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Walden University

College of Social and Behavioral Sciences

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Tonia Nixon

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Walden University
2021

Abstract

An Exploration of African American Women's Clinical Experience With European American Clinicians

by

Tonia Nixon

MSW, Georgia State University, 2015

BSW, Georgia State University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work – Clinical Specialization

Walden University

May 2021

Abstract

African American (AA) women experience decreased rates of retention and increased rates of mental health conditions. The purpose of this qualitative transcendental phenomenological study was to explore lived experiences of AA women who received therapeutic services from European American (EA) clinicians. The strong Black woman (SBW) schema served as a conceptual framework for this study. The research question was to examine how the endorsement of the SBW schema affect AA women's experiences of the therapeutic alliance during clinical treatment with EA clinicians. Data collection was accomplished through semi structured interviews conducted through Zoom from six participants in Atlanta, GA. Participant selection involved time-location, criterion-based, and snowball sampling. Participants were AA women, who received therapy from EA clinicians between the ages of 21 and 65 years. A qualitative analysis was conducted using Moustakas' data analysis method. Findings revealed participants felt discomfort and that their therapists were unable to relate to or understand the culture and life of AA women. Participants also felt a poor connection and engagement with therapists and maintained a lack of confidence in them. Findings also revealed double-sided notions of SBW schema, personal strengths of independence, and that SBW schema hinders the therapeutic alliance. This research serves as a call to action to further studies in the therapeutic alliance and prepare clinicians to engage and treat AA women, as implications lean toward improved cultural competency of EA clinicians to increase their understanding of the SBW and increase retention rates. This research supports the need for change in practice policy and potentially that of local licensing boards.

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Dedication

I dedicate this dissertation to my daughter Jasmine and my adoptive parents Edward and Lena Jones, for all the support they have shown to me.

Acknowledgement

I want to thank the contributing faculty who aided in my doctoral journey. Those included consist of my chair Dr. Pete Meagher, my second committee member Dr. Lakisha Mearidy-Bell, and my university research reviewer Dr. Sandra Harris. I would also like to thank Dr. Karen Watkins and Terri Lewinson, who encouraged, supported, and pushed me to obtain a doctoral degree. I send my thanks to all of the participants in the research, without them, I could not have obtained my goal. Many thanks and love to my daughter Jasmine who supported me and woke up at 3 am to bring me tea while I worked and said, “Mom, you got this.” Lastly, I would like to thank my academic advisor La Toya Johnson for your support and encouragement, and my best friend Belinda Momon for encouraging me to continue my education.

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Chapter 1: Introduction to the Study

Several researchers noted numerous mental health disparities for African Americans compared to their European counterparts (Jones et al., 2018; Mays et al., 2017; U.S. Department of Health and Human Services Office of Minority Health [USDHHS OMH], 2019). African Americans encounter unique complications in their contacts with mental health providers and are 50% less likely to receive mental health services over that of European Americans (Jones et al., 2018). African American clients have a higher likelihood of suffering from negative emotional states (e.g., sadness, hopelessness, and feelings of everything being an effort) and a higher rate of untreated mental health conditions, compared to Caucasian or European Americans (Jones et al., 2018; Mays et al., 2017; USDHHS OMH, 2019) by approximately 53% as they do not receive the same provision of services (U.S. Department of Health and Human Services Office of Minority Health, 2019). In addition, compared to European Americans, African American clients often encounter discrimination within mental health facilities and more often deem treatment they receive for mental illness as not being helpful (Jones et al., 2018). One such form of discrimination often ignored is that of colorism, which African American's often face, as many endure disproportionate treatement based on the lightness or darkness of their skin tone (Dixon & Telles, 2017; Landor & Barr, 2018).

Clinicians within the field of mental health comprehend that the therapeutic alliance is essential to attaining the client's positive therapeutic or clinical outcomes (Johnson-Hood, 2017; McLeod et al., 2016). African American female clients may find it challenging to develop a therapeutic alliance with European American clinicians due to

the endorsement of the strong Black woman (SBW) schema. The SBW schema is a theory that suggests that social conditions encourage African American women to endure, withstand hardships, be invulnerable, and keep things moving despite this affecting their mental health (Etowa et al., 2017). Previous research revealed that strong endorsement of the SBW schema may hinder help-seeking behavior for physical and mental health issues among women who endorse the schema (Nelson et al., 2016). Strong endorsement of the SBW schema may serve as a barrier to the development of the therapeutic alliances between clinicians and patients who endorse the myth.

The purpose of this study was to explore how the endorsement of the SBW schema may affect African American women’s experiences of the therapeutic alliance during clinical mental health treatment with European American clinicians. Because African American women are statistically less likely to utilize and benefit from therapeutic services than women in other racial and ethnic groups, they are more likely to suffer from conditions of untreated mental illness (Jones et al., 2018; Mays et al., 2017). It is important to understand how the SBW schema may affect the experiences of African American women concerning the therapeutic alliance with their European American clinician in order to serve these women more efficiently.

Findings from this research can be used to promote social change by bringing awareness to social workers and other health care professionals and providing a platform by which participants are empowered. This research demonstrates how the SBW schema’s endorsement may affect the experiences, views, and opinions of African American women about the cross-cultural therapeutic dyad. Social workers and other

healthcare professionals can use the findings of this research to advocate for and to inform clinical social workers of the need to expand their cultural awareness and understanding of how the SBW schema affects the therapeutic alliance. The increased knowledge and awareness among clinicians could lead to improvements in the quality of the therapeutic alliance and clinical services provided to African American women.

Chapter 1 will provide an introduction and discussion of the background to the problem as well as the problem statement. The chapter will also present the purpose of the study and research question while previewing the conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. Finally, there will be a conclusive summary.

