Banks & Kohn-Wood, 2007) in a mixed method approach to answer their research questions.

Respondents fell into one of three clusters, undifferentiated, integrationist, or race focused (Blackmon & Thomas, 2015). The undifferentiated cluster indicated that the respondent had not developed a Black racial identity that leans in any sociopolitical direction. Integrationists favor assimilationist and humanist beliefs over positive association with Black racial identity. Blackmon and Thomas (2015) stated integrationists “may be more likely to view themselves as

more American than African American” (p. 291). The race focused demonstrated a perspective consistent with those who hold their Black identity as central to their being.

Their findings indicated all participants had an emotional reaction to Trayvon’s death, mostly anger and anxiety. The degree of anger and anxiety determined the Black identity profile cluster of each participant. The race focused group was the only group to consistently reported concern for their safety. Each group also expressed a sense of loss for “racial progress” (p. 291), loss of a sense of safety, and the loss of a young Black male for racially motivated reasons. The authors stressed the care needed to support African Americans regardless of the personality cluster.

Cross and Strauss (1998) developed a theory of Black Identity in response to an emerging trend to equate Black identity with a form of coping they define as stigma management. The premise behind the theory is to show that while many of the behaviors African Americans exhibit daily are a manifestation of a larger issue of living in a society where we are vilified, there is so much of our identity that is, “about living, sleeping, arguing, laughing, and just being with each other” (p. 278).

The authors used Nigrescence theory to articulate various strategies African Americans use to function daily. Nigrescence is a French term used to describe the process of becoming Black. Specifically, Nigrescence theory is defined as “the identity conversion experience designed to increase the salience of race and Black culture in the organization of the person’s worldview” (Cross & Strauss, 1998, p. 269).

The components of Nigrescence theory are buffering, bonding, bridging, (Clark, Swim, & Cross, 1996), code switching, and individualism, (Cross, Clark, & Fhagen-Smith, 1998). Buffering “facilitates stigma management by protecting against racial situations”; bonding refers

to the attachment to Black people, culture, and the experience of being Black both from a historical and current perspective (Cross & Strauss, 1998, p. 270). Bridging refers to that ability to connect and communicate with people and institutions outside of the Black community. Code switching is the act of suspending behaviors indicative of Blackness. Switching is also commonly viewed as the bicultural presentation of African Americans to exist in a predominantly White world; the presentation that requires a different way of talking, of walking, of being (Cross & Strauss, 1998). Finally, individualism refers to a way of being that reflects one's personality as opposed to Black culture. Again, these components of Black identity represent both the ways in which African Americans navigate stigma and simply move through life wearing and honoring their own sense of Blackness. The authors caution us not to confuse the two.

Self-esteem and coping. This section speaks to the resilience of the African American community. The following literature identifies those ways the community thrives in the face of great injustice. Zora Neal Hurston (1979) speaks to the power of thriving as an African American despite the stigma associated with being Black:

But I am NOT tragically colored. There is no great sorrow damned up in my soul, nor lurking behind my eyes. I do not mind at all. I do not belong to the sobbing school of Negrohood who hold that nature somehow has given them a lowdown dirty deal and whose feelings are all hurt about it. Even in the helter skelter skirmish that is my life, I have seen that the world is to the strong regardless of a little pigmentation more or less. No, I do not weep at the world—I am too busy sharpening my oyster knife. (p. 153)

Constantine and co-authors (2002) studied collective self-esteem and coping styles in African American adolescents. They suggest that “the extent to which African American

adolescents positively view their cultural group may have significant effect on their coping behaviors and subjective well-being” (p. 699). Luhtanen and Crocker (1992) use the term collective self-esteem, which is the value that individuals place on their own social or cultural groups. Constantine et al. (2002) found that those adolescents with a higher collective self-esteem tend to use culturally appropriate coping strategies. Finding ways to successfully cope with challenges is an important component of one’s own sense of self-satisfaction and in this study, there is evidence to support using culturally based strategies to improve positive self-regard.

Cultural Mistrust

History provides a horrifying backdrop for African Americans. One must consider countless murders, slavery, Jim Crow laws, the Civil Rights Movement and many other events that contribute to the ways in which African Americans perceive the White community. But it is not just history that provides examples of racial hatred. For example, police involvement in the shooting deaths of African Americans are so common, the phrase “Death by Cop” is a known expression in the community (Journal of Blacks in Higher Education, 2015). Tragic events are too numerous, too traumatizing, and happening too quickly to adequately address the context of cultural mistrust, but whether it be the death of Sandra Bland, Philando Castille, Alton Sterling, Walter Scott, Trayvon Martin, Tamir Rice or the countless ways injustices occur, it all stands on a solid historical foundation. This section explores the element of cultural mistrust as a dynamic present for many African Americans.

Terrell and Terrell (1984) conducted a study on the experience of Black clients in therapy. Participants completed the Cultural Mistrust Inventory (CMI), (Terrell & Terrell, 1981) and other agency forms, and were randomly interviewed by either a White or Black counselor

with a follow up interview scheduled. Results indicated that Black clients with a high level of mistrust who were seen by a White counselor had a higher rate of premature termination from counseling than did highly mistrustful Black clients seen by a Black counselor (Terrell & Terrell, 1984). The study also determined that the more distrustful of Whites a client was, the more likely he/she was to terminate therapy. This finding, however, may be due to the possibility that the CMI identifies people who are mistrustful regardless of race (Terrell & Terrell, 1984). There was no significant difference in the termination rate based on the gender of the clients. The authors suggest that for those individuals who are found to be more mistrustful of Whites, it is best if they are at least initially treated by a Black counselor.

Arthur Whaley has been instrumental in studying cultural mistrust among African Americans and misdiagnoses of African Americans due to clinician cultural bias. In 2001, he published a meta-analysis examining whether African Americans with high levels of cultural mistrust respond to interracial interactions in counseling and therapy in a similar manner as they do in other social situations. The author used Terrell and Terrell's (1981) Cultural Mistrust Inventory (CMI) and hypothesized that this scale is biased in favor of Black college students, the sample used in this study, which would limit its ability to apply to the larger Black population. Another hypothesis was that higher effect sizes are related to use of the entire scale.

Results indicate that using the CMI Black male college students did not limit its applicability to the larger Black population. Studies using college or male samples did not indicate a significantly larger effect sizes for the CMI. The study also found that the higher effect sizes were related to the total use of the CMI scale. The hypothesis that African Americans with high levels of cultural mistrust respond similarly in social situations as in interracial interactions

in counseling was not supported, i.e., individuals with high levels of cultural mistrust are labeled as such because of the unique therapeutic relationship with White clinicians (Whaley, 2001).

Whaley (2004) later tested the reliability and validity of a two-stage approach to studying cultural biases diagnosing schizophrenia in African American psychiatric patients. Specifically, the goal was to determine if clinician bias and cultural bias are distinct phenomena in diagnosing psychiatric patients. Three hypotheses were posed with this study. First, understanding that African Americans were often misdiagnosed and/or over diagnosed due to failure to adhere to the appropriate diagnostic criteria and due to clinician cultural bias, Whaley conjectured that if one controlled for clinician cultural bias, the percentage of diagnosed schizophrenia in African American patients would significantly reduce. The second hypothesis involved African American clinicians as cultural experts. He hypothesized that cultural expert ratings of cultural mistrust would correlate with self-reported ratings of cultural mistrust in African American patient participants than with SCID interviewers (First, Spitzer, Gibbon & Williams, 1996). The final hypothesis was that there is a greater cultural bias in diagnosing the subtype paranoid schizophrenia than in schizophrenia. Measures used included Terrell and Terrell's (1984) Cultural Mistrust Inventory, Attitudes towards White Clinicians, Fenigstein & Venable's (1992) Fenigstein Paranoid Scale, and Dohrenwend, Shrout, Edgri, & Mendelsohn's (1986) False Beliefs and Perceptions scale.

Results indicated that despite controlling for cultural bias, cultural experts and SCID interviewer similarly diagnosed schizophrenia. Part of the methodology, the use of symptom profiles by both SCID interviewers and cultural experts, may have resulted in the strong correlation. Whaley offered that allowing cultural experts to conduct face to face interviews with participants, that methodology would have better controlled for all interviewer ratings. The

second hypothesis, that patient self report of cultural mistrust would correlate more with cultural experts than with SCID interviewers, was true but did not meet statistical significance. The third hypothesis, that cultural bias results in higher diagnosis of the subtype level, paranoid schizophrenia than schizophrenia, was supported.

Whaley (2011) replicated and expanded the earlier 2004 study to test two hypotheses. The first hypothesis was that clinician's ratings of cultural mistrust would be more highly influenced by the patient self report of cultural mistrust than by the patient's self report of paranoia. The second hypothesis suggested "that cultural expert's ratings would have more variance explained than SCID interviewer ratings in the latent construct of clinician-rated cultural mistrust" (p. 401). Further, Whaley sought to determine if discrepancies between SCID interviewers and cultural experts in diagnosing the subtype paranoia in a schizophrenic diagnosis is indicative of different levels of cultural competence. Expansion to this study include a larger sample size, use of the structural equation model, different means of measuring self-reported paranoia, and subscales of the Cultural Mistrust Inventory (CMI) (Terrell & Terrell, 1984).

Findings indicated that both hypotheses were supported. The first hypothesis, that participant's self-reported cultural mistrust would have a greater influence on cultural experts ratings than self-reported paranoia, had a slightly different outcome than anticipated. While patient's self-report of cultural mistrust positively influenced clinicians' ability to rate cultural mistrust, there was a negative correlation between participant report of clinical symptoms of paranoia and the clinical assessment. This finding supports the question of whether or not the assessment of cultural dimensions is distinct from clinical dimensions (Whaley, 2001).

The literature presents a clear picture of the phenomenon of cultural mistrust within the African American community. Studies suggest that therapy with African American clientele is

often terminated prematurely as a result of this mistrust. African Americans experience discrimination in a myriad of ways either on an individual basis or institutionally in a society where the norms are established by European Americans. This same group of providers has developed clinical practices built on norms which are most successful with European clientele with little regard or attention to the cultural differences that might impact African American clients. While there may be many reasons why cultural mistrust is present in the therapeutic relationship with African American clients and White therapists, the following section references literature that suggest the therapist's own bias and sense of privilege are factors contributing to the rift in the therapeutic relationship.

Clinicians have been trained to create a safe and supportive environment for their clientele to address their presenting issues and Russell et al., (1996) proved that even in this space that should be most safe, African Americans are still marginalized. The previous section addressed the sad reality of the mistrust African Americans have in general for mental health practitioners. This section expounds on the issues of bias and privilege in both clinicians in training and those who have been "trained" to address the needs of their clientele. These studies suggest that African American clients are justified in their continued mistrust of White clinicians. It is easily understood from the literature why African Americans tend to be more accepting of the therapeutic process when the treating clinician is also African American. The following section addresses therapist bias and awareness of privilege.

Therapist Bias and Awareness of Privilege

Most clinicians are trained to consider their own biases and values when entering a therapeutic relationship (Corey, Corey, & Callanan, 1993). However, for one to truly understand the importance of this aspect of training when dealing with African American clientele, one must

have an understanding of one's own bias as it relates to privilege. Even the most empathic clinician can make the grave error of not truly considering his or her own privilege in the therapeutic relationship. Hardy and Laszloffy (2000) suggest that privilege equates to power in relationships. Therefore, it becomes a dangerous risk an African American client takes when embarking in a therapeutic relationship with a White American clinician who has no sense of their privilege, and therefore their power. The following section explores the literature on bias and privilege among clinicians.

Theory and research on clinician stereotypes and bias. Curran (2007) describes White privilege as “invisible, structural, and systemic” (p 81). He details his journey as a White theologian who supported his African American peers, which resulted in an unintentional externalization of the issue of racism, one that separates him from the problem. He acknowledged this externalization as part of the problem as it makes the issue of race one that allowed him to deny his part in its existence. Ultimately, he challenges himself and other theologians to “shed light on this evil and overcome its invisibility” (p. 81).

Dei and colleagues (2004) further address the discourse of power, historically associated with Whiteness and White privilege, stating there are three basic assumptions: “(a) that power is a possession, (b) that power flows downward from a centralized point and (c) that power's primary function is repressive” (p. 60).

Cassidy and Mikulich (2007) make a similar assertion (White Privilege also supports the invisibility and systemic erasure of African Americans) as they challenge the silence among Catholic Theologians in matters of addressing racism in the United States. “The silence of white theologians bespeaks the contradiction between our claims for a universal, ontological human

equality and the reality of the social, political, and economic privilege white theologians and the ethicists consciously and unconsciously accept and assume” (p.4).

Abreu (2001) published an article in which he intended to “introduce theory and selected research on stereotyping and cognitive automaticity as a didactic resource base for multicultural trainers” (p. 491). This article outlines the processes in generalizing stereotypes and describes how much of this process is unconscious. Abreu (2001) then uses this premise to explain “perceptual bias” towards individuals and “racial bias” (p. 496-497) towards groups of people. The author suggests that bias, prejudice, and racism are parts of a fluid continuum rather than an “either/or” mode of thinking, i.e., either one is prejudice or one is not. Abreu suggests that training a clinician to access those processes that most often are “automatic, unconscious processes in social perceptions” (p. 505) is a key function to educating from a multicultural standpoint.

Paniagua, O’Boyle, Tan, and Lew (2000) conducted a study to assess the self-evaluation of biases and prejudices against African Americans, American Indians, Asians, Hispanics, and Whites. Thirty-nine professionals from numerous areas of expertise completed a questionnaire comprised of generalized questions which could be applicable to various settings but which would assess bias. Results indicated that “participants” mean unintended bias and prejudices across items were always lower toward clients from their own racial or ethnic group” (p. 827). Furthermore, among the five groups studied, American Indian and Asian clientele received a higher level of prejudice and bias than the other groups (Paniagua et. al, 2000). It was also noted that these biases appeared despite participants’ reports of receiving prior cultural diversity training.

Ancis and Szymanski (2001) conducted a “preliminary investigation of White counseling students’ awareness of White privilege (McIntosh, 1995) using Peggy McIntosh’s analysis of her own experience” (p. 550). These clinicians in training were directed to read the article, identify one of McIntosh’s points of privilege, and to write about their reaction to the point of privilege they chose. Study results suggested three themes: “lack of awareness and denial of White privilege, demonstrated awareness of White privilege and discrimination, and higher order awareness and commitment to action” (p. 554). There were a total of eleven sub themes present.

The reactions of students straddled all three of the themes nearly equally; however, the reactions depicted in theme one, “lack of awareness and denial of White privilege” seemed most disturbing to the authors as they state, one “reaction was shock concerning the blatant negative reactions and denial of White privilege expressed by some of the Theme 1 students” (i.e., those students who fell in the lack of awareness and denial of White privilege group) (Ancis & Szymanski, 2001, p. 562). The reaction demonstrated by students in this study are very concerning when one considers the African American client and the possibility of their entering a therapeutic relationship with a clinician who might have similar responses. This reaction is also a poignant reminder for the need of this study, that is, the need to add to the body of literature which demystifies the African American client in family therapy. The next section, consequently addresses the importance of racial matching between African American clients and their therapists and those styles clients prefer.

Client-Therapist Ethnic Match and Preferred Styles of Treatment

Thompson, Bazile, and Akbar (2004) studied the African American perception of psychotherapy and psychotherapists by facilitating focus groups. The study reported several relevant themes in regards to barriers to seeking therapy. Lack of knowledge about available

services, lack of financial resources, and the presence of alternative resources (pastoral counseling or speaking with an elder in the community) were listed as general barriers. However, the barriers that appeared to generate more discussion, and therefore, more feedback included cultural barriers and the stigma attached to seeking therapeutic services. Participants admitted to feeling as though seeking therapy was a sign of weakness.

The issue that generated the highest level of discussion was that of mistrust. Participants reported that while therapy might be helpful, they doubted that therapists knew enough about them and their daily struggles and experiences to accept or understand their needs. Participants discussed their fears of “misdiagnosis, labeling, and brainwashing” (Thompson et al, 2004, p. 23). Psychologists were perceived to be “White males, who were unsympathetic, uncaring, and unavailable” (p. 24). With regards to the issue of racial matching, participants reported that race should not matter but it ultimately did when considering a therapist. One participant stated:

I think on some issues, like racism or something like that, a White person can't really relate to that. I want someone [who] could really understand what I'm talking about. Even just with Black people in general, we have diversity and we have internalized racism within us. We have the whole thing about shades and I don't think a White person could really comprehend what I was talking about (p. 24).

This study speaks volumes to therapists about the perceptions African Americans have about therapy and practitioners. Their discussions seemed to be riddled with elements of fear, mistrust, and uncertainty around issues of therapy. Therefore, it is imperative that clinicians have an understanding of and sensitivity to the misgivings African American clients are likely to have in seeking therapy with non-African American therapists. The following studies in this section continue to expand on preferred styles of treatment and ethnic matching.

Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) examined the experiences of African American and European American therapists in addressing race in cross-racial therapist-client dyad. Results indicated that while both groups of therapists agreed to the benefit of such a discussion in cross-racial dyads, only African American therapists reported having such discussions in therapy. This result was in spite of both groups reporting that they felt no discomfort in addressing the subject. The authors suggest that perhaps since the African American therapist is more accustomed to negotiating racial differences than European American therapists, they are sensitive to client discomfort around the issue and are more likely to address it. Knox et al., (2003) suggest that since European American therapists are in privileged positions, they feel less obligation to address issues of difference such issues do not impact them in the same capacity.

Blank and colleagues (1994) examined the effect of racial matching on service provision in certain areas in the rural South. Specifically, the authors hypothesized that clients who were racially matched with their caseworker would utilize more services and would have fewer missed appointments than mixed-race dyads. They also predicted that cases where the client and caseworker were matched based on race a connection would occur more frequently by chance. Results indicated that regardless of case assignment, African American caseworkers had a disproportionately larger percentage of racially matched cases. As hypothesized, African American clients with White case managers had fewer visits while those with racially matched caseworkers had more visits than anticipated. However, racially matched African American clients also had more failed visits than racially matched White client-caseworker dyads. The authors suggest that the failed visits are due to more of a reliance on social networks of support, which may reduce the perceived value of support from mental health centers.

Russell and colleagues (1996) examined the relationship between therapist-client ethnic match and therapists' evaluations of overall client functioning. The study was developed as the result of a growing concern with the tendency for ethnic minority clients, specifically, African American, Asian, and Latino, to be "misdiagnosed and over pathologized" (p. 599) in treatment. The most significant finding from this study was that ethnically matched therapists for African, Asian, and Mexican Americans deemed them to be higher psychologically functioning than did mismatched therapists. This finding is consistent with other literature. Similarly, Li-Repac (1980) learned that ethnicity of both client and therapist affected therapist's clinical judgment. "White therapists rated White clients as affectionate, adventurous, sincere, and easy-going, while rating Chinese clients as more depressed, inhibited, less socially poised, and as having lower capacity for interpersonal relationships than did Chinese therapists" (Li-Repac, 1980, p.599). On the other hand, Chinese therapists rated those same White clients as "active, aggressive, rebellious, and outspoken; and rated the same Chinese clients as alert, ambitious, adaptable, honest, and friendly" (p. 599).