Background

African American females have a disproportionately higher rate of untreated mental health issues than European Americans (Jones et al., 2018; Mays et al., 2017). Data from the *2018 National Survey on Drug Use and Health: African Americans*, published by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), revealed racial/ethnic differences in the utilization rate of mental health services. Results from the SAMHSA report showed that among the overall U.S. population of adults 18 years of age and older, 56.7% of those with any mental illness (AMI) reported not receiving treatment. However, only 8.5% of African Americans utilized mental health services compared to 18.1% of European Americans (SAMHSA, 2015). Earlier data obtained from the 2008-2012 National Surveys on Drug Use and Health, revealed that White females had the highest rate of utilization of mental health

services by 21.5%, compared to only 10.3% of Black females reportedly using mental health services (SAMSHA, 2020).

The decreased utilization rate of mental health services among African American females is essential given that the rate of mental illness among Black women is equally as high and often higher (depending on the specific disorder) when compared to White females (USDHHS OMH, 2019). Overall statistics show that 3.7% of the population of Black (non-Hispanic females) and 4.2% of the White population (non-Hispanic females) are reported to have conditions of severe psychological distress (USDHHS OMH, 2019).

African American women maintain lower rates of therapeutic retention than European Americans who seek treatment (Davis & Ancis, 2012; Davis et al., 2015; Poleshuck et al., 2013; Williams et al., 2014). The endorsement of the SBW schema was proven to be a factor that contributes to the decreased utilization and continuation of mental health treatment among African American women (Donavan & West, 2015).

African American women who endorse the SBW myth often find requesting help difficult; thereby, they continue to struggle in silence (Donavan &West, 2015). Despite research surrounding the alliance, there remains a gap in the literature. This gap is based on the impact of the SBW schema on the experiences of African American women who receive therapeutic services from European American clinicians. An exploration of how the endorsement of the SBW schema relates to the African American women's clinical experiences, as it relates to the therapeutic alliance with European American clinicians, enhances the knowledge of clinical social workers and improve therapeutic outcomes.

This research has also addressed the concerns as to whether the therapeutic alliance is affected by the SBW schema.

Problem Statement

African American women experience decreased rates of retention and increased rates of mental health conditions. Data from the National Survey on Drug Use and Health revealed that 44.7 million adults suffer from mental illnesses (Ahrnsbak et al., 2017). African Americans are 20% more likely to suffer from acute mental disorders compared to European Americans (National Alliance on Mental Health, 2018), and they maintain a disproportionately higher rate of untreated mental health issues (Mays et al., 2017). Mays et al. (2017) further stated that among those who sought mental health treatment, 25% of African Americans, compared to 7% of European Americans, deemed the treatment received "not helpful at all." As a result, African Americans are not as likely as European Americans to obtain mental health treatment despite the importance of therapy (Jones et al., 2018).

Discrimination has been linked to elevated levels of psychological distress, depression, and poor mental health outcomes (Bordol et al., 2020; Sibrava et al., 2019; Vargas, Huey, & Miranda, 2020) and notable differences have been identified amongst racial and ethnic cultures in the prevalence and severity of PTSD based on socioeconomic factors (Sibraya et al., 2019). Juliette et al. (2021) argued that discrimination heightens the severity of post-traumatic stress disorders (PTSD) and that this significantly impacted African American women more than African American men. Individuals within the African American communities encounter unique obstacles in

their interactions with mental health services that include tones of discrimination (Jones et al., 2018). Roughly, 1 of 4 African American clients (25%) conveyed encounters of discrimination within mental health facilities, whereas the rate of such encounters among European Americans was 1 out of every nine clients, or 12% (Fripp & Carlson, 2017; Mays et al., 2017).

African American women maintain decreased rates of therapeutic retention compared to European Americans who seek treatment (Davis & Ancis, 2012; Davis et al., 2015; Poleshuck et al., 2013; Williams et al., 2014). The endorsement of the SBW schema was proven to be a factor that contributes to the decreased utilization of mental health treatment among African American women (Donavan & West, 2015). The absence of a strong alliance can increase dropout rates and challenges surrounding their mental health (Anderson et al., 2019). Endorsement of the SBW schema is another factor that serves as a barrier to positive mental health treatment outcomes among African American women (Etowa et al., 2017). The SBW schema is represented by African American women who view the ability to withstand hardships on behalf of others as being noteworthy of a survivor (Etowa et al., 2017). These women serve as the glue of the African American family and community (Etowa et al., 2017). As such, many African American women tend to incorporate the strong Black woman's strength as a fundamental characteristic of womanhood, despite the impact that this belief can have on their mental health (Watson & Hunter, 2016). It is also known that African American women develop meaning and pride as SBW. Still, the schema has the potential to hinder their role in help-seeking for psychological and physical health (Nelson et al., 2016). The

hindrance to seeking help may explain may explain the reason African American women are at higher risk for mental health conditions and even lower retention rates. For example, African American women frequently maintain the risk of depression two times higher than men (Holden, Hernandez et al.,2017). Furthermore, African American women have a lower rate of therapeutic retention than the overall population (Davis & Ancis, 2012; Davis et al., 2015; Poleshuck et al., 2013; Williams et al., 2014).

After conducting a thorough search of the literature, a gap was identified as I found very little research related to African American women and the therapeutic alliance with European American clinicians. I was not able to identify any research that related the SBW schema to the therapeutic alliance. Articles that have been identified were completed through quantitative methods (Poleschuck et al., 2014), mixed method (Davis et al., 2015), and literature review (Davis & Ancis, 2012). This gap necessitates the need for further research. This research was required to examine the issue surrounding the therapeutic alliance between African American women and European American clinicians through the lens of the SBW schema. It was imperative to explore how the SBW schema influenced the therapeutic alliance with European American clinicians and can hinder therapeutic outcomes for African women. Through gaining a better understanding of the SBW schema and how it affects the therapeutic alliance, clinicians may be better able to serve this population producing improved therapeutic outcomes and decrease therapeutic dropout among these women.

Purpose

As previously noted, the lack of a strong therapeutic alliance can decrease retention rates, therefore the purpose of this study was to explore the lived experiences of African American women who have received clinical mental health treatment from European American clinicians. This was accomplished through the use of a transcendental phenomenological approach. This exploration served to better understand how the SBW schema's endorsement related to African American women's therapeutic alliance with European American clinicians. To my knowledge this study has not been completed before. This study focused on the lived experiences of African American women who ascribe to the SBW schema and the therapeutic alliance with their European American clinicians.

Research Question

How does the endorsement of the SBW schema affect African American women's experiences of the therapeutic alliance during clinical treatment with European American clinicians?

Conceptual Framework

The SBW ideology was used as a conceptual framework to guide this research. The SBW schema provided the platform for open discussions about how an African American woman's therapeutic alliance, with their European American clinician, may or may not be hindered. The SBW schema holds that there are agreed-upon standards of behavior and beliefs for African American women (Haynes, 2019). Such expectations and standards are identified by the ability to advocate for self, display self-reliance, and

take care of those surrounding them to include within the community. Many African American women envision the SBW construct as a cultural endorsement of pride but do not acknowledge its ability to take a toll on their mental health (Etowa et al., 2017; Nelson et al., 2016). Many African American women often ignore their mental health and project an image of strength regardless of their emotional damage (Etowa et al., 2017; Nelson et al., 2016). Researchers have shown the ability to withstand such hardships is often perceived as noteworthy by African American women as they are willing to do nearly everything, along with serving as the glue within the family, church organizations, and communities (Etowa et al., 2017).

It is important to comprehend how African American women develop meaning in help-seeking behaviors to support psychological wellness (Nelson et al., 2016). The strong black woman concept has been well-documented as an image that many African American women aspire to obtain. At the same time, it is also a limiting affliction amongst the traditions within the African American women's culture in the United States (Etowa et al., 2017). One's perception of the importance ascribed to the African American culture or ethnicity may aid in establishing the meaning that they place on their racial identity (Endale, 2018). In this way, there is significance in the SBW schema, which is passed down from African American mothers to their daughters, as they are seeking to identify strength and independent attributes (SIA) (Oshin & Milan, 2019). The SBW schema will be outlined and explored in the literature review in Chapter 2.

The conceptual framework aligns with this study as the SBW schema appears to be important in the mental health of African American women who perceive themselves

as being strong Black women. The conceptual framework directly relates to the research question as the study aims to understand how the endorsement of SBW schema affects the therapeutic alliance of African American women with European American clinicians.

Nature of the Study

The nature of the study uses a transcendental phenomenological research approach. Transcendental phenomenology emphasizes the completeness of an individual's experience and explores the core meaning of those experiences while identifying those experiences and behaviors as a combined relationship of the subject (Moerer-Urdahl & Creswell, 2004; Moustakas C., 1994). Transcendental phenomenology attempts to, as much as it can, put aside biases and utilizes a systematic process to analyze the research data. Transcendental phenomenology is a method used when seeking to understand the experience of an individual (Sheehan, 2014) and thus aligns with the study's purpose. The core of transcendental phenomenology is the meaning or essence of an experience. Using a transcendental phenomenological method provided a rationale for acquiring and collecting data that provided the essence of how the endorsement of the SBW schema relates to the African American women's clinical experiences with European American therapist can hindered the therapeutic alliance.

I used epoché to describe my own experiences with this phenomenon, also known as bracketing (Beech, 2013). For this paper, the term bracketing will be used. I then completed interviews through the use of a teleconferencing platform such as Zoom. All interviews included the six stages of data analysis, as described by Moustakas (2011). These stages include bracketing, horizontalization, the creation of clustered meanings, the

creation of textural meaning, creation of structural meaning, and the integration of steps four and five into a summary. The themes were then synthesized into descriptions of experience from research participants to provide meaning to participant experiences (Moerer-Urdahl & Creswell, 2004); this is further detailed in Chapter 3. To address rigor, the researcher used an audit trail, member checking, reflexive journaling and triangulation.

Definitions

The definitions of terms used throughout this study are defined here.

African Americans: which are also mentioned as Black Americans, are comprised of Americans with ancestry from black African ethnic groups (Gayathri, Balachandran, & Muraleedharan, 2018).

Cultural mistrust/distrust: Cultural mistrust for this study will be focused on that of African Americans toward European Americans, suggesting that African Americans acquired mistrust of European Americans as a consequence of their historical and current experiences of oppression and discrimination (Terrell & Terrell, 1981; Whaley, 2001).

Clinician: an individual qualified in the proven practice of psychotherapy or medicine being notable in a particular specialization, techniques or theory (Bagic et al., 2018).

Discrimination: Unequal treatment that occurs from treating individuals differently based on age, race, or religion (Mays et al., 2017).

European American: is a term that represents “White” as it refers to the culture of Americans of European descent. This includes Americans from the initial European settlers as well as recent migrators from Europe (McMaster & McCormick, 2018).

Strong Black Woman (SBW) schema: The ideology that African American women have the ability to withstand hardships on behalf of others, such that they serve to hold together the African American family and community (Etowa et al., 2017). As such, the strong black woman’s strength is often viewed by African American women as a fundamental characteristic of womanhood, despite the impact that this belief can have on their mental health (Watson & Hunter, 2016).

Therapy: the management of psychological ailments by a psychological method. Evidence-based methods are used to assist individuals in the development of effective behaviors. An approach commonly used is psychotherapy (Singla et al., 2017).

Therapeutic alliance: Therapeutic alliance (TA) is an expression that refers to the interpersonal interactions that support a working relationship between the therapist/clinician and the client, which takes place in psychotherapy (Green, 2006).

Assumptions

As analytical thinkers, it is essential to maintain the consciousness of assumptions. Assumptions can often be necessary as it is often impossible to fact check information provided by participants (Smith & McGannon, 2018). Several assumptions were noted for this study. First, the willingness of individuals to come forth and participate in this study was assumed. This assumption was necessary as participants were crucial to the completion of the research. A second assumption was that participants

would openly discuss their experiences honestly and without hesitation. Honesty was one of the primary components as it pertained to identifying issues and preserving the quality of the research (Creswell, 2014; Mahmud et al., 2018). Thirdly, it was assumed that participants would have a clear recollection of the therapeutic experience as it was necessary for the collection of data. Lastly, the assumption was that participants would be willing and able to complete video-based interviews without any issues. Many individuals do not maintain access to the internet or electronic devices that will allow them to connect to the interview medium. The lack of ability to connect electronically has increased due to loss of employment surrounding Covid-19.