The previous studies highlight the tendency for clients to be perceived as higher functioning when they are in a racially matched client-therapist dyad. These studies support the literature which suggests that African Americans fare better with racially matched therapists. These studies are important because for therapists to consider as they provide useful information about what things should not be done in sessions as they are likely to further alienate the African American client who may be distrustful of European Americans and the therapeutic process. As a result of these findings, I intend to ask questions in my interviews that will specifically address the racial and ethnic differences between the client and therapist and how those differences are addressed in session.

Okonji and colleagues (1996) also addressed their concern for the underutilization of mental health services by examining the preferred style and ethnicity of counselors by African American males. The preferred styles considered in this study were reality therapy and person-centered therapy. Participants included 120 randomly chosen African American job corps students in Utah. Participants viewed video taped segments of African and European American therapists using both the person-centered and reality therapy approaches, after which each participant then rated the therapists.

Reality therapy, an approach developed by Glasser (1965), addresses therapeutic issues in a more directive manner with the therapist confronting clients in an effort to determine if their behaviors will result in their needs being met in the most effective way possible. Person-centered therapy (Rogers, 1965, 1980) focuses on the relationship between the client and therapist as key to the progress of therapy. However, in this approach, the direction of where therapy goes is determined by the client not the therapist. Results of this study found that African American male students preferred reality therapy over person-centered therapy. The study also showed that participants perceived the African American counselor to be more effective than their European American counterparts regardless of whether they were using reality or person-centered therapeutic approaches. This study provides evidence of the importance certain approaches when working with African Americans. It should be noted that the reality therapy approach detailed above is very similar to the direct manner with which African Americans are known to communicate with each other, and therefore, it is understandable that this is found to be the preferred approach to therapy. In working with African Americans in marriage and family therapy, it is critical to have a sense of those approaches that are more likely to help engage the client both in the process and the therapeutic relationship.

Dakof and colleagues (2001) studied the impact of the therapist's focus and the issues addressed in therapy on the level of engagement among African American adolescent males with substance abuse issues. Six themes were used to determine engagement in therapy: "a) mistrust, b) anger/rage, c) alienation, d) disrespect, e) the journey into manhood, and f) racial socialization" (p. 323). Findings indicated that use of the six themes, with the exception of trust vs. mistrust, in therapy resulted in more engagement in the therapeutic process. Specifically, "It appears that when an adolescent's angry feelings, sense of alienation, and feelings about what it means to be a Black man are discussed directly, the adolescent responds with more overall engagement in the next therapy session" (Dakof et al., 2001, p. 334). The authors explained that the issue of trust was addressed in terms of an element of the parent-child relationship that had been damaged as a result of the child's behavior.

Folensbee, Draguns, and Danish (1986) studied the effectiveness of two types of therapeutic interventions with African American, Anglo American, and Puerto Rican American students. The two interventions used were closed questions and affective responses. The authors hypothesized that African and Puerto Rican Americans would prefer closed questions while Anglo Americans would prefer the affective responses of therapists (Folensbee et al, 1986). They also predicted that the more acculturated the Puerto Rican American student, the more likely he/she would be to respond positively to affective responses. Results for the effects of acculturation with Puerto Rican American students were inconclusive but the study showed affective responses as the preferred intervention or style of treatment across populations (Folensbee et al., 1986).

The research in this section is based on studies in the United States and primarily advocates for racial matching between client and clinician or service provider. However, the next

section continues to address the issue of racial matching, service delivery from an international perspective, and challenges the idea that racial matching is most appropriate in meeting the needs of clients.

International Considerations of Culturally Specific Needs

The importance of attention to the culturally specific needs of clients is being addressed not only within the field of mental health service delivery in the U.S. but also internationally across human service fields. Patni (2006) published an article differentiating between “race-specific versus culturally competent” (p. 164) service delivery by social workers in the United Kingdom. She suggests that the two are not equivalent. Race-specific services, i.e., services geared toward a specific race or ethnic group are systematic ways to perpetuate the same insidious cycle they were created to subvert. That is to say, while there are benefits to service delivery where both the service provider and client are of the same race, suggesting that this is the only appropriate way to meet culturally specific needs denies our society the chance to move “toward peaceful co-existence, understanding, and dialogue” (Patni, 2006, p. 172). Patni’s argument is well taken and seems an appropriate foundation to understand therapeutic approaches and training that would take both clinicians and clientele from margin to center (hooks, 1985).

Williams and Soydan (2005) studied the tendency of social workers to develop treatment planning and treatment delivery based on a majority approach versus an approach that is specific to the culture of the child and family in question. Participants in this study were from Denmark, Germany, Sweden, Texas, USA and the United Kingdom. The results showed that while social workers used language that suggested some consideration to the relevance of the cultural needs of the child and family, there was no true indication that implementation of the treatment plan

had any significant evidence of serving families based on their cultural idiosyncrasies or their culturally specific needs.

The literature here identifies interventions, approaches, preferred styles of therapy, and specifics about the preference of racial matching in therapeutic and social service settings. Painful historical considerations, cultural mistrust, and therapist bias and privilege all provide strong support for African Americans having preferences when seeking therapy. Furthermore, the findings suggest that similar issues appear to be problematic abroad as well as within the United States. This section further adds to the foundation of information about working clinically with African American clients. There is a growing body of literature addressing the complexity of working with African Americans in a clinical setting, yet none of the studies explore what presenting problems African Americans identify in therapy. The following section explores existing literature related to presenting problems.

Presenting Problems in Therapy

Literature addressing issues African Americans present in therapy is minimal at best. Piercy, Fontes, Bischof, and Chang (1996) contributed a chapter to identifying resource literature that addresses presenting problems in family therapy. The authors limit their focus to family therapy used in treating substance abuse, sexual child abuse, HIV/AIDS, and family systems medicine. Although this text is intended primarily as a tool for gaining a basic understanding, it highlights several authors who have contributed literature that addresses specific presenting problems within a cultural context. Piercy et al., (1996) specifically reference Boyd-Franklin and others as noteworthy contributors to the literature on working with HIV/AIDS and the African American clientele (Boyd-Franklin, 1992; Boyd-Franklin, Aleman, Steiner, Drelich & Norford, 1995; Boyd-Franklin & Boland, 1995). Another contributor identified was Fontes (1995) who

addresses treatment of sexual abuse issues with nine different cultures including African Americans.

June, Curry, and Gear (1990) studied reported concerns of Black students and the services they used over an eleven year period. One of the services identified was mental health services. The authors hypothesized: a) there would be a difference in reported problems over time; b) based on the ranking of problems, users would differ from nonusers; and c) there would be a correlation between problems experienced and use of services. The study indicated that issues of concern for Black students were consistently related to living conditions, finances, and academic adjustment over the eleven year period with the exception of the year 1987 where the third most reported concern was more psychological and/or emotional. June et al. (1990) attribute the exception to a change in government funding for financial aid and to a general increase in racial incidents on college campuses. There was no statistically significant difference in ranking of problems between users and nonusers, i.e., both groups consistently identified the same three top concerns. Finally, while the use of services related to reported problems depended on demographic variables, students who reported psychological or emotional problems used mental health and other supportive services available to them more than students reporting any other problems (June et al., 1990).

Marriage and family therapy has added to the body of literature on issues of cultural diversity, particularly with regards to the African American client (Bean et al., 2002; Boyd-Franklin, 1992; Dakof et al., 2001; Hardy, 1989; Willis, 1995). Still there is more that can be learned. Clinicians have not yet fully embraced the complexity of working with this population. African Americans present unique circumstances in their family dynamics, in their subjugated positions in society, in their intimate relationships, and in the individual development of their

identities. The proposed study will seek to understand these dynamics as they relate to African American clients and their experience in relational therapy. The following section explains the theoretical framework of the proposed study.

Theoretical Framework

My theory about change in therapy is that it occurs through a reliance on the complexities of diversity, issues of social justice, our own personal life stories, and the belief that our healing can take us far beyond our circumstances. This theory is informed by my own personal story, the historical value of storytelling embedded within the African culture, a multicultural perspective, and the postmodern perspective of Narrative theory. This section addresses the concepts surrounding the theoretical framework that informs this proposal.

Story telling in the African American community. The art of storytelling has always been a part of African and later African American culture (Banks-Wallace, 2002; Fabius, 2016). Storyteller, Diane Ferlatte (2000), best articulates the importance of storytelling when she explains:

This is why I tell stories...This is what its all about...the little moment that lasts forever in ones memory: that time of intimate connection with the listener, even someone you hardly know. When we tell stories, especially personal stories where we open ourselves up to whoever is listening, there is often for the listener, the value to be learned, or encouragement to be gained, knowing that others before them have conquered fears and challenges similar to their own.

My hope with this research is to offer participants or co-researchers an opportunity to potentially impact White clinicians by offering their experience in therapy. I believe that sharing one's personal experience is a powerful way to allow us the opportunity to understand each

other. Furthermore, it is important to me as a researcher to conduct this study in a way that is reflective of my cultural context.

Multicultural perspective. I identify as African American and as a member of the same-gender-loving community or LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) community. While both of these positions are subjugated, I fully accept the ways in which I hold power. I am a well-educated, able bodied, middle class, adult. I am continually aware of the ways in which my reality might be different from others and I spend much of my life attempting to understand the perspective of those who are different from me while sharing vulnerable aspects of myself with others both in my professional and personal world. My views have been impacted by the Multicultural Perspective (MCP) (Hardy and Laszloffy, 2000) and by other scholars who specialize in the area of cultural diversity and social justice (Smith, 1998; Walker, 1997; McGoldrick, 1998; Boykin, 1996, Boykin & Harris, 2005; Boyd-Franklin, 1992, 2003; Franklin, 1999; hooks, 1985; Feire, 1998; Lourde, 1984).

The Multicultural Perspective (MCP) is the lens by which we begin to acknowledge certain dichotomies influencing the inequalities present in our society (Hardy & Laszloffy 1992, 1995, 2000). The dichotomies Hardy and Laszloffy (1995) address primarily reflect the possession of or lack of power where one is either privileged or subjugated depending on variables such as race, ethnicity, sexual identity, gender, physical abilities, or socioeconomic status. For the purposes of the proposed research, MCP is most applicable to the dynamic of race and how being Black impacts the client in the therapeutic setting. The Multicultural Perspective supports my assertion that the African American experience in relational therapy is worthy of further research despite existing literature because it highlights dynamics which may confirm the experiences of co-researchers in this study, i.e., racism, feelings of anger, rage, powerlessness,

oppression, and continued marginalization. My hope is to offer those who have been subjugated the opportunity to share to their experience (Hardy, 2013). The Multicultural Perspective and Narrative therapy are symbiotic in that both consider the complexities of social injustice as real and ever present in the day-to-day lives of African American clients. The following section reviews the Narrative therapy approach as it relates to this research.

Narrative Therapy. Michael White and David Epston (1990) developed the Narrative approach to treatment by integrating themes of oppression and liberation theory in their work with clients. White was influenced by French philosopher, Michael Foucault (1973, 1980), who believed those in power created narratives that subjugated marginalized populations. According to Foucault (1973, 1980), the disenfranchised internalized these oppressive narratives thereby judging themselves based on elitist views that held no regard for their perspectives or circumstances. White and Epston consequently believed clients were subjugated and oppressed not only by societal factors but also by the stories they told themselves about their experiences. They regarded clients as the experts of their own experiences and worked with them to redefine success regardless of their circumstance.

Narrative theory supports this research proposal in that it respects the experience of the client, and regards them as experts of their own experience. Another component of Narrative therapy is the externalization of problems in order to reframe the meaning clients make of their experience (White & Epston, 1990). This intervention is compatible with the proposed study in that it invites participants to externalize an experience in order to benefit the field of marriage and family therapy. Another possible benefit of participating may be the feeling of empowerment one might experience by being regarded as an expert and by potentially impacting the experience of future African American clients. Regardless of their initial presenting problem or its

resolution, telling their stories may allow participants to reframe their experience or their presenting problem in a way that has a positive impact on them. The following section identifies the research questions and hypotheses that will be addressed in this study.

Research Question

The research question addressed in this study is the following: what is the African American experience of relational therapy with White therapists?

Chapter two has described many critical aspects of the African American client; the importance of coping, the historical complexity of rage, and the negative sense of self brought on by the continued treatment as second-class citizens. Yet there is no research addressing the African American experience of relational therapy from their personal perspectives. This study attempts to address this gap in the literature. Chapter three presents the methodology used to answer the research question driving this study.

Chapter Three

Methodology

Phenomenology

This chapter details the methodology used in this research. First, I address the appropriateness of using phenomenological methodology to conduct this research. I later provide the historical relevance of phenomenology and its core fundamental concepts. One of the concepts involves my role as the researcher and I used bracketing so as not to impact the research with my experiences and the meanings I have given them. Other fundamental concepts include data collection and analysis and further steps taken to ensure the findings of this research are trustworthy.

Crotty (1998) suggests that in order to successfully conduct research, the researcher must 1) be clear about the research question; 2) determine the best methodology and methods to use to answer the research question; 3) justify methods and methodology used by clearly linking them to a theoretical perspective; and finally 4) be clear about his/her epistemology, i.e., the assumptions made about knowledge, meaning, language, and self (Schwandt, 2003). For the purposes of this research, and to follow the suggested format for successfully conducting research, the question I intended to answer is “What is the African American experience of couples or family therapy with White clinicians?” I used phenomenological methodology and semi structured interviews as my primary method of conducting this research.

Phenomenological research seeks to understand the “what” and “how” of an experience and is therefore best suited for the nature of this study (Creswell, 1998). My epistemological stance regarding knowledge, language, meaning, and the self are dictated by my belief that in order for therapy to be successful therapists must first seek to understand their clients. This

understanding must take into account those nuances of the person(s) that makes them unique. Cultural differences must be considered and addressed but not imposed on the client. However, while it is important for the clinician to have a foundational knowledge of cultural differences, it is just as important to seek from the client his/her perspective of how they define themselves from their own cultural lens. Given my epistemology, phenomenology, that is to say, the study of a phenomenon and the meaning a person makes of that experience, is the most logical approach to this research. The following sections detail the history and fundamental concepts of phenomenological research.

History. The German philosopher and mathematician, Edmund H. Husserl is credited as the founder of Phenomenological research (Crotty, 1998; Valle, King, & Halling, 1989; McCall, 1983; Creswell, 1998; Moustakas, 1994; Patton, 2002; Bogdan & Biklen, 1998). Alfred Schutz (Patton, 2002; Boss, Dahl, & Kaplan, 1996) and Merleau-Ponty (Boss et al, 2002; Creswell, 1998) have contributed to the foundation of phenomenology. Husserl (1962, 1967), while well versed in traditional scientific research, believed the consciousness of the experience and the meaning derived from this consciousness to be the true science. Levinas (1967) captures this belief when he writes:

For Husserl it is the subjective world that is real; the physical world has reality of another degree...the origin of all being, including that of nature, is determined by the intrinsic meaning of conscious life and not the other way around...In summary, the existence of an unperceived material thing can only be its capability of being perceived...a possibility which belongs to the very essence of consciousness...A material thing...is relative to consciousness—to say that it exists is to say that it meets consciousness (p. 58).

Husserl believed in the unbiased study of experiences without interpretation (Husserl, 1970; Valle, King, & Halling, 1989). Therefore, the meaning of a phenomenon is understood from the most basic level of our consciousness and is therefore free of one's cultural context (Dowling, 2007). This idea is called phenomenological reduction and it includes the concept of epoche and the method bracketing. Heidegger (1970) held a different view, that of interpretive or hermeneutic phenomenology. Lopez and Willis (2004) describe hermeneutics below:

In relation to the study of human experience, hermeneutics goes beyond mere description of core concepts and essences to look for meanings embedded in common life practices. These meanings are not always apparent to the participants but can be gleaned from the narratives produced by them (p 728).

Husserl and Heidegger used terms such as "lifeworld" to describe their understanding of experiences. Husserl viewed "lifeworld" as the way in which one or more social groups structured the world into objects (Beyer, 2016). In contrast, Lopez and Willis (2004) define Heidegger's view of "lifeworld" as the "idea that individuals' realities are invariably influenced by the world in which they live" p 729. The authors also describe "being in the world", another phrase used by Heidegger, to:

emphasize that humans cannot abstract themselves from the world. Therefore, it is not the pure content of human subjectivity that is the focus of a hermeneutic inquiry but, rather, what the individual's narratives imply about what he or she experiences every day (Lopez & Willis, 2004, p. 729).

This research follows Heidegger's hermeneutic approach to phenomenology as it seeks to make meaning based on the experiences of African American individuals, couples, and

families in therapy. In my joining participant systems to understand their experiences in therapy, I become a part of the process of co-creating the meaning I seek to understand.

Fundamentals of phenomenology. Heidegger (1977) addressed the meaning of phenomenon in the following: “Constructed from *phaino*, phenomenon means to bring to light, to place in brightness, to show itself in itself, the totality of what lies before us in the light of day” (pp. 74-75). Through the process of “bringing to light” one can truly understand a phenomenon. Moustakas (1994) refers to phenomenology as the process of getting back to things themselves. Husserl (1962) defines phenomenology as the study of how people describe events and experience them through their senses; he assumed that we can only know what we experience by paying close attention to our perceptions and meanings that awaken our awareness. As a result, Husserl primarily concerned himself with the discovery of the meaning and the essences in knowledge in his practice of phenomenological research (Moustakas, 1994).

There are fundamental concepts that create the foundation of phenomenological research. These concepts include: 1) the need for the researcher to employ the epoche or bracketing; 2) understanding both the role of the researcher and the participant; 3) the reduction of analyzed data such that the researcher can ultimately create a description capturing the essence of a phenomenon (Creswell, 1998; Moustakas, 1994).

Epoche. The epoche is considered a core concept in phenomenological research. It is the ongoing effort to suspend preconceived knowledge or judgment of a phenomenon (Moustakas, 1994; Patton, 2002). Patton (2002) refers to the epoche as the abstinence from every day, ordinary ways of perceiving. He suggests that the epoche or bracketing requires us to look at things in a different way, such that we truly see what is before us rather than what we have

constructed it to be through our own conceptualizations. Moustakas (1994) describes the epoche as:

a preparation for deriving new knowledge but also as an experience in itself, a process of setting aside predilections, prejudices, predispositions, and allowing things, events, and people to enter anew into consciousness, and to look and see them again, as if for the first time (p. 85).

In order to respect the process of bracketing in this research and add to the credibility of the research, I maintained a journal to explore my experiences and preconceptions of therapy with White clinicians. This process allowed me to acknowledge my beliefs and to reduce the potential hindrances they may have on the process and outcome of the study. Specifically, I drafted journal entries after each interview to minimize bias. I also added journal entries when I encountered information that stimulated a reaction. I discussed experiences documented in my journal with my advisors and colleagues to allow for dialogue that might assist me in my attempts to monitor my presuppositions within the process.

Self of the Researcher

Literature details the importance of minimizing the impact of the researcher in phenomenological research (Heiggeder, 1977; Husserl, 1962, 1967, 1970; Patton, 2002; Moustakas, 1994). I have documented my efforts to reduce my impact on this study in this chapter. However, just as Heidegger says, one cannot truly ever separate herself from her own context. Therefore, I attempt here to place myself within the context of this research as an African American woman in the social construct of a White majority, who attended therapy with a White clinician.