Scope and Delimitations

The research problem being addressed is based on the increased rates of mental health disparities, increased rates of untreated mental health, and little research investigating the therapeutic alliance amongst African American women, with none referencing the SBW schema. The study boundaries included only participants who self-identify as African American women and who have received therapeutic services from clinicians who identify as European American. Other populations of women were not included as their experiences did not contribute to understanding the therapeutic alliance of African American women with European American clinicians, specific to the potential effect of the SBW schema on the therapeutic alliance. Inclusion was based on purposeful sampling strategies (time, location sampling, and saturation sampling) and snowball sampling. Because of the restricted inclusion criteria, findings from this study may not be transferable to women of other ethnic backgrounds or nationalities. The results also may

not be transferable to African American men or different geographical locations. It does, however, provide transferability in its ability to allow participants to have a voice.

Limitations

All research studies have some limitations (Marshall & Rossman, 2010). Although phenomenological research provides numerous benefits when exploring the experiences of others, there were limitations related to the methodology (Johnson-Hood, 2017). The first limitation involved the use of video conferencing. This method was utilized due to the Covid-19 pandemic. Because many did not have access to an electronic device that allowed video conferencing, there was a decrease in participation. I used the Zoom videoconferencing platform and record the sessions, which allows the researcher to see the participant as if they were in the room. Videotaping enabled the researcher's ability to review the interview multiple times for clarity of the participant's experience. Another limitation of the study includes the ability to obtain participants. I attempted to offset this by offering a $10 Amazon gift card, which was emailed to participants at the end of the study. Lastly, the likelihood of bias was also present in the collection of data and interpretation procedures. One such bias that needed to be addressed as a researcher included my personal healthcare experiences as an African American woman with a European American healthcare professional. A secondary bias was that before this research, I ascribed to the SBW schema. I used bracketing through the research process to manage my biases. Bracketing was accomplished through the use of journaling and is further detailed in Chapter 3.

Significance

African American women tend not to seek mental health treatment as willingly as European Americans, and when they do, they are not as likely to remain in treatment (Davis et al., 2015). Through the exploration of the experiences of African American women, with regard to the therapeutic alliance with European American clinicians, factors that aid and hinder the development of a positive therapeutic relationship have come to light. The particular interest for this study was gaining an understanding of the impact of the SBW schema, which helped to identify potential avenues to support greater cultural competence among clinicians, which in turn may support improved cultural competency, and clinical outcomes for African American women seeking treatment for mental disorders. The ability of European American clinical social workers to practice with a higher level of competence and an understanding of how the SBW schema impacts the therapeutic alliance, as it pertains to African American women, enhances the likelihood of positive therapeutic outcomes.

The study informs the field of social work through addressing the gap in literature pertaining to the potential impact of the SBW schema on the experiences of African American women within the therapeutic alliance with European American clinicians. Positive social change was supported through an indirect ability to better understand the phenomenon, and the promotion of alternative training that can lead to potential improvement in the treatment retention of African American women, who maintain a disproportionately higher rate of untreated mental health issues. Social change was also promoted through the ability of participants to feel empowered by sharing their truth. The

findings of this research may provide enhanced awareness and comprehension surrounding the perceptions of African American women in terms of their lived experiences in cross-cultural dyads and the potential impact of the SBW schema within the therapeutic relationship.

Summary

Chapter 1 offered an overview of the phenomenon surrounding African American women engaged in the therapeutic alliance and the potential impact of the SBW ideology. Improved understanding of the experiences of participants who ascribe to the SBW schema may inform mental health practice, which could support changes that promote more positive outcomes related to the therapeutic alliance among African American women and European American clinicians. Information was also provided on the background, problem statement, purpose, and research questions, a synopsis of the conceptual framework, nature of the study, definitions, and assumptions. Lastly, information was offered on the scope, delimitations, limitations, significance of this study, and social change.

Chapter 2 provides a review of the literature that is relevant to the background and purpose of this phenomenological analysis on the experiences of African American women in therapeutic alliance with European American clinicians. Chapter 2 includes the introduction to the chapter, literature search strategy, an explanation of the conceptual frameworks used in the study, and summary.

Chapter 2: Literature Review

The problem addressed is that African American women experience decreased rates of retention and increased rates of mental health conditions. The purpose of this study was to explore the experiences of African American women who have received clinical mental health treatment from European American clinicians, to understand better how the SBW schema may affect the therapeutic alliance. Such a study is necessary as African Americans experience a 20% increased likelihood of suffering from acute mental disorders over that of European Americans (National Alliance on Mental Health, 2018). Individuals within African American communities encounter unique obstacles and factors that hinder their mental health-seeking behaviors (Jones et al., 2018). As a result, African Americans maintain a disproportionately higher rate of untreated mental health issues (Mays et al., 2017). According to Mays et al. (2017), roughly 1 in 4 African American mental health clients (25%) conveyed encounters of discrimination within mental health facilities, whereas those rates were 1 in 9 (12%) for European Americans. Mays et al. (2017) further stated that 25% of African Americans deemed the treatment received as "not helpful at all," as opposed to 7% of European Americans. Thus, despite the importance of mental health, African Americans are not as likely as European Americans to obtain or remain in mental health treatment (Jones et al., 2018).

More specifically, African American women, who are already at an increased risk for mental health conditions, also hold a considerably lower rate of therapeutic retention than the overall population (Davis & Ancis, 2012; Davis et al., 2015; Poleshuck et al., 2014; Williams et al., 2014). Thus, the purpose of this study is to examine how the

endorsement of the SBW schema affected African American women's experiences and perceptions of the therapeutic alliance with European American clinicians. Through a deeper understanding of the experiences of African American women in a therapeutic alliance with a European American clinician, factors may be revealed that can be used to support strategies for improved clinical outcomes. Such strategies may include clinician education in cultural competence within cross-cultural dyads and supporting positive social change.

This chapter reviews the literature search strategy and the conceptual framework on which the study is grounded. Concepts that are significant to the study will be examined in this section and include a focus on the African American woman's experiences with trauma and discrimination, barriers and lack of retention, and the therapeutic alliance and the need for cultural competence.

Literature Search Strategy

Several scholastic databases were used to search for the relevant peer-reviewed article. Such databases included Google Scholar, Academic Search Complete, SAGE Journals, SocINDEX, and PsycINFO. Between November 2018 and May 2019, the researcher conducted an exhaustive search for related peer-reviewed literature published within the last five years, which included culturally relevant clinical treatment dyads, the therapeutic alliance, and the strong black woman schema. This review also provides information on seminal research related to the conceptual framework. Completed dissertations located in the Walden University Library were also utilized. Research articles were found through the use of keywords such as cultural competence, social

work, therapy, African American, women, multicultural, counseling, medical mistrust, patient-provider relationship, perceived discrimination, African-centered psychology, African studies, depression, racial discrimination, socioeconomic status, trauma exposure, substance abuse, European American clinicians, critical race theory, black identity, and therapist. Various combinations of these key terms were used in searching the databases for relevant literature to include in this review.

Conceptual Framework

Strong Black woman schema (SBW) was used as the conceptual framework for this study. SBW schema provides a context to the lived experiences of African American women through an understanding of the impact of SBW identity in these women's lives. As such, the SBW schema will help in understanding the experiences described by the African American women who participate in this study concerning the therapeutic alliance by supporting the contextual understanding of experiences. SBW schema was described in this section to provide background information and enhanced understanding.

Strong Black Woman's Syndrome

Nelson et al. (2016) denoted the importance of comprehending how African American women develop meaning in help-seeking behaviors to support psychological and physical health. The construct of the strong black woman (SBW) is well-documented as an aspiring image and a restricting or limiting affliction among African American women's traditions within the United States (Etowa et al., 2017). Wood-Giscombe (2010) speak to the notion that African American women adopted the superwoman schema as way of combatting negative views and stereotypical images of African American women.

Watson and Hunter (2016) found that although strength is frequently incorporated as a fundamental characteristic of African American womanhood, it is rapidly impeding their mental health. The researchers further stated that the validation of the SWB schema among African American women had gained attention among researchers due to its association with detrimental concerns for mental health. Nelson et al., (2016) stated that the SBW construct is a means by which African American women find meaning in their roles within their race.

Researchers have revealed that many African Americans view the SWB construct as being sanctioned as a cultural form of pride, but also recognize the SWB construct as taking a toll on the emotional well-being of African American women (Etowa et al., 2017; Nelson et al., 2016). Both Etowa et al. (2017) and Nelson et al. (2016) noted that African American women perceive a SBW as being attentive to their families, communities, colleagues, and often their entire race despite the negative impact of such a concept on their well-being. African American women view the ability to withstand such hardships on behalf of everyone around them as being noteworthy of a survivor, one who is willing to do virtually everything, and serving as the glue of the African American family, church organizations, and communities (Etowa et al., 2017). Both Etowa et al. (2017) and Nelson et al. (2016) expressed that the expectancy and epitome of a SBW is to undergo and tolerate everything; that is, they are autonomous and invulnerable, willing to carry immeasurable burdens, and inclined to sacrifice everything at the cost of their health. The authors further agreed that African American women possess an engulfing

load of duties that they are accountable for, with little to no alternatives (Etowa et al., 2017; Nelson et al., 2016).

It is argued that a common survival strategy for African American women is to ignore their emotional state of mind and project an image of strength despite their emotional needs (Etowa et al., 2017; Nelson et al., 2016). Watson and Hunter (2016) suggested that while African American women maintain self-efficiency, they have unhealthy insinuations for self-care. Further, Watson and Hunter stated that the SBW schema creates adaptive reactions to ecological stressors while creating burdens that many African American women are forced to endure.

As a cultural norm, SBW are known to display exceptional and phenomenal fortitude that is often identified as superhuman strength (Watson & Hunter, 2016). Nelson et al. (2016) referred to this strength as being that of a *superwoman*. Watson and Hunter (2016) found as it pertains to the SBW schema, African American women communicate three different messages, which include:

1. the importance of being psychologically resilient while not engaging in behaviors that maintain or uphold mental and emotional durability.
2. that African American women are equivalent to others while allowing themselves to be oppressed; and
3. that African American women are feminine but discard the customary norms of femininity.

Nelson et al. (2016) identified the SBW conceptualization as an independent Black woman caring for family and friends, one who is hardworking and known to be a

high achiever and overcomes hardship. Etowa et al. (2017) added that African American women take pleasure in their survival as being hard workers while enduring racism and bias, taking concern for all of those surrounding them, providing for themselves, along with upholding cultural customs.

As per Etowa et al. (2017), a sense of pride in the SBW schema is noted to be an endorser of racism, which produces tension. Further, Etowa et al. explained that African American women maintain remarkable arrogance in that their descendants survived bondage and captivity, displacement, marginalization, poverty, and cruelty. Nelson et al. (2016) argued that the high achieving, emotionally contained SBW schema emphasized the significance of increasing consciousness of limiting gender-driven and racialized expectancies along with the yearning to maintain associations with the cultural heritage of African American women. Thus, as argued by Etowa et al. (2017), the African American family unit and religious organizations have an infinite source of workers in African American women. Social conditions have no reason to change when African American women continue to endure, absorb, and flourish on discrimination, deficiency, and sexism (Etowa et al., 2017). The perception of strength denotes that opinions, phobias, and concerns of African American women need not be accounted for (Etowa et al., 2017).

As previously stated, the SBW schema has been noted to amplify threats of depression in African American women thereby, increasing the risk of mental health disparities among African American women, as they find it difficult to seek assistance and would prefer to struggle in silence (Donavan & West, 2015). Despite the

acknowledgment of the SWB schema producing a barrier to the receipt of health services, and in particular mental health service, a gap is noted in the literature about the potential impact of the SBW schema on the experiences of African American women within the therapeutic alliance.