There are several contextual variables at play when considering my attending therapy with a White clinician. These contexts include my experience within the African American experience, the influences and meaning I give to being Black in a predominantly White world, and how trust and mistrust inform those meanings. Growing up, the messages I received about being Black were foundational. Specifically, my parents made sure I knew I represented them when I went into the community in any official capacity, i.e., school or church. My dress, posture, and manners as a young, black, respectful woman were important. Those messages were especially ingrained through my elementary school education. My parents chose to send my siblings and me to a black, private catholic school. Their decision was based on our receiving a quality education particularly given the poor standard of education in Louisiana public schools. I attended St. Francis Xavier Interparochial School from first through eighth grade. I am specific about this time because of the principal.

I remember instances of our principal, Sis. Patricia Ann, calling the entire student body to the auditorium to remind us of how we were viewed by White people. She reminded us that how we presented ourselves mattered. Our appearance was critical, uniforms pressed, shoes shined, etc. Our school was a part of the larger East Baton Rouge Diocese which meant we were compared with local predominantly White schools in academic performance. She reminded us that we had to work twice as hard to be viewed half as good as our White counterparts. Those reminders were especially strong when we competed with other schools in our diocese, schools whose students were predominantly White. So, I grew up with messages from my elders encouraging me to be my very best and with strong caution about what I might experience from White people. While I heard the message, I didn't really understand what she and other trusted adults meant until I became an adult.

My family rarely made overt statements about White people, but rather offered indirect messages. My mother often retold stories that conveyed her opinion of White people based on her experiences. One story that still strikes me was one she told about a trip to the grocery store when I was an infant. We were in the checkout line I said a phrase mimicking my maternal grandmother. I said, "Well hello there" to an older White woman. This is a greeting I'd heard my grandmother say often enough to understand when and how to repeat it. However, despite my saying it multiple times, the woman ignored me. My mother still remembers telling me not to speak to her again because she knew this woman heard me and suspected she was being rude because I was Black.

Another story was from a time when I was older and could understand the context a little better. At the time, my mother worked at a drug store. My maternal great-grandmother called her at work, requesting to speak with "Mrs. Brown." Her manager told my mom there was a call for "Mrs. Brown" on hold for her. My mother said she thought it was a business call. When she answered the call, she commented on the formality, and my great-grandmother said, without hesitation, "That's right. Make them White folks put a handle on your name!" In other words, make them respect you.

I could not put into words, at the time, the meaning of those stories, the inflection in her tone, or the force with which she told them. But I knew to be cautious of White people. I learned I was not likely to be considered equal in their eyes. Other family members were more overt. I can hear one of my aunts even today saying, "Melody, you know you shouldn't trust people." She was particularly strong in this advice if it was in the context of White people.

One of the most poignant moments with a White person was when I was in my master's program and working with a White family. During the first session, the father asked questions I

had grown accustomed to: “Do you have children, what experience do you have working with children, etc.?” A few days after the session, the program director asked to speak with me about the case. He informed me that the family would not be returning. When I asked why, he told me the father spoke of his discomfort with me working with his children because of the difference in our values. Naturally, I was confused but before I could ask more questions, the director told me with a sad expression that the father had a problem with me because I was Black. I felt like I had been slapped. For the first time, I could truly understand those stories from my childhood. Still, I was excited about beginning my studies at Syracuse for so many reasons, one being the opportunity to escape the oppression of the south. However, after a few weeks in upstate New York, I went shopping in Ithaca and noticed that wherever I went in the store, the security guard followed me. To my knowledge, it was the first time I was ever overtly profiled. By the time of that incident, I’d been exposed to so much racial injustice, I struggle to recall the full list.

Shortly after beginning my doctoral studies, I also began my coming out process. That experience is still powerfully critical in my identity development. I grew up in an African American Baptist community and attended an all-Black catholic school. Being anything other than heterosexual was severely frowned upon. Facing the shame of my sexuality and making that public was overwhelming because in coming out, I thought I was risking everything and everyone that felt like home to me, my family, my God, and my community. I decided to see a therapist but did not know where to begin. Also, sharing that shame was terrifying because of the messages I received about not “putting your business in the streets”. My advisor recommended a therapist and because I trusted her, I felt much more comfortable seeing him. He was a White Jewish male. All the fears of breaking the rules I had learned over the years about sharing the most vulnerable parts of myself with others, especially White people, were still there. He made a

difference because he made space for me to look at those fears. I never felt judged, and in fact, I felt cared for and respected. He also challenged the beliefs that held me back. My coming out became a very spiritual process for me and I needed someone to hold the space he held for that process to happen.

All of my experiences with White Americans, those that were both painful or frightening, and those that were beautiful and profound, were with me as I engaged in this research. My assumption entering this research was that African American couples and families held our pain in the complex context of our culture. I was interested in this research because I wanted to understand how their White clinicians attended to that context. Knowing my experience was a part of this research, I wanted to remain curious about the unique nuances of their experiences. I also wanted to understand their therapeutic relationships with their therapists as a part of their healing process.

Role of the Researcher and the Participant

The role of the researcher, as stated above, is to always act from a position free of judgment through disciplined efforts to set aside one's own experiences, preconceptions, and knowledge (Moustakas, 1994). This stance allows the researcher the freedom necessary to understand the meaning of experiences from the viewpoint of the participant. The researcher must create an environment of equality in the relationship to encourage open dialogue about the phenomenon. As in the post-modern tradition, the researcher assumes the participant is the expert of his/her own experience and therefore becomes the co-creator of the meaning of the phenomenon. The following sections will address how data will be collected and analyzed.

Sampling

The intention of this study was to learn as much as possible about the African American experience of therapy with White clinicians. Given the specificity of the research, I used purposeful sampling, i.e., the intentional selection of research participants who can best speak to the phenomenon or experience in question (Patton, 2002). Specifically, I used criterion sampling, that is, the recruitment of participants based on established criteria. The criteria established that participants must identify as African American, be at least 18 years old, and have participated in either family or couples therapy with a White clinician.

I initially recruited participants using emails, letters, and newspaper advertisements (See Appendices B through D). I sent emails to therapist colleagues using a listserv and asked if they would distribute the request for participants to any clinicians they knew or to inquire among former clients who might be interested. Those clinicians who responded were sent IRB approved emails introducing the request for participants. IRB approved recruitment letter and advertisement were attached to the email to further explain details of the study and criteria for participating. One potential participant was identified and contacted. However, no interview was conducted due to that person actively participating in therapy at that time.

Additionally, a newspaper advertisement was placed in a local neighborhood newspaper, known for its focus on issues related to the African American community. The same was posted electronically on Craig's List in several metropolitan cities known to have large African American communities.

I also attempted to recruit participants from the couple and family therapy clinic where this research is based. I collaborated with clinic faculty to identify former clients as potential participants. Former clients were identified and recruitment letters with self-addressed, stamped

envelopes were mailed requesting participation in the study. After several weeks, the same letter was mailed a second time to the identified list of former clients.

I then conducted a series of outreach efforts to church communities, non-clinical professional colleagues, family members and friends. I approached three pastors requesting permission to recruit participants from their congregations. Two pastors granted permission for the researcher to address the congregation. In addressing the members, I introduced the study, detailed the criteria and offered \$20 gift cards to either Wal-Mart or Target for their participation. I then provided the congregation a confidential means of communicating with me to discuss their interest in participating.

Using the content from IRB approved emails, advertisements, and/or newspaper advertisements I drafted emails and distributed them to non-clinical contacts such as family members, colleagues and friends in various regions across the United States. I posted the same message and “inboxed” contacts on Facebook. The effort of emailing non-clinical contacts and “inboxing” my contacts on Facebook meant there were several contacts that had received the request for participants twice. No announcements were made in posts that could be seen by unintended persons, i.e., nothing was posted on News Feeds or Timelines. These restrictions were applied to protect the anonymity and confidentiality of potential participants. Of the recruitment efforts detailed above, participants exclusively came from church communities, non-clinical professional colleagues, family members and friends. Most participants only agreed to participate because of a connection to me through a trusted friend or acquaintance, co-worker, pastor, congregation members, or family members. Given how participants were identified, it should be noted that while I started recruitment using purposeful sampling, snowball sampling best describes how participants were recruited. Snowball sampling has been described as a useful

research method specifically for marginalized populations and for populations known to be difficult to access (Cohen & Arieli, 2011; Petersen & Valdez, 2005; and Woodley & Lockard, 2016). Sampling may be an unintended limitation to this research as well as an indicator for future research. Limitations and implications are discussed in Chapter five.

Data Collection

Participants agreed to have their interviews digitally audio recorded (See Appendix A). I collected data by conducting interviews initially using a set of demographic questions followed by a set of open-ended questions intended to explore the experience of therapy (See Appendices E and F).

The proposal for this study called for fifteen to twenty interviews with the understanding that the number of interviews conducted would ultimately be determined by data saturation. Initially, each interview generated new information through the coding process. Attempts to recruit and interview were discontinued for two reasons. First, despite recruitment efforts, the study included eleven participants instead of the projected fifteen to twenty participants. The second reason for discontinuing recruit efforts is because information collected from interviews began to be repetitive and no new information or themes emerged. When data from interviews becomes or new information no longer emerges, it indicates data saturation (Fusch & Ness, 2015; Glaser & Strauss, 1967; Guest, Bunce, & Johnson, 2006). Once the researcher reaches this point, the recruitment and interview process should be terminated.

Trustworthiness

Research is deemed trustworthy if the study is found to be worthy of consideration, if the findings are true, if the study is replicable, and if participants agree that the findings adequately represent their experience (Lincoln & Guba, 1985). Trustworthiness is also established by

credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). According to Patton (2002), research credibility is established by “rigorous methods for doing fieldwork that yields high-quality data that are systematically analyzed” (p. 552). Credibility is the equivalent of internal validity in quantitative research. Internal validity is the implied causal relationship between dependent variables and independent variables (Lincoln & Guba, 1985). However, one of the most critical determinants of whether a study is credible in qualitative research is whether or not participants agree that the findings represent their experience.

There are a number of techniques used to ensure credibility. In addition to reflective journaling as detailed above, I employed peer debriefing, referential adequacy, and member checks. I held debriefing discussions with peers experienced in phenomenological research. This process helped to ensure I remained as neutral as possible. For referential adequacy, I digitally audio recorded each interview and I stored interviews on a separate hard drive. Finally, I used member checks to ensure the study is approved by those participants who completed the interview process. After data collection was complete, I contacted participants and requested they review their interview transcripts and brief descriptions of their experiences. For those who requested it, I also forwarded the recorded interviews for their review along with transcripts. I encouraged them to suggest revisions, additional explanations, or corrections. I also contacted four participants specifically for clarification on aspects of their interviews. All participants confirmed the accuracy of their experiences captured through transcripts and descriptions.

Transferability is the equivalent of external validity in quantitative research. External validity refers to how the results of the study are generalized to varying aspects such as participants from different geographical settings. Participants interviewed were from several regions of the U.S. including the West, Midwest, Northeast, Southeast, and Southern regions.

Transferability in qualitative research is achieved by two processes. The first process involves a “thick description” where the researcher provides as much detail as possible about how the research was conducted so that other researchers can determine the possibility of transferring this study to another participant group, under similar conditions (Lincoln & Guba, 1985). Providing thick descriptions also assist in establishing dependability. The second process in achieving transferability is the use of purposeful sampling as described earlier.

Dependability is equivalent to reliability in quantitative research and is defined as the process by which the research conducted is consistent, predictable, and replicable (Lincoln and Guba, 1985). Lincoln and Guba (1985) suggest internal and external auditors assist in ensuring the dependability of the research. Providing a “thick description” allows auditors to assess the stability and predictability of this research. Both internal and external auditors were used in this study.

Confirmability is the equivalent of objectivity in quantitative research and refers to the notion that the researcher neither disturbs or is disturbed by the interview process or information gathered from participants (Lincoln & Guba, 1985). Confirmability also means the outcome of the research can be corroborated independent of the researcher. Confirmability was established by employing triangulation through internal and external audits and bracketing through reflective journaling (Universal Teacher, 2017). To establish triangulation, both internal and external auditors experienced in phenomenological research monitored the process of the research from inquiry to outcome to insure the processes used were acceptable. The internal auditors, who were also advisors during this research and involved in all parts of the research, reviewed transcripts. After reading transcripts, they employed coding strategies and shared emerging themes they began to notice in their review. Additionally, external auditors were provided a minimum of

three transcripts and they replicated the procedures of the researcher detailed below in Data Analysis. After they completed their process, we met to discuss and compare our respective interpretation of the data. Despite the variation in semantics or our respective use of language, the identified codes, themes and subthemes were comparable. The following section addresses how data was analyzed.

Data Analysis

Creswell (1998) details the necessary steps for sound data analysis in phenomenological research. The initial step in data analysis is my description of the experience of the phenomenon of therapy with a White clinician. This step creates a personalization and an intimate connection to the research. Interviews are then conducted and transcribed. Horizontalization of data is the next step in analyzing data (Creswell, 1998). Horizontalization of data refers to the listing of statements that are unique to experience of participants. In this second step, each statement should have equal value, the nature of the list should not be repetitive, nor should there be any overlapping (Creswell, 1998). Moustakas (1994) further stresses the importance of “being receptive to every statement of the co-researcher’s experience, granting each comment equal value and thus encouraging a rhythmical flow between the research participant and researcher, interaction that inspires comprehensive disclosure of experience” (p. 122-123). Step three involves the grouping of statements into meaning units which the researcher describes the “what” of the participants experience through textural description (Moustakas, 1994; Clark, 1998). Moustakas (1994) defines textural description as the meaning the participant ascribes to the experience.

Step four involves the use of textural descriptions to create imaginative variation and or structural description. Imaginative variation seeks to answer the question of “how” a

phenomenon came to be by expounding on different positions, underlying factors and divergent perspectives (Creswell, 1998). This process helps the researcher “understand that there is not a single inroad to truth, but that countless possibilities emerge that are intimately connected with the essences and meaning of an experience” (Moustakas, 1994, p. 99). The next step in data analysis is to describe the essence of the meaning of the experience based on the textural and structural descriptions (Creswell, 1998). In this process, the researcher describes the universal experience of the phenomenon, that is, the commonality of the experience, the meaning shared by each participant of the study.

I conducted each interview either by phone or in person. Each interview was audio recorded and transcribed. I maintained both electronic copies of the audio recordings on my personal computer and hard copies of transcripts. Transcripts were secured in a locked file cabinet to which only I had access. Electronic records were stored on my computer using two password-protected levels of security to protect confidentiality. After each interview was transcribed, I followed the tenants of horizontalization and combed through each transcript highlighting any statement that reflected the experience of the participant while eliminating repetitive data.

Next, I employed what Moustakas (1994) refers to as reduction and elimination. Reduction and elimination uses two questions to “test” for the relevance a statement:

- a. Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?
- b. Is it possible to abstract and label it? If so, it is a horizon of the experience.

Expressions not meeting the above requirements are eliminated. Overlapping, repetitive, and vague expressions are also eliminated or presented in more exact

descriptive terms. The horizons that remain are the invariant constituents of the experience (p. 121).

I assigned labels or “meaning units” to the statements thus establishing invariant constituents. Once invariant constituents were established, and as the data grew with each interview, similarities began to emerge. Similar labels were then clustered into groups of related themes and subthemes. Specifically, three themes emerged: *Lived Experiences of African Americans*, *Lack of Culturally Responsive Clinical Practice*, and *What Works in Therapy*.

The next step was to review each interview transcript and construct individual textural descriptions (Moustakas, 1994) of each participant experiences. Each participant was processed through another test with the following questions: (1) Are they expressed explicitly in the complete transcription? (2) Are they compatible if not explicitly expressed? (3) If they are not explicit or compatible, they are not relevant to the co-researcher's experience and should be deleted (Moustakas, p. 121). Structural descriptions answer the “how” of participant experiences (Creswell, 1998). Textural descriptions were used from each interview to ensure that the meanings ascribed to individual participant experiences lined up with the overall experience of the collective group of participants (Polkinghorne, 1989). In other words, did each participant experience match the overall description of the phenomenon in question? The next section is a narrative introduction of the participants.

Participants

Eleven interviews were conducted with participants from various regions across the nation, i.e., West, Midwest, Northeast, Southeast and the Southern regions of the United States. Of the eleven participants, ten were female and one was male. The significance of the gender of participants as well as the time required to recruit participants, over four years, will be addressed

later in this chapter. The age of participants ranged from mid-thirties to mid-sixties. All participants have obtained a minimum of an undergraduate degree. Each participant answered a list of demographic questions and another list of questions related to their experiences in relational therapy with European American clinicians (See Appendices E and F). The following narratives described the context for each of the participants based on information gathered from demographic questionnaires as well as information disclosed during the semi-structured interview. Fictional names are used to protect confidentiality.

Kathy. Kathy is a 43-year-old single mother of three who was raised in the Midwest by her mother. For Kathy, the fact that she was raised primarily by an African American woman was significant because it meant that Black men were absent from her life, a dynamic she said has been prevalent for several generations. Therefore, the absence of Black men in her life has significant meaning and is an important dynamic she thought therapists should understand. Kathy attended family therapy with her children, with her mother and individually for herself. She described her therapeutic experiences and the lack of cultural awareness and self-awareness of therapists with whom she had worked over the years. Specifically, she had experiences where she “felt there was some intimidation often that they would become intimidated which would interfere with our ability to communicate.” As a result, she said: “I mean I really felt like people were not equipped to deal with my anger.”

Debbie. Debbie is a 49-year-old female, originally born in the south, who was raised in the Midwest, and is a single mother of three adopted siblings. Knowing she had to ensure they had the best chance to heal from the hurts often endured by youth prior to finding permanent families, Debbie sought therapy for her children. She also sought couple’s therapy with her same-sex partner of eight years. Theirs was also an interracial relationship where Debbie

identified as African American and her partner as multiracial. Debbie's experiences with White clinicians were antagonistic at best and, at times, overtly insulting both in couples' therapy and in family therapy with their children.

Fredrick. Fredrick is a 36-year-old male, raised in the South, who is a divorced, single father of a teenage daughter. He attended relational therapy to address parenting dynamics and marital issues with his now ex-wife. While he had positive experiences with both White and Black clinicians, he spoke of other experiences, particularly his work experience and how it impacts his daily experience as a Black man, the assumptions that are made about him, and his experience of being further marginalized by a larger social discourse. As he speaks about important areas of his life, he touches on nuances of the various contexts of his life, i.e., being a single father, a Black male, a husband, a Christian, and one of the few men of color at his place of employment.

Juanita. Juanita is a 33-year-old, single woman from the Southeast. Juanita attended mediation therapy with her White co-worker to improve their working relationship. Juanita's experience in therapy included discussion about racial and ethnic differences as well as gender dynamics and age difference in the work setting. Infused in her experience of therapy was the richness of her personal experience from the perspective of a larger social discourse. Of the eleven participants interviewed, Juanita's was the only White clinician who addressed cultural and other contextual variables as a part of the therapeutic process. Initially hesitant to attend therapy, Juanita began to appreciate the process and was able to address contextual dynamics with her co-worker.