The conceptual framework aligns with this study as the SBW schema appears to be important in the mental health of African American women who perceive themselves as being strong Black women. The conceptual framework directly relates to the research question as the study aims to understand how the endorsement of SBW schema affects the therapeutic alliance of African American women with European American clinicians.

African American Women's Experiences with Trauma and Discrimination

Researchers have identified the need to examine and understand the complexity of ethnicity and race in the United States, particularly concerning the relevance and impact of historical discrimination on health-seeking behaviors and overall health outcomes (Belgrave & Abrams, 2016; Howard & Navarro, 2016). Discrimination has been linked to elevated levels of psychological distress, depression, and poor mental health outcomes. (Bordol et al., 2020; Sibrava et al., 2019; Vargas et al., 2020) and notable differences have been identified amongst racial and ethnic cultures in the prevalence and severity of PTSD based on socioeconomic factors (Sibraya et al., 2019).

Research shows that discrimination in the healthcare setting could contribute to inequalities in the health outcomes for African Americans (Mayus et al., 2017). Cuevas et al. (2016) indicated that African American women would perceive discrimination quicker than European American women. African American women will often note

discrimination not only from their clinicians but also from the office staff upon entering the facility (Cuevas et al., 2016). Cuevas et al. also contended that when one perceives feelings of discrimination, outcomes can lead to anguish, fury, and perceptions of unresolved issues, all of which affect behaviors.

Discrimination has been correlated with depression and poorer outcomes among African Americans to include that of the therapeutic alliance (Cuevas et al., 2016; Hudson et al., 2016; Mayus et al., 2017), particularly as it relates to the accessibility of services (Kugelmass, 2016). Special conditions by which therapists conclude who should obtain access to services may be encouraging the development of unconscious prejudices that foster biased options surrounding accessibility to care (Kugelmass, 2016). Kugelmass (2016) also noted that stereotypes related to the working class might bring about undesirable reactions to requests for treatment. African Americans are also less likely than European Americans to be offered appointments (Kugelmass, 2016).

Dixon and Tellers (2017) and Landor and Barr (2018) identify a form of discrimination not often mentioned, which is that of colorism. Dixon and Tellers defined colorism as a prejudice against those with darker skin complexions. They argue that it may lead to direct or indirect, trauma reactions, that produce undesired outcomes on health and interpersonal relationships of African Americans. Landor and McNeil Smit (2019) note that colorism can produce emotional trauma due to guilt and shame of the use of skin tone as influence or power. They also mention colorism’s ability to produce physical trauma that manifests in such conditions as high blood pressure. African American women report both a higher frequency of discrimination and a greater extent of

discrimination, as well as inferior societal and psychological well-being, compared to European American women (Calabrese et al., 2015). African American women experience a greater extent of symptoms related to depression and decreased societal well-being than even that of African American men (Calabrese et al., 2015). Further, the frequency of discrimination and the extent of that discrimination could facilitate the relationship between ethnicity and mental health, with a more substantial effect through increased occurrences among African American women (Calabrese et al., 2015).

However, several limitations were noted in the study completed by Calabrese et al. (2015). Participants will be recruited through targeted approaches that may not represent of a larger population of sexual minority groups. Self-selection bias also may have manipulated the generalizability of conclusions, particularly with participants who did not maintain the concentration and mobility required to engage in lengthy interviews. Lastly, the analysis did not encompass an African American female heterosexual contrast. Thus, variances based on sexual orientation among African American women were unable to be assessed.

Mistrust of healthcare clinicians is associated with an impediment in the use of healthcare systems and undesirable experiences (Cuevas et al., 2016). Hauff et al. (2017) identified the most reported unique experience of trauma through a statement offered by an African American female participant, who stated, “My race has a history of being oppressed, discriminated against or threatened by genocide” (p. 2377). Mays et al. (2017) found that discrimination within healthcare was identified by 52% of African Americans interviewed who cited race and ethnicity as the most common reason for healthcare

discrimination. It was further expressed that African Americans are more likely than European Americans to receive an unsuitable healthcare diagnosis and substandard care.

For the most part, incidents of discrimination within mental health and substance abuse facilities appear to be low; however, occurrences are two to three times more common among African Americans (Mays et al., 2017). Prather et al. (2016) categorized social determining factors of discrimination, which include employability, poverty or destitution, and inadequate education, as contributing factors to disparities in health that are emphasized by racism. Further, Prather et al. (2016) contended that African American women cannot evade racism, which represents a significant psycho-social stress factor for African American women (Bacon et al., 2017).

Lack of Retention

African Americans and Hispanic-Americans have been known to discontinue mental health services at an increased rate compared to other ethnicities (Taha et al., 2015). One reason for discontinuing mental health services among African American women is the desire to deal with the issues on their own (Taha et al., 2015). Other reasons for discontinuation of mental health services given by African American women, as reported by Taha et al. (2015), included not requiring assistance any longer or improved conditions. According to Davis et al. (2015), African American women report lower levels of retention in substance abuse facilities. A common reason for the lack of retention among African American women receiving treatment from European American clinicians is the reported adverse perceptions of the clinician toward the client (Davis et al., 2015; Poleschuck et al., 2014). African American women report perceptions that

European American clinicians are not trustworthy and lack pertinent skills of cultural awareness (Davis et al., 2015). African American women also report feeling that European American clinicians are reluctant and incapable of connecting with African American women, which hinders retention (Davis et al., 2015).

Factors related to the delivery of treatment, such as issues of interactions with the clinician, serve as barriers to the retention of African American women in mental health treatment (Williams et al., 2014). African American women held feelings of distrust toward European American clinicians due to past discrimination experiences that existed before or during the distressing event (Williams et al., 2014). Poleschuck et al. (2014) noted that African Americans reported perceptions that European American clinicians are often controlling and dismissive of their preferences and recommended activities or therapies that were not satisfactory. Additional reasons offered for poor retention among African Americans included low motivation, anxiety in utilizing public transportation, doubt that therapy would work, and anxiety surrounding stigma, susceptibility, weakness, and exposure (Cheng & Lo, 2015; Poleschuck et al., 2014; Watson-Singleton et al., 2017).

In contrast, these retention barriers are less noticeable among European American women in need of mental health services, as positive social perceptions of help-seeking in mental health have gained momentum (Cheng & Lo, 2015). Anyikwa (2015) noted that although barriers created due to the use of alcohol are not as likely within the African American community as it is among European Americans, other significant barriers to African American women seeking mental health services include the lack of access to

coverage through insurance plans (uninsured, underinsured, Medicaid insured), lack of support from family and friends, anxieties surrounding the risk of losing custody of their children or rights as a parent, and demands within the family dynamics that hinder therapeutic progress (Anyikwa, 2015; Cheng & Lo, 2015)

Therapeutic Alliance and the Need for Cultural Competence

In this day and age, there is a need for enhanced efforts for treating racial minorities within the therapeutic settings (Taha et al., 2015). The effectiveness of clinicians varies, as some are more effective while working with European Americans, while others are better working with African Americans (Davis et al., 2015; Hayes et al., 2015). Sue (2015) contended that differences in opinions among European Americans and African Americans are due to controversial perspectives of worldviews.

Mental health clinicians must begin to acknowledge that diverse ethnic communities frequently have unique healthcare experiences (Taha et al., 2015). These experiences are often comprised of a reluctance to converse about health concerns outside of immediate family members, mistrust of healthcare systems to include both medical and psychological services, and an increased probability of using informal religious sources of support to treat mental health conditions (Taha et al., 2015; Williams et al., 2014). Williams et al. (2014) further stated that clinical treatment could be hindered if clinicians fail to adopt new approaches that encompass racial-related trauma and cultural differences. Williams et al. (2014) noted that despite the need for adaptations in treatment among African Americans, limited examinations had been completed to measure the efficacy of such adaptations, consequently restraining the clinical applicability.

Clinical counseling encourages the bonding of clinician and patient and identifies this bond as being essential to obtaining a quality, person-centered treatment of clients (Percival, Donovan et al., 2017). Two key attributes of clinicians were noted: clinician's attitude and clinician's enabling character. Patients admire clinicians that take into consideration their distinct mannerisms, share pertinent private information, provide acceptance, display interest, provide clear interaction and listening skills, collaborate on convenient goals, and authorize more patient self-care and empathy (Percival et al., 2017; Hauff et al., 2017).

Investigations on the psychological treatment of minorities have produced insufficient and serious lack of access and effectiveness among different client cultures (Curtis-Boles, 2017; Lenz et al., 2018). Historically, African American clients were not provided adequate mental health services by psychological treatment facilities, with research supporting concerns of insufficient diverse cultural knowledge, inconsiderateness, bias, and inadequate care (Curtis-Boles, 2017; Lenz et al., 2018). Best practices developed from previous research include acknowledging racial variances in context (instead of using a standard approach) to permit a patient's narrative and collective experiences of life to regulate the timing and method in which subject matter is raised (Curtis-Boles, 2017). Accordingly, clinicians should not assume clients will address concerns in the therapeutic relationships associated with race and must take the initiative in addressing the possibilities of such concerns throughout treatment (Curtis-Boles, 2017). They are increasing one's knowledge surrounding diversity within the

African American culture and methods in which such variants may influence worldviews, clinical exhibitions, and proposed treatment (Curtis-Boles, 2017).

Diversity is comprised of unique cultural characteristics, assimilation, socioeconomic status, and religiosity (Curtis-Boles, 2017; Ebede-Ndi, 2016). Thus, clinicians should be prudent when making postulations, but rather, they should cultivate and elucidate the lens through which they perceive the client based on his/her story. Clinicians should develop and relate talents outside of customary therapy approaches to respond proficiently and efficiently to clients needs they arise (Curtis-Boles, 2017; Sue, 2015). Such abilities include case management, advocacy for clients, and intervention during periods of crisis. Also, clinicians should deliberately become involved in activities intended to empower clients. The difference in power between client and clinician may be bridged with thoughtful use of self-disclosure, viewing problem solving and treatment goals in the cultural framework, and maintaining the ability to relate to clients personalities on a personal and professional level (Curtis-Boles, 2017). Finally, it is key for clinicians to create continuous practices of serious self-examination. Comprehending one's individual biases and stereotypes can aid in the production of precise and impartial interpretations of ethnic dynamics related to treatment and minimization of possibly damaging cultural countertransference responses (Curtis-Boles, 2017).

Summary and Conclusion

As it currently stands, research has never addressed the issue of the therapeutic alliance from the lense of the SBW schema, so there is no literature to compare. Research that was identified in the connection the the therapeutic alliance was insufficient to

compare as 90% of its participants were European American, therefore the information obtained was squed as it relates to African Americans. A great deal of research surrounds the importance of establishing the therapeutic alliance as it relates to a more positive clinical outcome (Johnson-Hood, 2017).

Understanding the SBW schema may be a significant concept in the development of enhanced therapeutic alliance. SWB schema has been known to be endorsed by the African American community as a positive attribute, despite its ability to diminish the mental health seeking behaviors of African American women (Watson & Hunter, 2016). Clinicians must begin to comprehend how African American women make sense of their role and their ability to seek mental health services (Nelson et al., 2016). Particularly in terms of maintaining mental and emotional strength without the assistance of others (Watson & Hunter, 2016).

Occurrences of discrimination in the healthcare setting could contribute to inequalities in psychological health of African Americans in terms of access and care (Mays et al., 2016). Trust in the medical community is limited among African Americans due to historic discrimination and destructive treatment in the African American community (Ceballo et al., 2015; Hauff et al., 2017), as well as increased rates of misdiagnosis and substandard care among African Americans, over that of European Americans (Mays et al., 2017). Also, mental health dropout rates are highest among Hispanic-Americans and African Americans, compared to other races. Reasons for the discontinuance of clinical services include unpleasant perceptions that European American clinicians are not to be trusted and lacked cultural awareness (Davis et al.,

2015). Barriers to retention among African American women particularly have resulted from interactive issues during the delivery of treatment (Poleschuck et al., 2014; Williams et al., 2014), poor motivation and anxiety (Poleschuck et al., 2014), religious and social stigma (Wharton et al., 2018), and lack of access to services through insurance coverage (Anyikwa, 2015).