Melinda. Melinda, a 43-year-old native of the South, lives in the Midwest. Melinda attended couples therapy with her ex-partner and with their adopted sons. Melinda and her

partner are an interracial couple. Melinda noted that one therapist never acknowledged their dynamic, what it meant for her to be a person of color in her relationship or how her experiences might be different as a result of her ethnicity. She described her experience as “isolating” primarily because of the dynamics between her and her ex-partner. Melinda also spoke of instances in her life as a woman of color that illuminated her experiences of being treated differently than her White counterparts. While these experiences are not related to relational therapy, they speak to the experiences of some African Americans in the context of the larger White majority culture or the larger social discourse.

Erica. Erica is a 40-year-old single mother living in the southeastern region of the U.S. Erica had two experiences in family therapy with White therapists. Her first experience was brief, only two sessions, and was what she described as professional but surface. She and her daughter attended ten sessions with this clinician and felt she trusted this clinician. She described her experiences as positive overall and noted that neither therapist made any mention of their ethnic or racial differences.

Marsha. Marsha is a 39-year-old mother and wife from the southeastern region of the United States. She and her husband attended couples therapy and also had a positive experience. Marsha noted her husband was hesitant about attending couples therapy particularly after two sessions with a White clinician where he felt judged. They found another White therapist whose approach changed his negative opinion about couple’s therapy. Neither therapist mentioned ethnic or racial differences between themselves and the couple.

Viola. Viola is a 60-year-old married female from the Midwest area. She participated in couple’s therapy in her early thirty’s with her now ex-husband, a white male, because she wanted to leave him and dissolve their marriage. Another significant part of her experience is that she is

a survivor of sexual assault from a family member. Consequently, she had little trust for men and therefore, knew she would need a clinician who would consider her context in therapy. She described her therapist as condescending, cool, and aloof. He did not attend to her context as a woman of color, the cultural/ethnic differences in the client-therapist relationship, the fact that she was in an interracial marriage, that she had a history of being abused or how being in therapy with two men might impact her given her history.

Francis. Francis is a married female in her fifties in a same-sex relationship. She and her wife attended premarital counseling approximately twenty years ago with the pastor of their church. Their goal was to find a church that would be accepting of their union as a same-sex couple. Once they found a congregation where they felt comfortable, they consulted with the pastor about officiating their wedding. He agreed pending premarital counseling, a requirement for all couples that have wedding ceremonies at this church. Francis describes a very positive experience with the minister. While he never addressed their differences in the context of ethnicity, it was important for Francis that they felt accepted both as an African American couple and as a same-sex couple. Francis felt the minister had an “open heart.” When they approached him about officiating their ceremony, they learned they were the first same-sex couple in his pastoral career. She described her experience in the context of difference and issues African Americans face. She also described her family’s process in considering therapy and other treatment options for their adolescent son.

Coreen. Coreen is a 39-year-old married woman with three children of her own and six stepchildren. She lives in the southeastern region of the United States. She participated in couples’ therapy with her ex-husband. Coreen initially said her experience was good with her therapist but she later admitted that he did not understand the depth of her hurt. She presented

him with the goal of working on their marriage but felt as if what he gave her instead was a way out of the marriage. There was no mention of cultural, ethnic, or racial differences, nor did Coreen expect or require this disclosure while working with the clinician.

Dorothy. Dorothy is a 47-year-old married female. She participated in couples' therapy to resolve marital issues five and ten years ago respectively. She was living in the northeastern region of the United States during her first experience in therapy and her second experience in therapy took place while her husband was living and working in the southeastern region of the U.S. Dorothy described two different experiences in therapy; however, her perspective of her experiences were impacted more by whether or not the clinician was able to successfully engage her husband in therapy. In short, their first therapist understood the problematic dynamics in their relationship and was able to point those dynamics out rather than siding with one or the other of them. While she said her husband did not approve of the clinician, she felt as if he heard her and understood her perspective, something that was valuable to her. Their second therapist initially began working with her husband in individual therapy and later she joined them for couple's therapy. Dorothy felt with this relationship that the therapist had developed a relationship with her husband and sided with him rather than remaining objective. She noted that eventually the clinician changed her demeanor but did not really offer anything that would improve their relationship. During member checks, she noted that unlike some, she was unashamed of going to therapy and felt it worked despite her and her husband ultimately filing for divorce.

Chapter Four

Findings

This chapter addresses the findings of eleven participants and answers the following research question: what is the African American experience of relational therapy with White clinicians? Chapter four begins with an explanation of themes and their respective subthemes using quotes from research participants. Three themes emerged each with correlated subthemes. Chapter four ends with *additional perspectives* from participants. Their perspective did not fit within the established themes but support the final theme: what works in therapy.

Themes

Open coding and bracketing were used to determine commonalities in participant experiences in therapy. This process resulted in three themes, Lived Experiences of African Americans, Lack of Cultural Responsiveness, and What Worked in Therapy. Lived Experiences included the following sub-themes: the Impact of White Privilege, the Impact of Marginalization, and Therapy with White Clinicians. Lack of Cultural Responsiveness included Cultural Awareness and Cultural Knowledge as sub-themes. What Worked in Therapy included Cultural Awareness, General Clinical Skills, and Therapist Qualities. All relevant terms, themes and sub themes are defined below and participant quotes will be used to further understand their experiences and how they culminate in the results of this research.

Each of the eleven participants described their experiences in therapy. Several of those experiences are reflected in the third subtheme, therapy with White clinicians. Six of the eleven participants, Fredrick, Juanita, Melinda, Viola, Debbie, and Kathy, described their experiences in the context of how they are impacted by White Privilege or Marginalization. Of the six, Fredrick addresses his experience with marginalization. The remaining five participants depict

experiences that represent a combination of two or all three of the subthemes, i.e., the impacts of White privilege, marginalization, and therapy with White clinicians. Melinda details how she is impacted by both marginalization and White privilege in day-to-day life. Juanita describes how her clinician helped her and her supervisor unpack her experiences of White privilege and marginalization at her place of employment. Viola and Debbie describe how they experienced marginalization in therapy with White clinicians. Finally, Kathy discusses her experiences with White privilege and marginalization both in therapy and at her place of employment. The following section details quotes from participants related to the theme, Lived Experiences of African Americans.

Theme One: Lived Experiences of African Americans

White privilege is often exerted silently, unconsciously, and at other times it is loud, demonstrative and exerted with conscious force or as Curran (2007) describes it, “invisible, structural, and systemic” (p. 81). Participants offered descriptions of their daily lives that delineate the differences in their experiences from those of their White counterparts. As a result of their descriptions, the subthemes of the Impact of Marginalization and the Impact of White Privilege emerged as having significance in understanding the meaning of their experiences with White clinicians. White privilege and marginalization share a complementary relationship. That is to say, the marginalization of people of color cannot exist without White privilege and vice versa. Consequently, where research participants describe their experience of marginalization, the other side of that experience is that their White counterparts have the privilege of not having to be subjected to similar treatment and are often unconsciously the initiators of such subjugation.

Differences in daily life experiences. Research participant, Melinda, describes an

instance below where she felt invisible:

Visually, people typically judge you initially from what they see, and then from there you know it felt like... kind of like a trickle down theory. So then they put you in a category or place, so you know I would get...you know...more looks or different treatment like—sometimes I'd say invisible. And it's like if I go to the store sometimes I would get different reactions. Like...Tiffany & Co. and Shane & Co. for example are two places that I've noticed this. I went into the Shane & Company and was looking around...its just a jewelry store here in town...and I was looking around and the person didn't say anything. And so I went into the other salesroom floor, that person didn't say anything so then I went back, you know, looked around a little bit. Went back in the other salesroom floor and I was walking through the door, this gentleman that walked in and the same person said "Hello" greeted him "Hello how are you doing?" You know, and then you know walked on around then a lady walked in she said, "Hello how are you doing?" And I thought to myself you know I've been here for at least five, ten minutes.

And haven't been greeted at all, and I watched two different Caucasian people walk in and get greeted right away. So I mean its stuff like that I notice. And then in Tiffany's in particular, I remember walking in and you know I kind of got little looks and then like nobody greeted me and then it's kind of a similar situation. And even though I could afford to pretty much get whatever it is I was looking for there I just felt like I got different treatment.

Melinda's example is one of several similarities related to the differences in the day-to-day lived experiences of African Americans from White Americans. These differences revealed how African Americans felt they have been treated, perceived, or ignored by their White

counterparts either in their place of employment or in their personal lives. The differences then become the systemic erasures that result in feelings of invisibility. Before giving that example, Melinda began with the impact of encountering White privilege in her daily life. She speaks to how a simple task of going into a store shifts her attention from “what she wants to be thinking about” to how she was treated differently than another customer. Melinda stresses here that such encounters affect her ability to be happy:

Let’s say I go to the store and I get different treatment than someone else who’s of a different ethnicity...I’m probably going to be thinking “you know that was interesting...well you know I’ve noticed this person treated me differently.” So that kind of changes... it affects my ability to be happy...Because instead of thinking about what I probably want to be thinking about, I’m thinking about the experience that I just had.

Participant experiences showed that marginalization through microaggressions can occur in a variety of settings, including the workplace, for example. Fredrick discusses the way he experiences differences and similarly became invisible:

I deal with issues as far as dealing with Whites and there’s a difference. There’s a difference because most of them...they really don’t view us as equal. Something very minor as far as speaking...I’ve noticed that I walk into a room of my co-workers and if they are all White, there may be a few Blacks in there, when I walk into the room I’ve noticed that the Whites don’t speak. So if I walk in and say “Good morning,” you know they choose not to speak to me...but the funny part is if one of the White guys walked in there with their same group of people, they acknowledge him, they speak to him. We have contractors at the company and the majority of them are Black and they really treat them differently...their tone of voice when they are talking to them. They’re talking to them like

they're beneath them or that the White people that work there are above them. And they constantly yell at them...it's almost like a slave and master type mentality.

The impact of White privilege. White privilege and Marginalization exist in a symbiotic relationship. In other words, White privilege cannot exist without a subjugated counterpart; neither can there be a subjugated person or population without a person or population who escapes subjugation. Research participants provided examples above that spoke of the ways they experience differences as people of color, i.e., their experiences of subjugation. The inverse of their experience is the White privilege their counterparts received (White Privilege). In the example Melinda provided, the male customer who walked into the jewelry store ten minutes after her was greeted upon entering the establishment while she was ignored. He experienced the privilege of being treated as a viable consumer while she was treated as if she didn't exist. Similarly, in the example Fredrick provided, he and other Black co-workers were either ignored or yelled at while his White counterparts were greeted upon entering the room. His White co-workers experienced the privilege of not having to be yelled at or ignored while Fredrick and other Black co-workers were treated as invisible or openly mistreated while on the job.

Their experiences also speak to the impact of encountering White privilege. Melinda describes the impact as “little tears” that change the “dynamics of your thought processes,” “the way your day is going,” or the “way you may act or react to certain things.” Fredrick later describes the impact of White privilege by way of inequitable treatment and the pejorative view White Americans have of African Americans, particularly Black men. He describes perceptions of himself and other Black men as “deadbeat dads,” “thugs, gangbangers, rappers, entertainers, or athletes.” In other words, the advantage White privilege affords White Americans is the privilege of never having to be regarded in the ways Fredrick described based solely on their

race. Research participants provide other experiences related to the impacts of White privilege. Those examples will be discussed further as participants describe the ways they are impacted by marginalization below. The lack of distinction between the impacts of White privilege and the impacts of marginalization are due to the symbiotic nature of their relationship. This symbiosis makes it difficult to address one subtheme independent of the other.

The impact of marginalization. The impact of marginalization emerged through experiences with stereotyping, institutional racism, discrimination, systemic erasures, and microaggressions. Microaggressions can occur in one of three categories: microassault, microinsult, and microinvalidation. Research participants also disclosed statements that indicated their value in discretion particularly in the presence of their White counterparts.

It is important to note that while the experiences described fall into specific categories, these categories are not mutually exclusive and can therefore overlap or be considered as more than one form of Marginalization. For example, Fredrick and Melinda have provided experiences that speak to racial microaggressions; i.e., derogatory slights communicated intentionally or unintentionally to people of color, (Sue et al, 2008). However, their experiences of not being acknowledged can be considered microassaults, a specific form of microaggression and conscious acts intended to hurt a person through avoidant behavior or purposeful discriminatory actions (Sue, 2010). Similarly, where theme one, Lived Experiences of African Americans, as stated above, has two sub-themes: the Impacts of White Privilege and the Impacts of Marginalization; the experiences research participants offered can fall into one or both of the subthemes. The details they described demonstrate the interconnectedness of the subthemes and therefore the complexity of the Lived Experiences of African Americans. Fredrick offers an example of this complexity when he states:

And I think the biggest part about it is not only being a father but then being a father of a female...That right there is a different vibe. Like it's a different...and you know, even going back to one of the questions, you know, you asked about, you know, what do I-how do I feel a Black man is viewed? Deadbeat dads, we run out on our kids, we don't support our kids, we don't even acknowledge our kids, you know? That's something that American society looks at us when they see a male, "oh yeah, he probably got two or three kids." Or "he might be a father of ten kids, but how many is he taking care of?" Or "How many stay with him?" You know? Those are the views that society has as far as Black men.

Fredrick goes on to speak of other ways Black men and Black Americans are viewed:

We're not viewed equally I could tell you that but-you know, we're not viewed equally as far as the same opportunities that White males deal with/have, that's for one. Number two; we're viewed as unintelligent. You know, lacking knowledge, lacking understanding and lacking education. And we're also viewed as...I mean I hate to say it but you're viewed as thugs no matter what. And they think we're all supposed to be...wanting to be some type of rapper, wear our pants hanging off our behinds, have some type of gold in our mouth and talk with some type of a particular slang. So that's how, you know, that's how we're viewed and they figure we're always supposed to...instead of trying to purchase things that are going to appreciate in value, they figure we are supposed to purchase things that are going to depreciate such as cars and rims, and you know, things like that, where we're not going to be the ones that appreciate in value like buying a house first or buy land, those types of things. Not supposed to be self-employed, you know and make our own money, you know? They think we're all gangbangers, drug

dealers or a rapper, entertainers or athletes. We're not supposed to be working in corporate America, or wear shoes and ties, and be able to talk, with some type of educational background so...I believe that...I mean, they have a point because the majority of us act that way but that's not all of us, that we have some...we have more...who bring more meaning to life, to society than that. That's how I kind of feel that we're looked at. How I feel we are viewed, you know? And when you look at TV, when you look at different shows or whatever, these are the things that they portray as far as Blacks.

Fredrick began this part of his interview speaking about the lived experience of being a Black father of a female child. His experience is complex because he speaks of facets of his life as a man, as a Black man, as a father, and as a Black father of female child. His description is also complex because it contains evidence of his facing the misconceptions White Americans have about Black men. This experience of having to face the stigmas of being a Black man, a Black father is an example of his dealing with the stereotyping, the generalizations White society places on Black men. Again, stereotyping is a form of marginalization and in this instance, the impact of marginalization is a systemic erasure leaving him invisible. Similar to Ellison's *Invisible Man* (1952), Fredrick faces the stereotypes on a daily basis that dismiss the father, the Black man he feels he really is, one who is very present in the daily life of his daughter and who provides not only financial but emotional care for her as well.

Kathy's experiences speak to other ways marginalization occurs: (1) through racial discrimination in the workplace; and (2) stereotyping and institutional racism. For example:

I remember...I mean there are so many instances of crap that I have taken on. I do remember being on a job and not getting a promotion, I wasn't written up because I was

not doing the job. But you know how we have to...we are taught to CYA-cover your ass...you do that. You always do that. So I documented all that stuff for a very long time, I went to my review and they kept telling me I was wrong. So, what do you want me to do, tell me what to do because...so I took good notes, documented that. I'm like "so maybe I'm not understanding, I'm not understanding what is happening." I need a neutral party, or something, I've got two people here telling me I'm way wrong and I'm not understanding it because I see what I'm doing, can't communicate it. I called HR. HR tells me they don't have somebody who could serve in that capacity; we get a new manager in who happens to be Black. Five minutes into the conversation not only am I sent out of the room, I'm backdated my raise for nine months. But I go through that whole thing questioning what it is I'm doing wrong, but the reality was it was all about judgment on my skin color. I carry that...These are things that are part of who I am and have...and that's one instance. I interviewed for the same job, not the same position but the same job title seven times, in a company that, with (*removed company name for confidentiality*), seven times for that position, every time they gave me this list I needed to work on. I even once led the diversity team, created a diversity plan to advance because we didn't have people of color moving and I didn't qualify for the job...seven times for the same job. Letters of commendation all throughout my file, promotions...I mean not promotion but bonuses, almost top rank bonuses and I'm talking \$3,000 bonuses, raises, letter of recommendation, mentioned almost in...we would have these quarterly letters that come out for clients that we served...my name was always on it. I have a notebook full of commendations, recommendations that I have, they showed me how to do that and I still never qualified for a promotion. I served on every mentoring

diversity committee within our department, I'm not at my desk every day, because they have me doing everything else but I'm not qualified to carry a title within my department...when I walk into a room, all of that stuff walks in with me.

The experiences Kathy detail here again demonstrate the complexity of the impacts of both white privilege and marginalization. She addresses her experience of differential treatment as a Black person in her place of employment at a large corporation. Her account details multiple instances of Marginalization through institutional racism and by default racial discrimination; where institutional racism is defined as an institution that deliberately or indirectly discriminates against certain groups of people to limit their rights (NSW Department of Education, 2015), and where racial discrimination is the unfavorable treatment of an employee or applicant because of race or characteristics indicative of race (U.S. Equal Employment Opportunity Commission, n.d.). Since the definition of institutional racism includes discrimination, the experiences Kathy describes includes both particularly when considering the job opportunities she missed in spite of being a highly praised employee. Her experience is also another example of how African Americans become invisible.

Institutional racism played a part in her marginalization in that she worked in a system that was set up to allow her to be supervised on nebulous improvements but never rewarded for her efforts as employee. Similarly, Kathy was discriminated against when she performed well enough to earn recognition and appreciation but despite her efforts was denied promotions and/or pay increase. Her description also included elements of tokenism when she spoke of multiple commendations and her service on "every mentoring diversity committee." In Leong's *Encyclopedia of Counseling*, Delgado-Romero and Wells (2008) define Tokenism as:

Tokenism involves the symbolic involvement of a person in an organization due only to a specified or salient characteristic (e.g., gender, race/ethnicity, disability, age). It refers to a policy or practice of limited inclusion of members of a minority, underrepresented, or disadvantaged group. The presence of people placed in the role of token often leads to a misleading outward appearance of inclusive practices. The term token is derived from the Old English word taken, which means “to show.” Thus tokenism exists because inclusion of the person or group is required or expected, not because of inherent value (p. 1349).

Finally, her frequent encounters with both discrimination and institutional racism are examples of her experiences with being marginalized, resulting in the same systemic erasure Fredrick experienced. She addressed the impact of White privilege and her marginalization when she says:

But I go through that whole thing questioning “what it is I’m doing wrong,” but the reality was it was all about judgment on my skin color. I carry that...These are things that are part of who I am and have ...and that’s one instance.

Kathy also speaks to how she is impacted when she says, “When I walk into a room, all of that stuff walks in with me.”

Discretion for self-preservation. The final impact of Marginalization that emerged in the research is the value in discretion particularly with regards to sharing personal struggles or seeking help for those struggles. This value reflects the importance of self-preservation among African Americans and speaks to several dynamics such as racial identity and cultural mistrust particularly with regards to mental health services with White Clinicians (Nickerson, Helms, & Terrell, 1994; Watkins & Terrell, 1988; Whaley, 2001; Parham & Helms, 1985; Parham & Williams, 1993; Want, Parham, & Baker, 2004). Parham (2002) cites self-pervasion, “the

capacity to protect one's self from danger or harm," (p. 44) as one characteristic essential to all living beings. Research participants Juanita, Viola, and Francis acknowledged their beliefs about sharing personal struggles:

Juanita: 'The way I've grown up especially being Black...you don't share your misery with other people. In fact, you don't talk about your business in the streets and you don't put things out there.'

Francis: 'It's a weakness to admit that there's a problem.'

Viola: 'We don't tend to trust as much, and I think that's with good reason. So if there were any problems, you don't air your dirty laundry. You should stay within, you know, and suck it up.'

Francis connected this discretion to her and her partner's decision to seek therapy. Viola challenged the need to re-evaluate the value in using discretion when it comes to seeking help.

Francis: 'I have at first, kind of resisted feeling that we could handle the issues on our own...when...things...became...something that was a little out of our control, we did seek help.'

Viola: 'If there were any problems, you don't air out your dirty laundry...you should stay within...and suck it up. I want...somebody to really encourage breaking that model especially for women of color because it's very difficult to talk.'

The second theme that emerged was Lack of Culturally Responsive Clinical Practice where several participant day-to-day experiences mirrored their experiences with White clinicians in relational therapy. For example, those experiences where marginalization occurs in their daily lives are replicated when participants saw clinicians who lack the necessary tools to practice using the cultural context of African Americans.

Theme Two: Lack of Culturally Responsive Clinical Practice

Theme two is Lack of Culturally Responsive Clinical Practice. Again, this theme emerged as participants divulged experiences of marginalization not only in their personal lives with their White counterparts but also as consumers of mental health services from White clinicians. In this theme, several participant experiences in therapy are explored and found to have a common formula. This formula is described, and consequently, an inverted formula for practicing from a culturally responsive lens emerges. Subthemes include Therapy with White Clinicians, Unpacking the Infraction, and Defining Culturally Responsive Clinical Practice.

Therapy with White clinicians. Research participants Kathy, Debbie, and Viola detailed experiences that suggest the same influences that create the marginalizing experiences of African Americans in their personal lives are replicated in therapy. These experiences indicate their respective clinicians lacked both cultural awareness and cultural knowledge. Kathy admitted that she never felt as if she successfully completed the process of therapy because of the encounters she experienced:

I don't think that I've ever finished personally because either they were, in my opinion... (pause) they would get uncomfortable or they'd want to medicate. So I remember in a couple of instances. One time this woman just wanted me to take all these tests and... oh yeah, I forgot about that one. She wanted me to take these tests, she wanted me to... it was for the situation of depression. My doctor referred me and so she kept wanting me to take these tests and every time I would talk, which was rare that she would allow me to talk, I cried and she immediately would start talking about medication or something. So she was just crazy and I didn't want to deal with her, and I didn't go back.

Kathy sums up her experience with that clinician by saying:

We could never connect. I mean I just felt like she was always wanted to...I felt like I needed to work through stuff and I felt like she wanted to fix stuff and her solution was never what mine was.

In another therapy experience, Kathy recalls the following:

Then there was another one...I went to see...(pause) and I tried to really more...not to...to try to work and make it clear, you know learning more about this...I wanted to um...I know myself pretty well. I know where I shut down. I know those things I talked and tried to interview and make sure I have someone who could more effectively deal with me. And...if I got loud or emotional, you could clearly see the whole vibe change...body language...tone um...and then I responded to that. I also never felt like I...I think there was a level of rage that I hold and what I found as a general place is that White people can't relate to that rage. White people can't relate to that rage. And so there's a sense where for me it feels like there's fear dealing with me. Whereas what I need is a place that it's okay for me to scream and cry and shake, and do what I need to do, I'm not gonna hurt you. I'm hurting myself (i.e., I'm the one hurting), I'm not going to hurt you.

Debbie detailed instances with a White clinician while in couple's therapy. Debbie experienced the therapist joining more with her partner who was biracial, White and East Asian. Further, Debbie knew she was being treated as an "angry Black woman" a common experience among African American women (Ashley, 2014).

She clearly identified with my partner more because, my partner was bi-racial but she could not identify with me. If I would get upset, she would seem threatened... ..as if I were an angry Black woman that was going to assault her. And would ask if we had

instances of domestic violence. Yes. Well, she asked in front of me and in front of my partner, do you feel afraid when she gets like this, do you feel for your safety, do you feel that she is a threat, and I had to ask her, “Are you trying to insinuate, why are you trying to insinuate that I have issues with anger management, that there’s something wrong with me?” I said, “Because I am, in fact, the least violent person in this room,” and she said, “well, you seem hostile, and she seems so timid.” I said, “you haven’t gotten past our first names. You don’t know why she’s timid. Why she is timid is why we’re here and it has nothing to do with me. But again it has everything to do with me because I’m involved in the relationship so it actually involves me.” I felt that she was trying to do was to suggest my partner didn’t need to be with me because I seemed to have problems with anger management. We hadn’t really discussed what the problems were and she tried to diagnose what she felt was wrong. I was angry and why was I angry, and she kept focusing on why I was angry.

The experiences Debbie and Kathy provide are examples of the marginalization that occurs when White clinicians project stereotypes onto clients which results in systemic erasures. Their descriptions about these instances in therapy with White clinicians demonstrate the similarities with what other participants experience in their day-to-day lives with their White counterparts. Assuming that Black women are angry is a stereotype based in fear that hindered the therapeutic connection, therapeutic process, and ultimately resulted in therapy being unsuccessful.

Debbie described an experience in family therapy where the therapist commented on a “pre-existing condition” of having large lips as the source of some of his academic difficulties:

Okay...the one therapist we had for family counseling with a White therapist, she could not stay focused because she kept looking at my child's lips. That drove me up the wall. I had to report her. She just drove me up the wall. Complaining about them. They were too big. That if they weren't so big he wouldn't have some of the problems and he needed it greatly and that he would not benefit from speech therapy or any other kind of therapy. Because his lips were big...there are some things that Black people should understand the problems that we have that sometimes we have pre-existing conditions that we cannot overcome. And I was very angry because she had been giving him therapy without any supervision. And had been saying things like that to him. Yes and I just happen to...once I got custody, started going to the therapy sessions. She had been doing private sessions and so we did two with her and when I heard that and saw her behavior, I immediately cut it out.

Viola, who identified as being in an interracial marriage when she attended therapy, said she chose a white therapist because her ex was more likely to feel comfortable. She admitted that part of the work she needed to do in therapy involved dealing with the anger and hurt she had with men after past sexual trauma. When asked about her relationship with their therapist, she described him as cool and indifferent and the therapeutic work as superficial:

Cool, indifferent. He was condescending. It wasn't so much what he said as he never listened to what my needs were. It was all about who he knew what he knew and we had to fit into the, you know, cubbyhole or the box that he put us into. He was very aloof.

There was very little (pause) At the time in the West Coast, it was not – He needed to be Mr. Cool... and talking about intercultural or interracial relationships wasn't cool. And so it was more like it's the right thing to do rather than any kind of, you know, sincerity to it.

There were other areas their therapist did not address in treatment aside from the cultural differences. For example, the fact that they were an interracial couple was never addressed nor was the anger Viola admitted to having towards men.

I had issues that really impacted me fairly young. I was raped by a family member. And with men, I kept a distance as far as trust. It seemed at the time it was insignificant, but in retrospect, I think had we been able to talk and discuss personal issues rather than...

(pause) You have to remember, I came from an era where women didn't talk about that.

And it was a different; you know philosophy than it is today. I think in retrospect that had I been able to really discuss my personal feelings with my ex a lot and really let out some of the anger that I had in a healthy way the rest of my life. You know, I wouldn't have been doing it for years later. You know, that anger has impacted that mistrust. And the lack of understanding about, as I said, at that time, (pause) many... in the sixties and seventies there was a lot of "wanna be understanding" but not really getting it and no, he never really got me. He just wanted to be cool. A lot of it was image with him. I don't know that it was racially driven as much as it was this person being very patriarchal.

Her experience demonstrates marginalization as a woman in a patriarchal environment in the early seventies. Although there is no description of overt infraction, when her therapist neglected to attend to the context and dynamics of their relationship, he missed attending to a major source of pain impacting her marriage.

Unpacking the infraction. These descriptions indicate a pattern with ten of the twelve White therapists that lead to clinical practice without cultural responsiveness. As stated above, the same influences that create the marginalizing experiences of African Americans in their personal lives are replicated in therapy. Given their descriptions, the pattern that emerged is

illustrated below.



Figure 1:

Formula demonstrating a lack of culturally responsive clinical practice.

The descriptions Kathy, Debbie and Viola offered about their experiences in therapy all follow the illustration. To understand the similarities, it is necessary to unpack specific aspects of their reports to demonstrate how they align with the formula in Figure 1. With her first experience, Kathy said, “every time I would talk, which was rare that she would allow me to talk, I cried and she immediately would start talking about medication or something.” Here the therapist demonstrated a lack of cultural awareness about her client’s expression in therapy. This lack of awareness led to a lack of cultural knowledge, the ability for her to understand the context of her client’s distress. Stated differently, the therapist lost a chance to understand whether or not there was a connection between her depression and her context as a single Black mother trying to raise three sons. Having neither cultural awareness nor cultural knowledge

meant she was not capable of having the cultural clinical skills necessary to practice in a culturally responsive way. In Kathy's words, they "could never connect."

Her second, similar experience left Kathy feeling her therapist was afraid of her. "If I got loud or emotional, you could clearly see the whole vibe change...body language...tone um...and then I responded to that. I also never felt like I...I think there was a level of rage that I hold and what I found as a general place is that White people can't relate to that rage." This example follows the same formula of the therapist demonstrating a lack of cultural awareness of what African Americans experience as a result of White privilege and marginalization. Not having a cultural awareness meant she could not gain cultural knowledge, and therefore did not have the necessary cultural clinical skills to practice through a culturally responsive clinical lens.

Debbie was overtly stereotyped as an "angry Black woman." She left her experience feeling as though her couples' therapist over identified with her partner. This therapist stereotyped Debbie as the "angry Black woman" which demonstrated her lack of cultural awareness of how African Americans are erroneously perceived and how she participants in perpetuating that stereotype. Her lack of cultural awareness stunted her capacity to understand Debbie and her perspective (cultural knowledge). Not having cultural awareness or cultural knowledge meant she could not use cultural clinical skills or practice from a culturally responsive lens.

The same formula applies in the more blatant example of the therapist who said her son's lips were too big. That experience in therapy was an example of a Microinsult (Sue et al, 2007) and one of greatest injustices described among participants. Not only does her description follow the formula described above but it also demonstrates how African Americans can have similar experience in their daily lives mirror their experiences in therapy with White clinicians.

The clinician who treated Viola in couples' therapy followed the formula from a different contextual perspective. Viola admitted to having had a sexual trauma, which impacted her level of trust for men. His presentation left her with a set of vivid descriptors such as "cool, indifferent, aloof, and condescending." In her experience, he demonstrated a lack of cultural awareness about his context as a White male and hers as a woman with sexual trauma. Without this cultural awareness, he loses the ability to attend to her cultural context. In this case, her experience as a woman with a history of sexual trauma, rather than her context as an African American was the context that needed consideration. His lack of cultural awareness resulted in his not having the cultural knowledge or clinical skills to practice from a culturally responsive lens with Viola.

Their experiences led to the following definitions for cultural awareness, knowledge, and skills. These components ultimately constitute culturally responsive clinical practice.

Defining culturally responsive clinical practice. Cultural awareness is the ability to understand there are cultural dynamics and experiences other than one's own experience. For White clinicians, having this awareness mean they also understand 1) who they are in the context of society, 2) the privileges afforded them and, because of that privilege, 3) the power they possess to marginalize and subjugate anyone who is not White.

The experiences Debbie, Kathy, and Viola shared indicated their clinicians lacked cultural awareness on two levels. The first level of awareness missing was a personal understanding of the impact of the experiences of their clients as African Americans. The second missing element from their practice was their understanding of themselves in the context of others, specifically their African American clients.

Cultural knowledge is the understanding that White privilege and marginalization impact the experiences of African Americans through microaggressions, institutional racism, racial discrimination, and systemic erasure. Cultural awareness is a precursor to cultural knowledge. That is to say, cultural knowledge has the potential to develop because the White clinician understands that they too hold White privilege and this privilege if not acknowledged can serve to replicate marginalizing experiences with clients.

Cultural skill is the ability to combine one's cultural awareness and cultural knowledge into application in therapy. The process of using cultural skills is one that is maintained throughout the therapeutic relationship, from engagement through the use of broaching differences to the working, consolidation, and termination stages.

The formula in Figure 1 illustrated the factors that contributed to several participants describing negative experiences with their therapists. There were also participants who had positive experiences in relational therapy with clinicians. Their descriptions suggest the inverse of the formula in Figure 1 as a component of successful treatment with African American clients and is discussed in theme three, What Works in Therapy. This formula will be examined through additional participant experiences in the third and final theme.

Theme Three: What Works in Therapy

Participants disclosed several examples of positive experiences with their clinicians. Their descriptions clustered around their therapist's ability to attend to cultural contexts, their clinical skill and their ability to successfully join with participants and make them feel comfortable during the process of treatment. Participants who indicated successful joining and levels of comfort with their therapists gave specific characteristics and clinical actions their respective therapists used to engage them. These clustered qualities converged into the following

subthemes: Cultural Awareness, General Clinical Skills, Therapist Qualities. Debbie, Dorothy, Francis, Marsha, Erica, and Fredrick all indicated positive aspects of their experiences with their clinicians. Descriptions of positive experiences in therapy follow the equation in Figure 2.



Figure 2. Formula for practicing from a culturally responsive lens.

Cultural awareness. Two participants, Juanita and Melinda, worked with White therapists who addressed their experience as African Americans. Debbie, who detailed experiences above with White clinicians, also worked with an African American therapist. Given her description of this experience, the therapist provided the most thorough infusion of culturally responsive clinical practice and savvy clinical skills. This section details the participant experiences most congruent with the formula for culturally responsive clinical practice.

Debbie provided the most comprehensive example of a positive experience in relational therapy. Debbie described her therapist as African American but never overtly correlated her success in therapy to their similar ethnic identities. Instead, she described her as mature, experienced, centered, and spiritual. She also described techniques this therapist used which led

to her defining this experience as a success. Debbie was asked to clarify what contributed to this being a positive therapeutic experience. Her response is below:

Well one thing that made it more positive is when I went to an older, more mature doctor. She was a lot more mature; a lot more grounded, you know, more open, more centered. And she did not appear to be a very religious person but seemed to have a good, sound, spiritual connection. She was not judgmental, she wouldn't force her opinion on me, she was comfortable where she was, comfortable where I was, in both of our lives.

When asked what she meant when she described the therapist as "more centered," Debbie added:

Well...she had a good sense of self-being. She looked like she was between fifty-five and sixty. And like there were no surprises in life. She had...you know, a sense of who she was and what her life was really about. Where the other therapists were very young White women. I realized that made more difference...it actually made more difference for me that she was older than if she was same gender loving.

In her follow up interview, Debbie explained more about experiencing her therapist as mature and what maturity meant to her. In her explanation, she spoke of the therapist's clinical skills, specific questions she asked, the space she created to allow for Debbie's perspective, and in doing so, how she created possibilities by encouraging Debbie in the use of her spirituality and her community. Debbie also compared her experiences with both therapists, one of whom was a young White woman and the other was a 'more mature' Black woman:

I would add that as a result of being more mature, there were some questions that...some areas that she would delve into better. Um, for example, um...let's see how I can describe this...the younger lady made some assumptions, generalizations, about us being black, being uh impoverished economically and being adopted families, among other things.

She just made assumptions. While the other lady, being more mature, she didn't make any assumptions. She asked questions. I could tell that was after years of maturity and experience, she would hear things, you know she didn't just automatically say, "A-ha, that's it, it's because this." She took a lot more things for um... She allowed for more factors.

Whereas the other lady um... If you said for example, I said "You know, he's been stealing." Right away she says, "Well you know, a lot of adopted children steal," and that was the end of it. Period.

Debbie unpacked her experiences with both therapists by comparing what she got or did not get out of the therapeutic process. Much of her experience with the White clinician was addressed in Theme Two. The initial follow up interview question was about gaining an understanding of how she perceived her therapist to be mature. She attributed several dynamics within the therapeutic process to the maturity of the clinician including the questions she asked, the way she felt she allowed Debbie to express herself, and how she used what Debbie contributed in session to facilitate progress rather than making statements that seemed to stunt the treatment process. Her approach to working with Debbie would suggest a high level of clinical skill. A part of her skill involves her ability to be inclusive of the client's perspective, worldview, and position as an expert in her own life. This approach demonstrated her acute cultural awareness, cultural knowledge, and subsequently, cultural clinical skills that culminated in a culturally responsive clinical practice.

Melinda was one of two participants whose therapist specifically addressed her context as an African American woman. Melinda, who attended couples therapy on two separate occasions with her White partner, said the following about her experience:

The second (therapist) I felt like kind of understood that things were different for me because of my racial ethnicity. And one of the things that came up in therapy was the fact that I had a hard time in (city name omitted for confidentiality) which is, you know... predominantly a Caucasian environment. I think most of (city name omitted for confidentiality) is but I think for some reason I feel even more isolated (here) and maybe its because it's a...more saturated um...in a more pretentious manner, that's how I personally felt. So I think it was not really a very ethno-friendly environment. So I think the second therapist acknowledged that more so and addressed that more so than the first therapist did...I felt that she actually took a step further in considering the entire dynamic of both perspectives brought in to the session...she would...maintain the balance of the dynamics more...she seemed more aware of it and more aware of the fact that it was something that was an underlying issue for me. So the fact that she acknowledged that and would bring it up was validating and made me want to open up more to her...

Melinda further referenced both her partner and their therapists when she speaks to her experience as a Black woman living their neighborhood when she said:

One of the things that I would say is in session with the therapists and with our partners is...every day I would walk out of the door of the same house it was a different world for me than it was for her.

Her description is complex in that it addresses several important elements of this research. First, Melinda speaks to an impact of encountering White privilege and marginalization as she addresses her struggle with living in a "pretentious" area. While there is no specific event described that identifies a trigger to her feeling isolated, she speaks to the difficulty of living in a state and, more specifically, an economically privileged area where there are few African

Americans. Second, Melinda initially implied that she was not invested in attending therapy. However, she became invested and successfully engaged in the therapeutic process because of the validation she received from the therapist. Specifically, Melinda described the therapist's acknowledgement of her daily experience as a woman of color, who is in an interracial relationship, and who is living in an economically privileged neighborhood where she feels isolated from other people of color. Her explanation suggests that her therapist had the self-awareness (Cultural Awareness) to understand that Melinda's experience could be different specifically because of the intersection of her ethnic identity and economic standing. Further, because of this understanding, it allowed her to have the knowledge (Cultural Knowledge) that allowed her to integrate those dynamics into their therapeutic work (Cultural Clinical Skills).

Juanita described her experience with her therapist who included her difference as an African American woman in the context of her presenting problem. Juanita identified his skills in applying cultural awareness to their therapeutic process, his use of personal disclosure, and his investment in her as reasons for defining her experience in therapy as positive. The dynamics of her therapeutic relationship were rather unique in that she and her White supervisor sought mediation to improve their working relationship. Below she not only describes the mutual respect she felt between her and her therapist but she also explains how he applied his cultural awareness and cultural knowledge about her context as an African American woman to their presenting problem:

It was actually pretty good. Like I feel like that sometimes he's more (—) there were sometimes he keeps me on task and there were other times it was more conversational, so he shared with me his experiences too. So, I think he has, I guess a healthy admiration for me (—) well, I think for both of us because the other people [sic] I mean, we've taken

full advantage of it because the other people who can do it and not, but he said we've actually like gone all in.

And I think he appreciates that I'm committed to the process for just even beyond the aspect of just getting along with my supervisor like just in general, like I figure I might as well take advantage of it to be a better person. So, I think he respects [sic] he likes that I respect like the potential of what he could offer.

When asked to elaborate on how her therapist attended to her cultural context, Juanita said the following:

We have talked about those things sometimes...the different cultural ways that people deal with things. When I've had other conflicts with people in the building, he has brought it up you know (—) and a certain portion of it, maybe someone's personality and the other portion of it is their cultural background and a way in which we deal with people.

There were things around that time when we first started. [sic] We had gotten into a conflict that was about a meeting that we were supposed to go to. I left before him and they had called (him) to say they had changed location. Well, I wasn't called [sic] but he had never called to tell me their location. He was already there at the meeting and so I walked in late (—) and I think for me, I was extra angry and I made comments. I can't afford to walk into a meeting late the same way he does.

It's not viewed the same way. [sic] People already think I'm young, I'm Black or whatever. So, I have to make that extra effort. I can't be the last person to walk into a 10-person meeting. [sic] And so I looked like a derelict and he was just sitting there the whole time when he could just say [sic] the meeting was not on the 18th floor, and I'm

just sitting upstairs by myself waiting for the meeting to start. So, I think it came out like that but race wasn't the center point. But I brought it up [sic] (in) how it plays into like the perception of me.

The experience Juanita describes represents several dynamics of the research. First, her description begins with her addressing the positive regard she held for the therapist based on several factors. She focuses on her perception that he appreciated them for their engagement in the mediation/therapeutic process. She then discusses how he attended to their various cultural and contextual differences to show how those factors played a part in their presenting problem, i.e., the conflict in their working relationship. This acknowledgment leads to her revealing an experience that demonstrates the impact of White privilege and Marginalization as a Black woman in a predominantly White work environment. She expanded on how the therapist made a positive impact on her, not only with his skill at incorporating cultural dynamics, but also by his willingness to share some of his personal dynamics. She finishes her explanation of her experience with him by clarifying why she felt "he had her best interests at heart."

The similarities between Juanita and Melinda's experiences have to do with their respective therapists incorporating their cultural context as a meaningful variable that impacted their presenting problem. Neither Juanita nor Melinda indicated any direct need to have their cultural context addressed. Nor did either participant see their presenting problems as problems of cultural difference. However, once their therapists included their differences in the conceptualization of their presenting problems, both left their respective therapeutic experiences with a sense of being seen and understood. Melinda, initially not invested in attending therapy, became more invested in opening up during the process. Juanita seemed to leave with a high regard for her experience in therapy because of the multiple ways the therapist facilitated the

process in a culturally inclusive and personable manner. Their respective experiences follow the formula illustrated in Figure 2. Both clinicians demonstrated culturally responsive clinical practice by understanding their client's cultural context (Cultural Awareness). This awareness led to the knowledge that the context of their clients impacted their presenting issues. Because of their cultural knowledge, they were able to demonstrate the cultural clinical skills, thereby practicing through a culturally responsive clinical lens.

General clinical skills. Participants who disclosed a positive regard for their clinicians based on their general clinical skills are described below. Dorothy, Erica, Fredrick, and Marsha elaborated on basic clinical skills, assessment questions, and interventions.

Dorothy conveyed her feeling that the counselor understood her perspective of the concerns in her marriage. She shared the following about her therapist:

I felt comfortable right away and I felt like, you know, how its flowing, if you talk to someone and not just a friend because a friend has always been on your side but...and they seem to get it, and you feel like you could just like take a deep breath because someone else, I mean, you know you can only say two words and then...and they are just like, "oh my God! They get it." And it was just a relief and they were very good at what they did. I don't know how to explain it, I don't know, I just didn't feel anything like this person was judging me based on my race.

Marsha expressed explicit praise for her therapist and their relationship: "After meeting him, I knew he was the one. He was very open and sincere." She also spoke to how he presented as a person as well as techniques he used in session:

After we met...that was about two sessions...he was a very humble person, and he said the reason he was a counselor was because at some point in his life, he needed counseling

himself he was very open and wasn't judgmental and he offered wonderful exercises that just make you feel very comfortable with him.

We had a great experience in therapy...it really was. It was wonderful because my husband did not want to do counseling...and after the first session, his mind about counseling had changed. He was very open minded about going back. That's how we ended up going back.

Francis described positive regard for the therapist based on what she perceived as character traits: "He had an open heart." She also enjoyed their work together because of the level of skill he demonstrated as he assessed her relationship:

We talked about how we got along. He asked us numerous questions about our meeting, what was important in our lives, I guess...what was the reason we wanted to marry. In other sessions, he talked about how we worked on problems. This was very helpful. The experience was rewarding. He offered a lot of positive guidance.

Erica, who spoke of two experiences with White clinicians said:

They both were successful. I got from them what I needed. The coping skills, the acknowledging the problem, and the tools to fix the issue, and if it happens again what to do, you know getting the experience knowing that therapy is good. And I think that was why I was so open for the second one. The first one showed me okay, it does work...its good.

This quote suggested Erica had some hesitancy about engaging in therapy. Her hesitancy seems congruent with a value in discretion, a subtheme identified in theme one. With her second therapist, Erica expressed an even better experience: "The second time it was more...it was professional but we were more engaged and did a lot of back and forth talking, and letting go.

This was more...I would say...in depth.” She further stated: “with the second one, we really did have a good relationship. I trusted her and I think it would have improved even more.” Initially it seemed Erica’s experience was based on the general skill of the clinician. However, in following up with Erica to get examples of “letting go,” she connected “letting go” to her allowing herself to trust the therapist.

Sometimes you’re not actually, you know, ready for the healing process. And then you go back for that second time, you know, you’ve already experienced it. You kinda have some type of comfort level. And you kinda know what the expectation is...and then you’ve grown on the person and then you share your feelings better. And then too, generally speaking, it takes a minute for me to warm up, you know, in regards to most things. So usually, if I have a second interaction, with a particular subject or a particular person, I’m more at ease.

Fredrick attended therapy with both Black and White clinicians. He shared positive experiences that reflected both the clinical skills of the therapists as well as their ability to consider his cultural context. With regards to the White clinician, he spoke to her open-minded presentation, her clinical skills and understanding current issues teens face and present with in therapy:

She was very insightful as far as looking at things with an open mind...so she was able to give me some healthy advice, and through the advice that she gave me, I actually-I used it and applied it to everything and it actually helped a lot of different situations that I ran across.

When asked to clarify what “open mind” meant to him, Fredrick said the following:

A neutral point of view. Not looking at the situation based on their past experience, you know with no pre-notion or bias to one experience or side. Someone who can give an honest opinion without allowing the other side to sway your opinion. I was concerned about that because in the beginning, when I went to my first counselor, I didn't have a true idea of "should I be going to someone who's open minded"...now that I've been to a few, I want someone who is open minded. When I was married to (my wife), I told her I wanted to go to counseling or we're done. I said you know let's go to someone that she knows or someone that doesn't know us at all that way they won't be biased. You know it also means you are willing to accept some new alternatives to a situation. When you're set in your ways...not willing to accept new ways to deal with a situation. Same thing with a counselor. Someone who is willing to try new approaches and new advice given...based on the new occurrences/situations, blended families, all these different variations.

Juanita finishes this subtheme with her description of her therapist's use of personal disclosure as a means of joining. Further, she describes her sense of how the therapist regarded her as his client.

Therapist qualities. Below, Juanita describes what her therapist did that contributed to her positive regard for him and their work together. Specifically, she speaks about his use of self-disclosure and her sense that he had a positive regard and respect for her: "I think it helped him when he started sharing from his own experiences and position and then [sic] it kind of built a little bridge".

She describes his regard for her as a client below:

Like he seems to generally have like my best interest at heart. So, he is just not talking from like a plain perspective of like, how can you just be a better employee for like this department. And he has even said, you know, he may have to dig to like, “Is it time for you to outgrow this?” He was like “I’m not here to work for them” but they’re like, “So you’ll walk away to be a better you.” So, they’ll come up with plans of how to do things so at least -- if like -- if the ends is here, ‘cause it’s probably going to have to come to end like what else...what else am I going to do, like if not for here or at least how to set my stage so I can better -- be a better person there, so when I leave it’s not on sort of negative note or like work about just my own image – in general how it’s viewed in the workplace. Juanita participated in a follow up interview where she further clarified more about how she felt their therapist had her best interest at heart:

I think his approach was a little more personal approach to it. And then he would have meetings like offline with me. And I think because he understood the whole eco system that I was in [sic]. Whereas I guess most therapists are only privy to what you come and tell them for that hour a week. They don’t see you outside of their... or understand the other players in your life.

I think because he was in the work setting he got to see all the other players in the situation and he’s also known some of them far longer than I had been there. So I think him also understanding their pathologies probably brought a lot more information to the table to help sort of see some of the pieces a little better. And some of the politics and the landscape of with which I was operating within. I also think probably...um...what...what played into his... probably some of his own background...Some therapists share a little.

He shared a little bit more I think of him having a special needs daughter she's about in her early twenties I think probably also changes his level of compassion I think for people. So, he didn't take the line, despite him being in our workplace setting and ...of work of what was in the best interest of work per say but...and then he also talked about it in a larger context. So not only with ... I mean you should do this because you're here but overall, be thinking about what this means for you personally in your overall professional career and not you know, just sort of, for this situation. 'Let's take some steps back and think about some other things that may also be feeding into the conflicts you're are having with your supervisor.'

There were similarities in how participants defined positive experiences with White clinicians. The first similarity is their ability to practice through a culturally responsive clinical lens. The second similarity is clinical skills. Interventions, assessment questions, and knowledge about the current trends for certain populations such as adolescents all seemed to have a significant impact and to contribute to their estimation that treatment was successful. Another variable was the overall presentation of the clinician, particularly with regards to whether or not they seemed "open" to the participant. Without directly stating as much, participants seem to hold some reservation about whether or not they would be judged by their White therapist. This reservation matches the discretion observed as a value among several participants. Several of those who perceived their therapeutic experience or their relationship with their clinician positively, did so regardless of whether or not there was a direct attention to their differences in ethnicities or their experience as African Americans. The final subtheme addressed the use of personal disclosure and how participants felt their therapist viewed them. In discussing their

experiences, several participants summarized poignant insights about missteps made by their respective therapists. Their perspective is described further below.

Additional Perspective

There were instances in the interviews where participants shared statements that were quite powerful and indeed succinct and sage advice to White clinicians. Several statements shared were about their desire to be intentionally included as a part of the therapeutic process. Viola, Kathy, and Debbie each shared similar language regarding their sense of being excluded from “a partnership” with their therapists in their healing. When speaking about the therapist who only wanted to medicate her, Kathy said: “I felt like I needed to work through stuff and I felt like she wanted to fix stuff and her solution was never what mine was.” When Debbie compared her experiences with a younger White clinician to a “mature” African American clinician, she listed a host of ways the mature therapist gave her what she needed. While she never said she needed to be a partner in her healing process, she was clear when that invitation was not extended: “We were partners in their (her children’s) development, you know, and I never felt like I was a partner with the other lady. I didn’t feel like she was part of my team, my village, my anything.” Viola similarly shared one of the reasons why she did not find therapy helpful with her now ex-husband.

The thing that I objected to most in “Talk Therapy” if you will is that it’s almost like the therapist doesn’t go where I’m at but is running it according to their guidelines if you will, whatever background they have. You know, whatever form of therapy they’re using whatever. It’s all according to their guidelines. And it almost never is about where I’m at. Hey, I’m sitting here, you know. I might be able to lead you a little bit but you have to help me fix me. Now you can’t fix me, but you can help me fix me.

Their message seems to be this: “Involve me in my treatment. Partner with me. I am the key to the resolution I want. Meet me where I’m am. I am the expert of me.” Melinda warned clinicians as she reflected on her experience as a Black woman: “When you don’t have to live with that difference, there are a lot of things that people take for granted or don’t realize.”

Summary

The first theme, Lived Experiences of African Americans, underscored the intersection of White Privilege and Marginalization. White privilege has been described by experts as invisible, structural, and systemic (Dei et al, 2004) and is a necessary agent for marginalization to occur. The first theme to emerge in this research, Lived Experiences of African Americans, highlights participant encounters with White Privilege and Marginalization. Their experiences in both their professional and non-professional worlds expose the complementary relationship between the impact of marginalization and the impact of White privilege in that it seems one cannot exist without the other. Participant experiences also exposed multiple ways marginalization can occur such as through microaggressions, institutional racism, discrimination, stereotyping, and systemic erasures. The final impact of marginalization that emerged was the value in discretion for self-preservation. This value emerged as several participants discussed their belief about not sharing their personal “business” or struggles.

Theme two addresses the lack of culturally responsive clinical practice. It begins with demonstrating how negative experiences in the day-to-day lives of African American clients were replicated in therapy with White clinicians. Two formulas were illustrated. The formula for the lack of culturally responsive practice was discussed. Then the formula for practicing through a culturally responsive lens was illustrated and its elements were defined. Theme two ends with

participant experiences demonstrating when White therapists practiced through a culturally responsive lens.

Theme three, what works in therapy, begins with the illustration of the formula for practicing through a culturally responsive clinical practice. Participant experiences are used to demonstrate when therapists practiced through a culturally responsive lens. Cultural awareness and general therapist clinical skills are described as key components of what works in relational therapy with African American clients. Additional perspectives follow theme three, offers further insight, and redirects therapist toward a clinical practice that is more inclusive of the client.

Chapter Five

Discussion

This research explored the meaning African Americans made of their experiences in therapy with White clinicians. Literature regarding the experience of African Americans from their own perspective is sparse; therefore, the voice of African Americans is underrepresented, leaving mostly statistics and numerical data to represent one of the significantly marginalized populations in the United States. Statistics and data, while critical to understanding an issue, cannot speak to the vulnerabilities, the pain, and fears of African Americans. Neither data nor statistics can fully describe the unspoken realities of the African American community. Without this context White clinicians may be ill equipped to work with this population. This study sought to answer the research question: *What is the African American experience of relational therapy with White therapists?* Chapter five synthesizes the findings from chapter four while considering current and past research. Implications for training and administrative policies are addressed. The limitations of the study are then detailed followed by suggestions for future research.

Phenomenological research seeks to understand an experience rather than to validate or invalidate a hypothesis (Creswell, 1998). Themes that emerged in the research are important to understand from a larger context. In this study, the themes that emerged were *Lived Experiences of African Americans, Lack of Culturally Responsive Clinical Practice, and What Works in Therapy*. Subthemes for *Lived Experiences of African Americans* were Differences in Daily Life Experiences, the Impact of White Privilege, and the Impact of Marginalization. Subthemes of *Lack of Culturally Responsive Clinical Practice* were Therapy with White Clinicians, Unpacking the Infraction, and Defining Culturally Responsive Clinical Practice. The final theme, *What*

Works in Therapy, included subthemes of Cultural Awareness, General Clinical Skills, and Therapist Qualities. Themes are discussed below.

Lived Experiences of African Americans

The intent of this research was to study African American client experiences with White clinicians in relational therapy. However, participants also reported how several of their experiences in therapy mirrored their lived experiences with their White counterparts. Significant subthemes included *differences in the daily life experiences of African Americans, the impact of White privilege, and the impact of marginalization*. Participants detailed stories of being ignored as consumers, being passed over for promotions, and disregarded or mistreated in the workplace. Similarly, some of these experiences were replicated in couple, family, or individual therapy with White clinicians. Those experiences represented multiple examples of marginalization because of White privilege. It is also important to note that the experiences of African Americans emerged without specific, planned questions about their experiences outside of therapy. Venzant-Chambers and McCready (2011) similarly found their participants had multiple experiences with marginalization. Hall and Fields (2015) detailed narratives of Black adults in their experiences with microaggressions and their resulting health-related stress.

Participants' lived experiences point to the remaining subthemes reflecting the impact of White privilege and marginalization. The results of this study indicate that a primary difference in the experiences of African Americans' daily lives is that they are subject to the negative impact of White privilege via an intricate and subversive web of mistreatment, both conscious and unconscious by White people. It stands to reason then that part of the experience as a White American is the absence of such systemic erasures. Study participants highlight that marginalization is a by-product of White privilege and that in order for a marginalized

experience to exist; there must also be a privileged experience. Wise (2011, 2015) similarly asserts that if one group commonly encounters discriminatory treatment, i.e., marginalization, there is a group that benefits from the absence of this mistreatment. Emirbayer (1997) supported the “relational” nature of White privilege and marginalization by suggesting that all things are connected and therefore cannot exist in isolation.

Marginalization was also found to be experienced in a myriad of ways including stereotyping, institutional racism, discrimination, tokenism, and through various forms of microaggression. There is a plethora of literature documenting each of these types of marginalization (Moskowitz, Stone & Childs, 2012; Walter, Ruiz, Tourse, Kress, Morningstar, MacArthur, & Daniels, 2016; Mendez, Hogan, & Culhane, 2014; Sellers, Copeland-Linder, Martin & Lewis, 2006; Chae, Nuru-Jeter, Adler, Brody, Lin, Blackburn & Epel, 2014; Rospenda, Richman, & Shannon, 2009; Yoder, 1991; Anisman-Razin & Saguy, 2016; and Winnick & Bodkin, 2008). It is important, however, to understand the connection between these experiences, these slights, or what Sue (2010) calls microaggressions, and their impact on African American clients’ experiences with White clinicians. Melinda refers to the impact of her experiences in Tiffany & Co. and Shane & Co. as “little tears.” Debbie and her son experienced the same damaging marginalization with their therapist who blamed her son’s deficits on the size of his lips.

It would be helpful for White clinicians working with African American clients to understand how microaggressions occur and profoundly impact the lived experiences of African Americans. For example, when Melinda is ignored in a store, clinicians must understand that her experience is indicative of both a microinsult and a microinvalidation. Further, when Kathy is passed over for jobs or becomes a token, she is experiencing a microassault and a microinsult.

Regardless of the form it takes, marginalization results in the invisibility, or the systemic erasure, of African Americans and is reminiscent of Ralph Ellison's *The Invisible Man* (1952):

I am an invisible man...I am invisible, understand, simply because people refuse to see me...When they approach me they see only my surroundings, themselves, or figments of their imagination -- indeed, everything and anything except me. Nor is my invisibility exactly a matter of a bio-chemical accident to my epidermis. That invisibility to which I refer occurs because of a peculiar disposition of the eyes of those with whom I come in contact. A matter of the construction of their inner eyes, those eyes with which they look through their physical eyes upon reality (p. 3).

Franklin (1999) was among the first to discuss the phenomenon of invisibility in the scholarly literature on mental health. In later publications, Franklin (2004) and Franklin, Boyd-Franklin, and Kelly (2008) addressed the consequences of this invisibility for African Americans. The authors described the potential outcome of race-related stress, internalized racism, chronic indignation, depression, addiction, and PTSD. Tovar-Murray and Tovar-Murray (2012) found that those participants who experienced the phenomenon of invisibility also had feelings of "hopelessness, anxiety, and anger." Participants in the current study reported similar reactions to their lived experiences.

The final impact of marginalization that emerged in this study was the value in discretion for the purpose of preservation. While it is not clear from participant responses exactly why discretion is valued, they implied cultural mistrust in the larger social context, i.e., the dominant presence of power within White society. Systemic cultural mistrust remains problematic in our society and is well documented (Fields, Reesman, Robinson, Sims, Edwards, McCall, Short, & Thomas, 1998; Pittman, 2011; Ashley, 2014; Chito, 2005; and Jeffries, 2006). A public opinion

survey administered in the aftermath of hurricane Katrina found that seventy-seven percent of blacks surveyed believed the government would have responded sooner if the victims were mostly White (Pew Research Center, 2005). In their study about the experiences of potential Black patients' initial mental health encounters, Earl, Alegria, Mendieta, and Linhart (2011) found: "Prospective Black patients interacted with their non-Black providers exercising caution and skepticism. Their previously established levels of healthy cultural paranoia seemed to function as a filter through which the present encounter was viewed" (p. 523). Their participants identified the importance of "trust" and "safety" with their providers as two positive indicators of their experiences with non-Black providers. These indicators demonstrate similar elements of mistrust and subsequent discretion with White society present with several participants of this study. Further, Moseley, Freed, Bullard, and Goold (2007) found cultural mistrust among African American parents of children in the healthcare system to be as high as African Americans within the mental health system.

The literature also offers conflicting views on discretion for the purpose of preservation. For example, the belief in "secrecy" within the African American community is also documented. In her thesis about the dynamic of secrecy about familial childhood sexual abuse, LaReux (2015) noted, "African-American mothers teach their children, especially their daughters, at a very young age, not to relay information to anyone outside of their home, perpetuating the culture of 'keeping your business out of the street' even at the risk of harm" (p. vi). Winnick and Bodkin (2009) found that secrecy among incarcerated African American men was less than that of their White counterparts. One of the reasons their findings are significant is the supposition that because racial stigma is so prevalent, Blacks are assumed to have criminal records. Therefore, maintaining the secrecy of a criminal record, as an ex-con will make

rejection that much more likely. Further research is needed to understand the value in discretion for preservation.

Lack of Culturally Responsive Clinical Practice

The subthemes found under lack of cultural responsiveness in clinical practice are *therapy with White clinicians, unpacking the infraction, and defining culturally responsive clinical practice*. The first subtheme, therapy with White clinicians, detailed stories about missteps and mistreatment on the part of White therapists with participants. These missteps and instances of mistreatment are a replication of what several participants experienced in their day-to-day lives. Moreover, it appears that several White clinicians demonstrated gross ethical violations in their clinical work from a place of fear, prejudice, counter-transference, ignorance, and bias.

The subtheme *unpacking the infraction* explains how similar patterns of negative experiences in therapy culminate in a formula. This formula shows what contributes to the theme *lack of culturally responsive clinical practice* and is linked to the final subtheme, defining culturally responsive clinical practice. The final subtheme reverses the formula in Figure 1 (p. 101) to demonstrate what is needed to correct the missteps participants described. Debbie's experience with a "mature African American" therapist is used to explain the formula.

The first infraction in the formula from Figure 1 begins with White clinicians lacking cultural awareness, a concern well-documented in the literature (e.g., Imel, Baldwin, Atkins, Owen, Beardseth, & Wampold, 2011; Constantine, Juby, & Liang, 2001; Curran, 2007). This awareness includes White clinicians understanding who they are in the context of a diverse society, the privileges afforded them because they are White, and the power they possess to marginalize and subjugate anyone who is not White. This self-awareness seems to fit within

“Self of the Therapist” dynamics and according to Simon (2006), should include cultural awareness. Other research, although very savvy about self of the therapist dynamics within a systemic lens, does not attend to the intersections between self of the therapist and social justice contexts (Aponte & Kissil, 2014; Regas, Kostick, Bakaly & Doonan, 2017).

Lack of cultural knowledge is the second infraction in the formula for the lack of culturally responsive clinical practice. Therapists who have a cultural awareness as it is defined in this study have the foundation to develop cultural knowledge, i.e., the understanding that White privilege and marginalization impact the experience of African Americans. The skill set that emerges as a result of combining ones cultural awareness and cultural knowledge is cultural skill. This skill is defined by the clinician’s ability to apply awareness and knowledge to their clinical work throughout the stages of therapy/counseling. Cultural skill is the third infraction in the formula. The absence of each element constitutes the lack of culturally responsive practice. The corrective formula as illustrated in Figure 2 (p. 106) defines culturally responsive clinical practice.

Cultural awareness leads to cultural knowledge. Cultural knowledge increases the capacity to develop cultural clinical skills. Cultural awareness, knowledge, and skills are the foundation of a culturally responsive clinical practice. The formula asserts that each element relies on the other to exist and that one’s capacity to develop a culturally responsive clinical practice begins with and depends on the cultural awareness of the clinician. While Figure 1 illustrates the “lack” reported in the experience of several participants, it implies the inverse as the formula for practicing through a culturally responsive lens. As important as attending to context and practicing through a culturally responsive lens, participants offered other factors that

contributed to what they considered positive experiences in couple or family therapy with White clinicians.

What Works in Therapy

The subtheme *what works in therapy* includes cultural awareness, general clinical skills, and therapist qualities. With regards to cultural awareness, it is critical to point out that only three clinicians seen by the eleven participants attended to their cultural context in a way that demonstrated a culturally responsive clinical practice. Moreover, only one therapist broached the subject of their client's ethnicity or the racial difference between the clinician and client. Upon reflecting on the fact that neither of her therapists mentioned her context as a Black woman, Kathy said: "No, nobody has ever acknowledged that as a black woman you might experience or whatever, it has never been acknowledged to me that way or even acknowledged, I mean I'm a black woman and you can't ignore that." Despite the limited scholarly literature in mental health on discussing matters of race, culture, language or other contextual identities, having such a discussion is documented as beneficial for the therapeutic relationship (Sue & Sue, 2015; Choi, Mallinckrodt, & Richardson, 2015; Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake, & Douglas, 2007).

The combination of clinical skills and character qualities emerged as other contributing factors to successful therapeutic experiences. Participants defined general clinical skills in terms of interventions used, homework assigned, or therapists' ability to understand the complexity of presenting issues. Therapist qualities included their ability to convey a presence of "openness" without judgment. One therapist was praised for sharing that he too had been in therapy. It is possible that this disclosure was normalizing in such a way that it countered the stigma of therapy. De Jesus and Earl (2014) found similar results from a qualitative study that explored

patient perspectives on the quality of care in outpatient settings. Researchers found practitioner relational competencies to be significant indicators of quality of care. Specifically, subcategories such as practitioners perceived to be non-judgmental and aware of cultural differences were indicators of quality of care. Earl et al, (2011) found specific indicators of good or poor initial encounters with mental health practitioners. Specifically, participants used “healthy cultural paranoia” to “scan” their encounters with practitioners. If participants felt ignored, misunderstood, or disrespected by providers, or if they were mistrustful of, uncomfortable with, felt unsafe disclosing personal information with providers, they were considered to have poor encounters. Conversely, patients who felt comfortable, safe disclosing, and who trusted, felt understood and respected qualified their encounters as good.

The results of this research are similar to those found by Elias-Juarez and Knudson-Martin (2017). Using grounded theory, they studied cultural attunement between marital and family therapists and Mexican/Mexican-American couples. Their findings resulted in a model of “cultural connection through personal engagement” (p. 100). Hoskins (1999) described the components of cultural attunement as acknowledging the pain of oppression, engaging in acts of humility, acting with reverence, engaging in mutuality, and coming from a place of “Not Knowing”. Elias-Juarez and Knudson-Martin (2017) found that cultural attunement happened through multiple phases of personal engagement. Similarities between the current study and the authors’ research include the awareness of one’s power and the existence of oppression, creating relationships where clients felt accepted and/or respected, and demonstrating a willingness to share their experiences.

Both studies also reflect the need to employ cultural humility with clients (Tervalon & Murray-García, 1998; Hook, Farrell, Davis, DeBlaere, Van Tongeren, & Utsey, 2016. Foronda,

Baptiste, Reinholdt, and Ousman (2016) conducted a concept analysis to define cultural humility. Using a method of concept analysis developed by Rodgers and Knafl (2000), 108 articles were analyzed. They ultimately defined cultural humility as “a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals” (p. 213).

The importance of the similarities between the respective results are twofold. First, despite significant differences in methodologies, clients responded to therapists working through cultural connections and the personal engagement as a successful approach to treatment. Further, the fact that the studies focus on different marginalized populations suggests a greater chance for transferability (Lincoln & Guba, 1985).

Limitations of the Research

The limitations of this study are primarily related to the challenge of recruiting participants. Purposeful sampling was initially used as the method for recruiting. As discussed in chapter three of this study, snowball sampling became the means by which participants were successfully recruited. Without further research, it is difficult to say with certainty but cultural mistrust and an underuse of social media may have contributed to the difficulty with recruitment.

Therapy remains taboo in the African American community. Additionally, many African Americans including participants Juanita, Francis, and Viola share the belief in discretion for self-preservation. Phrases such as Juanita’s: “you don’t talk about your business in the streets, you don’t share your misery,” or Francis’: “It’s a weakness to admit that there’s a problem” are common. Therefore, cultural mistrust may have had an impact even though I too identify as Black or African American.

Social media is now one of the primary means of advertising but it was beginning to replace email listservs and written forms of media such as newspapers at the start of this study. There is little research on social media and snowball sampling (Dusek, Yurova, & Ruppel, 2015; Baltar & Brunet, 2012; Head, Dean, Flanigan, Swicegood, & Keating, 2016). Further research is needed to understand the effectiveness of using social media in recruiting African Americans given the value in discretion.

Clinical Implications and Recommendations

The findings from this study suggest that while some form of multicultural training is expected in clinical training programs, most of the clinical experiences described do not reflect that training. The recommendations from this study reflect a more systemic approach to a culturally responsive clinical practice that also includes navigating the nuances of contextual intersections, i.e., various contexts such as sexuality, interracial relationships, religion, gender roles, etc. Clinical training from master's and PhD level programs, conference workshops, and circuit training is not sufficient to treat clients on the margins (hooks, 1985). After completing their degrees, clinicians have little accountability to practice through a culturally responsive lens.

Second order change means the rules of practice and engagement have changed (Watzlawick, Weakland, & Fisch, 2011; Bateson, 1972; Davey, Davey, Tubbs, Savla, & Anderson, 2012). In order for that change to take place, each level of our professional system needs to be engaged in the process. Those in leadership in our professional organizations should undergo training meant to understand the perspective of clients on the margins (hooks, 1985). Too often, this knowledge lies only with those "experts" who themselves are marginalized. In order for training to improve, the expectation must reach beyond degreed programs, beyond those of us in subjugated positions.

Further, faculty in clinical programs should be able to demonstrate a level of proficiency with teaching from a culturally responsive lens regardless of their area of expertise. If only one or two faculty are champions of training from a culturally responsive lens, they likely bear the weight of social justice issues in isolation. The dissonance between those who do and do not teach from a culturally responsive lens jeopardizes the overall quality of training for student clinicians as shown by several participants of this study.

Clinical training and supervision should include a focus on self of the therapist issues while incorporating social justice dynamics. Students often learn more about themselves in the context of their families, their beliefs, and values while in clinical training. However, not all clinical programs incorporate self-work in the context of social justice. The clinicians who never attended to differences between themselves and participants in this study likely never got to consider themselves and the power and/or pain they represent for clients on the margins (hooks, 1985). As Kathy stated:

Honestly the other thing that I think is critical for anybody who is dealing with people who are different is to know your shit. You need to know where you fit in that...where are your stumbling blocks, what are the things that have shaped what you believe about people of color.

The experiences shared by participants have the potential to reach clinicians in training in a more profound way. When it comes to issues of power, privilege and oppression, I have watched White students justify and defend against quantitative data in a defensive and often dismissive way. However, when I quote participant experiences to trainees, I watch students visibly cringe. Sharing participant experiences has helped students, particularly privileged, White students, understand the power they have in therapeutic relationships and the potential

harm they can cause marginalized clients. If there is a way to incorporate the actual voices of those who have been subjugated by the effects of power, privilege, and oppression in training, perhaps their experiences can help trainees understand the culpability they have in maintaining the status quo of injustice in this society.

The intersections of client identities became an important aspect in participant experiences. For example, Fredrick explained what it meant to have one of his therapists consider his context as a Black man, a Christian, a father of an adolescent daughter, and a husband. Juanita's example included not only her context as an African American woman in a predominantly White work environment, but also the context of working with an older White, gay male supervisor in mediation with a Jewish male therapist. This study points out the importance of the intersectionality of each participant in the therapeutic relationship, i.e., the client(s) and clinicians. While the focus of this research was on African Americans with White clinicians, their experiences reach beyond these two contexts and raises questions about many other contexts.

Most participants detailed specifics about the various contexts of their lives, i.e., the intersections of their identities based on gender, ethnicity, sexuality, religion, socio-economic standing, country of origin, and age/stage of life dynamics. The influence of their various contexts suggests that clinicians should include the lens of intersectionality as a component of their therapeutic work. Academic literature is becoming more rich and inclusive of dialogue about and practical use of an intersectional lens in therapy (e.g., Hernández & McDowell, 2010; McDowell & Hernández, 2010; Hall & Carlson, 2016; and Watts-Jones, 2010). Further, scholars are stretching the boundaries in considering intersections into specific identities (Gangamma &

Shipman, 2017; Addison & Coolhart, 2015; McDowell & Fang, 2007; and Niño, Kissil & Davey, 2016). It is my hope that this research helps continue this dialogue.

Future Research

The results of this study indicated several options for future research. To build on this research, it would be beneficial to replicate the current study using different marginalized groups and different groups of clinicians to test the transferability of the study. For example, despite the injustices I have experienced as an African American woman, my identity as a Christian is one that is privileged and my treatment from a place of ignorance has the potential to marginalize those who are not. Even though I understand how religion, and even God has been used to ostracize non-Christians, I may be culpable in my client's pain if I did not consider myself in the context of their world. Replicating this study using different client and clinician contexts or intersecting identities may help to determine if the pattern of culturally responsive clinical practice is transferable to other dynamics.

The second recommendation for future research is a study that tests the validity of the formula for culturally responsive clinical practice specifically with regards to supervision and clinical training. In recent literature, authors have detailed their personal journeys in understanding the privilege of being White and its impact on others. McIntosh (1995) is best known for chronicling her journey to understand her privilege as a White woman in academia. Others have created spaces to consider themselves in the binary context of privilege and marginalization (e.g., Kaschak, 2015). The literature is extending to case studies on the process of White clinicians developing their awareness (Hernandez-Wolfe & McDowell, 2013). The foundation of the formula relies on White clinicians having enough self-awareness about their own context and an understanding that their context is different, particularly from those who are

marginalized. It would also be beneficial to explore this formula with clinical trainees from marginalized contexts, i.e., transgender clinicians, clinicians of color, clinicians of various nationalities, to compare the development of their culturally responsive clinical practice.

Another recommendation for future research is a study that determines whether or not clinicians can develop a culturally responsive clinical practice using specific systemic theories. Kathy said in her interview that therapy was never meant for us, i.e., African Americans. Sadly, she is correct, most theories ignore cultural contexts. Further, as reported by most of the participants, clinicians rarely ever address obvious ethnic differences between themselves and their clients. Therefore, they never consider the client's various identities in the context of the therapeutic work. Relational-Cultural Theory (Jordan, 2010) appears to be one of the approaches that allows the clinician to consider clients through their contextual reality. RCT has been well received and critiqued as a model that augments a therapist's existing approach to treatment in a way that honors the intersections of a client's context (Harper, 2010; Hammer, Crethar, & Cannon, 2016; Headley & Sangganjanavanich, 2014; and Duffy & Somody, 2011). The field would benefit from having a broader understanding of what it means to incorporate a culturally responsive practice when training students on systemic theories.

The final recommendation is for further qualitative research studying the experience of marginalized clients while considering the intersections present in their lives. While quantitative data offers much in the way of supporting theory and the efficacy of a specific methodology for treatment, such research cannot capture the meaning behind the numbers. Further, clinical theory development can improve from a larger base of qualitative research. We are complex beings with many facets to our identities that inform how we navigate the world. Also, as researchers or clinicians, we can only truly know our own experiences. A clinician who is also a veteran is

likely to have a strong understanding of that shared experience with a veteran client. However, the veteran client whose intersecting identities include being a woman, whose ethnic origin is from another country, and who identifies as a lesbian will be quite complex. Those intersections need to be taken into account. Similarly, the client who is a descendant of refugee parents will have a very different view of how to navigate the world that is complex because it deals not only with their current experience in the United States, but also includes a historical backstory that is rarely integrated into the therapeutic process (Gangamma & Shipman, 2017).

Qualitative research has the potential to fill in a missing component from clinical theory development. That is to say, it can give voice to the marginalized client who has been shaped by their encounters with power, privilege and oppression. Their voices and experiences with marginalization can then shape clinical work in a more systemic way. For example, once participants in this study began to speak about their experiences with White privilege and marginalization outside of therapy, they provided a narrative for a truth that is not well understood. Their truth is that those instances where they experience marginalization, oppression, and subjugation in their daily lives are replicated in the very spaces meant for their healing process, their therapeutic relationships. Rarely are their experiences told from a narrative or qualitative perspective in theoretical literature nor in published research. Qualitative research can then ultimately help bridge the gap in what is often missing from clinical theory, a more complex consideration of those intersecting identities and their experiences as a result of those intersections.

Conclusion

The findings of this research call for clinicians to use a profound level of intentionality in their work with African Americans, to consider themselves in the context of diverse realities, and

to always embrace those realities when bearing witness (Weingarten, 2000) to clients' journeys. It also calls for the vulnerable, human, qualities that make us "real" and worthy to hold the experiences of those brave enough to seek change. African Americans face different challenges than White Americans. Frequent exposure to marginalization, both in their personal lives and in their therapeutic experiences, has deleterious effects. Participants witnessed their children being openly criticized about their physical features, they were denied the opportunity to advance in their careers, denied services as consumers, and were openly scolded in the workplace. This is the diverse reality that clinicians either ignored or forced on their clients. These infractions caused "little tears," created mistrust and anger, and ultimately rendered most participants invisible. The culmination of their experiences provided a formula for how to and how not to engage with African Americans in therapy. However, participants also gave evidence of what works in therapy.

Participants, in sharing their experiences, challenge White clinicians, clinical training programs, regulatory boards, and our systemic professional organizations to rethink our treatment of African American clients and other clients on the margins (hooks, 1985). Training should be extended beyond those in training programs and workshops to administrators, faculty, and regulatory board administrators. Further, there needs to be a vehicle to demonstrate efforts to engage in culturally responsive clinical practice and leadership oversight. Given the recent drastic shifts in our government, I cannot think of one marginalized group that has not feared for its survival, not to mention its freedom. It is more critical than ever that clinicians prepare themselves to serve clients on the margins.

Appendix A



Syracuse University

Consent Form

Title of Study:

“In Our Own Words:” The Phenomenological Exploration into the African American Experience of Relational Therapy with European American Therapists

Introduction:

Hello, my name is Melody Brown and I am a doctoral student in the Marriage and Family Therapy department at Syracuse University. I am seeking your consent and participation in this study because you identify as an African American over the age of 18 who has been in couples or family therapy with a European American therapist. Fifteen to twenty individuals are expected to participate in this study. The following details important information about this study. However, please contact me with any further questions you might have at 303-548-4435.

Background/ Purpose:

The purpose of this research study is to understand your experience in couples or family therapy with a European American therapist. My hope is that your willingness to share your experience will inform how clinicians work with African American clients in therapy.

Procedures:

Your participation will include either a face-to-face interview or an interview by phone which will last thirty minutes to one and a half hours. Should you consent to participate in this study, Carol Weaver, a research assistant, will contact you to schedule an interview. She will work with you to determine the location of the interview based on your needs. Possible options include your home or a nearby public library.

I am the primary researcher for this study and will be conducting all interviews. I will provide you with a copy of your signed consent form at the time of the interview. I will ask you several demographic questions and will then ask other questions which will allow you to talk about your past experience in therapy with European or White therapists. I am also requesting your permission to audio record your interview. Recordings will be stored electronically on a password secured computer and, once transcribed and printed, in a locked file cabinet in my office. No identifying information will be used in this research. Your name will be substituted with a false name or with a number during transcription. Those who will have access to this information include my dissertation adviser, the contracted person who will transcribe the interviews, the graduate student who assists in coding interviews, and I.

You may request a free copy of your interview and/or a copy of the summary of the results at the end of this consent form. Requests to receive this information will only be honored if indicated on this consent form at the time of the interview. Upon completion of the study, I will destroy all data. I will contact you by phone or email to discuss your preferred method of receiving the summary of the results of the study and/or a copy of your interview. You will not have access to the interviews of other participants.

Voluntary Participation:

Your participation in this study is completely voluntary even during the interview process. You may withdraw your consent from participating at any time without penalty.

Risks:

The risk to you in participating in this study is minimal. Participants, however, may experience some discomfort in discussing issues that are related to racial differences that they may not have explored prior to this interview. Should you experience discomfort as a result of participating in this study, please contact me at (303) 548-4435 as I am prepared to offer referrals to clinicians of African American, Latino/Chicano, or of European American descent. I am also prepared to refer you other non-clinical resources to resolve any discomfort you might experience as a result of participating in this study. An example of a non-clinical resource is a connection with a local minister or with community agencies sensitive to the needs of American Americans in your local community. You will be responsible for any cost incurred as a result of using any of the referrals suggested to you.

Benefits:

A benefit is the potential for your stories and experiences to create a different awareness of what some African Americans might need from a European American therapist. This different level of awareness might benefit the mental health field. Another benefit might be a sense of empowerment and validation in having your experience heard.

Cost/Payments:

There is no cost to you for participating in this study unless you are referred to a clinician. Participants will receive a \$15 gift card from either Target or Wal-Mart. Should you withdraw from the study or decide not to complete the interview, I will end the interview process immediately, and you will receive a \$5 gift card from either Target or Wal-Mart.

Questions:

If you would like to contact me with questions or concerns I can be reached by phone at (303) 548-4435, or by email at mmbrown977@aol.com. You may also contact my faculty research advisor, Linda Stone Fish, PhD, at (315) 443-3024. Should you have any questions, concerns, or complaints you wish to address beyond me or my advisor, please contact the Syracuse University Institutional Review Board at (315) 443-3013.

I agree that am 18 years or older. My date of birth is _____ (month/day/year).

I agree to have my interview audio recorded

I would like a copy of my interview

I would like a copy of the summary of the results of this study

All of my questions have been answered and I agree to participate in this research study.

Participant Signature: _____ Date: _____

Printed Name: _____ Date: _____

Participant Telephone number: _____

Signature of Researcher: _____ Date: _____

Appendix B

Recruitment Email

Hello.

My name is Melody Brown and as a doctoral student in the Department of Marriage and Family Therapy at Syracuse University, I am conducting a study on *The African American Experience of Relational Therapy with White Therapists*.

Attached is a copy of the recruitment letter and advertisement which further detail the study. Please feel free to contact me if you would like to participate or forward this email if you know of anyone who might be interested.

Your assistance can potentially impact the practice of clinicians with a population that continues to be marginalized and disenfranchised despite our historical gains.

Thank you,

Melody M. Brown, MA, LMFT

Appendix C



Recruitment Letter

My name is Melody Brown, and I am a doctoral candidate in the Marriage and Family Therapy Department at Syracuse University. I am conducting a study of African American adults who have participated in couples or family therapy with White or European American therapists.

Eligible participants 1) will identify as African American; 2) are age 18 years or older; and 3) have participated in therapy with a European American clinician but who are no longer in treatment.

Those who participate in this study will be interviewed either by phone or in person. All interviews will be digitally recorded and will last approximately 30-45 minutes. Strict measures will be taken to protect confidentiality. Recordings will be stored electronically on a password secured computer and, once transcribed and printed, in a locked file cabinet in my office. No identifying information will be used in this research. Your name will be substituted with a false name or with a number during transcription. Those who will have access to this information include my dissertation adviser, the contracted person who will transcribe the interviews, the graduate student who assists in coding interviews, and I.

This research may benefit the mental health field by increasing the understanding of the experience of African American clients who have participated in relational (couples or family) therapy. Participants may also benefit by exploring their past experiences in therapeutic relationships that are deeply rooted in a historical context. Another benefit may be an understanding of how their experiences with their former therapist reflect their experiences with European Americans in general.

Participants may experience some discomfort in discussing issues that are related to racial differences that they may not have explored prior to this study. These risks will be kept to a minimum by the researcher. The researcher can also provide participants with appropriate referrals for therapy to a host of clinicians of European American, Latin American, or African American descent. Participation is completely voluntary and a participant may withdraw from the study at any time, without penalty.

Please feel free to contact me or my advisor with any questions you may have about this study or about participating in it. I may be reached by telephone at (303) 548-4435 or by email at mmbrown977@aol.com. My advisor, Linda Stone Fish, may be reached by telephone at (315) 443-3024 or by email at flstone@syr.edu. This research study has been approved by the Syracuse University Institutional Review Board (IRB). If you have any further questions, you may also contact them by phone at (315) 443-3013.

Thank you for your interest and participation.

Melody M. Brown, MA, LMFT

Linda Stone Fish, PhD

Appendix D

News Paper Advertisement

Have Your Voice Heard

Participate in a Research Study Exploring the Experience of African Americans in Therapy with White Clinicians

- ◆ **What?** 15- 20 people needed to participate in an interview for a research study where you describe your past experience in couples or family therapy with a White/ European American therapist
- ◆ **Where?** In the comfort of your own home, in a nearby public library, or by phone. (Interviews will last 30 to 90 minutes)
- ◆ **How?** Contact Melody Brown at 303-548-4435 or mmbrown977@aol.com
- ◆ **When?** Interviews will be arranged according to your schedule of availability

*Together We Can Change the World...
One Person at a Time...One Step at a Time*

Appendix E

Demographic Questions

- 1) What is your age?
- 2) How old were you at the time you were in therapy with a White clinician?
- 3) Who lives in your household? What are their ages?
- 4) How many children do you have?
- 5) What is your relationship status?
- 6) What is your employment status (employed, unemployed, disabled)?
- 7) What is/was your occupation?
- 8) Where do you live?
- 9) When were you in therapy with a White clinician?
- 10) Who attended therapy with you?
- 11) How long did therapy last?
- 12) What was your reason for seeking therapy?

Appendix F

Interview Questions

- 1) How did you make the decision to see a White clinician?
- 2) Describe your relationship with the therapist.
- 3) How did your therapist acknowledge your ethnic/racial differences in therapy?
- 4) How did the difference in your ethnicity impact your therapeutic relationship?
- 5) How did your therapist demonstrate an understanding of what it means for you to be an African American person?
- 6) What did your therapist/s do to address your presenting problem in the context of you as an African American/Black American?
- 7) What would you want therapists to consider when working with African American clients?
- 8) What would have made your experience in therapy more positive?
- 9) How would you describe your experience in therapy?

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- Wise, T. (2011). *White like me: reflections on race from a privileged son: the remix*. CA: Soft Skull Press.
- Woodley, X. M., & Lockard, M. (2016). Womanism and snowball sampling: Engaging marginalized populations in holistic research. *The Qualitative Report, 21*(2), 321-329.
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Curriculum Vitae

EDUCATION

Syracuse University. Syracuse, New York. Doctor of Philosophy in Marriage and Family Therapy. 2017.

Northeast Louisiana University. Monroe, Louisiana. Master of Arts, major in Marriage and Family Therapy. 1997.

University of New Orleans. New Orleans, Louisiana. Bachelor of Arts, major in Psychology. 1993.

LICENSURE

LMFT - Licensed Marriage and Family Therapist, Conferred on January 5, 2006 by the State of Colorado, Board of Marriage and Family Therapist Examiners. License number 737.

PROFESSIONAL AFFILIATIONS

American Association for Marriage and Family Therapy

Colorado Association for Marriage and Family Therapy

TEACHING EXPERIENCE

Adjunct Faculty. Fall 2013 – Present. University of Colorado Denver. Denver, CO. Provide clinical group supervision and oversight of internship sites.

Faculty Member/Clinical Supervisor. Fall 2004 – 2014. Denver Family Institute. Denver, CO. Provide clinical training in Marriage and Family Therapy through experiential learning and group supervision.

Courses include:

Applied Cultural Competency -course designed to enhance knowledge and experience in negotiating the contexts of cultural differences within the therapeutic process. Therapists in training encouraged to identify and challenge their beliefs, values, and behaviors while assessing their impact on the therapeutic process.

Couples I. Co-facilitated - teaching therapists to create a safe and therapeutic space with effective use of self. Subjects such as the emotional regulation of the therapist, the therapist's ability to maintain maneuverability and leadership with high-conflict couples, and the therapist's ability to isolate personal biases which could impact the process are discussed. Students are encouraged to have an experiential and/or somatic understanding of conducting couples counseling.

ADMINISTRATIVE EXPERIENCE

Director of Foster Care. April 2010 – August 2011. Adoption Alliance. Denver, CO.

Manage program budget. Supervise staff in placement and case management duties. Ensure the safety of foster children in placements by maintaining regulatory standards and practices. Conduct homes studies and maintain small caseload. Recruit and license foster families.

Project SUCCESS Supervisor. April 2010 – August 2011. Denver Children's Home. Denver, CO.

Managed grant application process and was awarded grant funded SAMSHA approved drug prevention program in collaboration with East High School. Maintain budget. Supervise Staff. Train and educate parents on program and curriculum.

Director of Community Based Services. July 2007 – April 2010. Denver Children's Home. Denver, CO.

Provided clinical and administrative oversight for six clinical and community-based programs. Programs include In-Home Therapy, Therapeutic Emancipation, After School, and Community Outreach programming. These programs collectively account for nearly \$1 million of the overall \$5.5 million agency budget.

East Denver Collaborative, Family to Family Site Coordinator. December 2006 – July 2006. Denver Children's Home. Denver, CO.

Established community partnerships throughout the East Denver region. Maintained a collaborative relationship with Denver Department of Human Services to prevent out of home placement. Maintained program budget. Provided clinical and administrative supervision.

CLINICAL EXPERIENCE

Clinical Supervisor/Psychotherapist. August 2011 – Present. University of Colorado Denver. Denver, CO.

Provide clinical supervision for practicum students in the CPCE program. Maintain a caseload of up to 25 clients and provide crisis counseling to CU Denver students. Collaborate with university stakeholders to ensure the academic success of the student body. Develop and facilitate harm reduction groups for Auraria campus students. Specializing in supervision through a systemic and social justice lens.

Family Therapist/Clinical Assistant. 2002 – 2006. Denver Children's Home. Denver, CO.

Conduct individual, family, and group therapy with adolescent males in residential setting using a systemic theoretical approach to treatment. Attend court proceedings to provide clinical recommendations based on the client's/family's history of progress. Coordinate and facilitate staffings with families and collateral contacts. Provide emergency clinical interventions with high risk behaviors. Develop treatment and plans and reporting on progress made. Coordinate transition plans for residents' return to the community. Act as Treatment Leader in the event that the current Treatment Team Leader is unavailable.

Family Therapist. July 2001 – September 2002. Savio HBI, Inc. Colorado Springs, CO. Provide intensive in-home therapeutic services to children and families at risk for foster care placement. Services include the provision of daily case management and weekly family therapy sessions using the Multi-systemic therapy model.

Family Therapist. August 1999 – May 2001. Syracuse University. Syracuse, New York. Provide counseling and psycho-educational training through Catholic Charities, Brighton Family Center, and Job Connections, which are affiliates of Catholic Charities. Conduct group sessions with

adolescent girls focusing on raising self-esteem, providing job readiness training, and resolving interpersonal relationship issues. Develop support group assisting non-custodial fathers seeking entry or re-entry into the workforce. This position was specifically designed as a community based graduate assistant title.

PUBLICATIONS

- Addison, S. M. & Brown, M. M. (2002). Working with couples on ethnicity and sexual identity: The “parts” interview. *The Therapist’s Notebook for Lesbian, Gay, and Bisexual Clients*.
- Addison, S. M. & Brown, M. M. (2002). Creating a cultural and sexual genogram. *The Therapist’s Notebook for Lesbian, Gay, and Bisexual Clients*.
- Brown, M. M. & Addison, S. M. (2002). Knowing you, knowing me: Sexual identity and the couple. *The Therapist’s Notebook for Lesbian, Gay, and Bisexual Clients*.
- Brown, M. M. & Addison, S. M. (2002). Who am I really: Understanding the intersection of sexual and ethnic identity. *The Therapist’s Notebook for Lesbian, Gay, and Bisexual Clients*.
- Brown, M. M. & Addison, S. M. (2002). Creating a “Thicker Description”: Understanding Identity in mixed-identity relationships. *The Therapist’s Notebook for Lesbian, Gay, and Bisexual Clients*.

PROFESSIONAL PRESENTATIONS/GUEST LECTURER

- Brown, M. M. (2016 February). African American Dynamics in Relational Therapy. Guest lecture, course: Advanced Assessment and Treatment in Family Systems. University of Colorado Denver, Denver, CO.
- Brown, M. M. (2015 April). African American Couples in Therapy. Guest lecture, course: Social Work Practice with Couples. University of Denver, Denver, CO.
- Brown, M. M. (2015 January). Child Abuse Reporting. Guest lecture, course: Advanced Assessment, Theory and Treatment in Family Systems. University of Colorado Denver, Counseling Program, Denver, CO.
- Brown, M. M. (2014 September). African Americans in Relational Therapy with White Clinicians. Guest lecture, course: Multicultural and Diversity Issues in Counseling Individuals and Families. University of Colorado Denver, Counseling Program, Denver, CO.
- Brown, M. M. (2014 May). African American Couples in Therapy. Guest lecture, course: Social Work Practice with Couples. University of Denver, Denver, CO.
- Brown, M. M. (2013 May). African American Couples in Therapy. Guest lecture, course: Social Work Practice with Couples. University of Denver, Denver, CO.
- Brown, M. M., Howard, M., Parrish, D. L. (2009 October). Demystifying the African American Client: Tools, Strategies, and Interventions to Address Overrepresentation of African

- American Clients in the Child Welfare System. Child Welfare League of America National Conference, Breckenridge, CO.
- Brown, M. M. (2008 May). Disparity and Disproportionality in Child Welfare. Curriculum Co-Presented on behalf of the National Child Welfare Leadership Institute, Seattle, WA.
- Brown, M. M. (2007 September). Working with African Americans with HIV and AIDS. Contracted Training Presented for Diverse Management Solutions, Denver, CO.
- Brown, M. M. (2007 July). Keynote Address. Annual National Facilitator's Conference. Hosted by Annie E. Casey Foundation, Denver, CO.
- Brown, M. M. (2005 June). Diversity training: An introduction to working with the LGBT Community. Training presented to Adams County Internal Treatment Team, Denver, CO.
- Brown, M. M. (2005 April). Diversity training: Working with the African American client. Training presented to University of Phoenix, Denver, CA.
- Stonefish, L., Clarke, D., Harvery, R. M., Brown, M.M., & Hardy, K. V. (2003, October). Doing Relationships: A clinical pathway to therapeutic development. Institute presented at the 61st Annual American Association for Marriage and Family Therapy Conference, Long Beach, CA.
- Clarke, DeMarquis & Brown, M.M. (2002, October). Unbreakable Attractions: the Resiliency of African American Couples. Roundtable presented at the 60th Annual American Association for Marriage and Family Therapy Conference, Cleveland, OH.
- Boyd, C. J., Whitman, J. S., Hollingsworth, L., Didelot, M., Noffsinger-Frazier, N., Raina, K., Shulman, J., Addison, S. M., Brown, M. M., & Astramovich, R. (2002, March). Counseling Lesbian, Gay, and Bisexual Clients: Exercises that Enliven the Treatment. Presentation based on upcoming publication The Therapist's Notebook for Lesbian, Gay, and Bisexual Clients: Homework, Handouts, and Activities for Use in Psychotherapy, presented at the Annual American Counseling Association Conference, New Orleans, Louisiana.
- Harvey, R., Brown, M. M. & Addison, S. M. (2001, June). Negotiating Diverse Identities. Presented at the Fourth Annual In The Family Conference, San Francisco, California.
- Brown, M. M. (2001, April). Working with African American Families. In-service presented at Catholic Charities, Syracuse, New York.
- Brown, M. M. & Johnson, L. A. (2000, November). Dismantling Stereotypes within African American Couples. Roundtable presented at the 58th Annual American Association for Marriage and Family Therapy Conference, Denver, Colorado.
- Brown, M.M. & Gruber, R. (1997, August). Family Mentoring. Training workshop presented at the West Monroe Community Center, West Monroe, Louisiana.

Svenonius, K., Brown, M. M., Thies, A., & Lucas, A. Y. (1996, October). Duck Duck Goose. Presented at the Louisiana Counseling Association State Conference, Lake Charles, Louisiana.

Svenonius, K., Brown, M. M., Thies, A., & Lucas, A. Y. (1996, November). Duck Duck Goose. Presented at the Northeast Louisiana Association for Marriage and Family Therapy Monthly Luncheon, Monroe, Louisiana.