The literature lacks research on the experiences of African American women within a therapeutic alliance with a European American clinician and the role and perceived impact of the SBW schema on the client-clinician relationship especially since most clinicians are European American (Lin, Stamm, & Christidis, 2018). It is noted that in 2015, 86% of psychologists actively working in United states were European American, 5% were Asian, 5% were Hispanic, 4% were African American and another 1% were from remaining ethnic groups (Lin, Stamm, & Christidis, 2018). Literature also has yet to identify aspects related to successful formation of therapeutic collaborations between African American women clients and European American clinicians. This study explored the lived experiences of African American women who sought mental health treatment from European American clinician. Moreover, through this exploration of the experiences of African American women, this study sought to understand how the SBW schema may affect the therapeutic relationship, helping to inform strategies to improve outcomes toward positive social change. This study increases the knowledge in clinical social work as it pertains to the need for further education on cultural competency relating to cross-cultural dyads in therapeutic settings with African American women.

While there has been a correlation between disparities and barriers faced by African American women to the therapeutic alliance, I found very little research related to African American women and the therapeutic alliance with European American clinicians. I was not able to identify any research that related the SBW schema to the therapeutic alliance. Articles that have been identified surrounding the general need for a strong alliance, were completed through quantitative methods (Poleschuck et al., 2014), mixed method (Davis et al., 2015), and literature review (Davis & Ancis, 2012). This gap necessitates the need for further research

This chapter has provided an overview and discussion of the related literature and theoretical basis for the study. Chapter three includes an introduction, the researcher's role, and the methodology chosen for the study. Included in the next chapter will be an explanation of the participant selection logic, the instrumentation, the procedures for recruitment, participation and data collection, the data analysis plan, and a summary.

Chapter 3: Research Methods

Introduction

Chapter 3 includes the procedures and methods of this study. The subject matter is comprised of an overview of the purpose of the study, the research design, and the logic explaining the reason for the use of the chosen design. Chapter 3 presents the researcher's role, the methodology by which the study will be conducted, and the instrument that will be used to collect data. Other topics discussed in this chapter include the research question and the related interview protocol. Lastly, Chapter 3 stipulates the plan by which data will be analyzed, clarity on how trustworthiness will be established, and how the research will ensure the highest ethical standards.

The purpose of this study was to examine how the endorsement of the SBW schema affects African American women's experiences of the therapeutic alliance with European American clinicians. This qualitative, phenomenological study of the experiences of these women supports a better understanding of how the SBW schema may serve to aid or hinder the therapeutic alliance or the African American woman's ability to accept services from a clinician that does not represent her nationality.

Research Design and Rationale

This study focuses on the lived experiences of African American female clients and the therapeutic alliance with their European American clinicians. This study used the following research question: How does endorsement of the SBW schema affect African American women's experiences and perceptions of the therapeutic alliance with European American clinicians?

A qualitative transcendental phenomenological research design was the best choice for examining how the endorsement of the SBW schema affected African American women's experiences and perceptions of the therapeutic alliance with European American clinicians. Qualitative research is used to gain an in-depth understanding of a phenomenon or event (Bengtsson, 2016). Rather than seeking answers to a phenomenon, transcendental phenomenology derives meaning from the participants' environment and experiences, and how these experiences and meaning influence behavior (Moerer-Urdahl & Creswell, 2004; Moustakas, 1994). Qualitative research aims to get a better understanding of the first-hand experience through observation and interviews in a natural setting (Bengtsson, 2016). Because this study was focused on the experiences of African American women in a therapeutic alliance and their perceptions of the SBW schema and how these perceptions and experiences may affect the therapeutic alliance, a qualitative method was deemed appropriate.

Phenomenology is a research design used to explore participants' perceptions, opinions, and feelings based on their lived experiences with a particular phenomenon. The phenomenological design involves investigating the experiences of individuals to obtain "comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essence of the experience" (Moustakas, 1994, p. 13). Thus, researchers use a phenomenological design to garner the essential meaning of lived experience as it pertains to the research focus. Moustakas (1994) argued that the phenomenological researcher is concerned with understanding the phenomenon from the participant perspective, and therefore, the lived experiences of those involved.

According to Moustakas (1994), phenomenology offers a scientific approach to examining the lived experiences of a phenomenon or event. Transcendental phenomenology was selected as a suitable method for this study because this research searches for the meaning of experiences of African American female participants related to the therapeutic alliance with European American clinicians. Moustakas (1994) noted the importance of qualitative inquiry, emphasizing the totality of the experience and a search for the heart of those experiences (meaning) while recognizing the multiplicity of factors involved. The emphasis of phenomenology includes a systematic investigation with the scientist putting aside biases and utilizing systematic processes for analyzing information (Moustakas, 1994).

Traditions of Research: Qualitative and Quantitative Studies

There are several approaches used to complete in-depth research studies in the field of social work. Despite the method chosen, all of them have components that include standard processes such as the collection of data, the analysis of the data, and the continued discussions surrounding the research (Johnson-Hood, 2017). Approaches to research may include mixed-methods, quantitative, or qualitative methods (Dörnyei, 2007).

Qualitative and quantitative inquiries are the leading models in research used in personal and social disciplines (Rahman, 2017). Qualitative research attempts to explain an individual participants' worldview 'from the inside out' (Flick et al., 2004). Qualitative research strives to promote better compassion for social experiences and concentrates on the processes, patterns of meaning, and operational features. According

to positivists philosophy, quantitative research is pure in nature and objective, if parts of the investigation maintain a subjective component, then the analysis of the data is also personal (Onwuegbuzie & Leech, 2005).

Qualitative studies are founded on a constructivist or naturalist method and began in opposition to the positivist model (Moustakas, 2011). Qualitative research maintains that reality is seen through the viewpoint of participants in the study. The investigator interacts with research participants throughout the research project. Qualitative research is about inspecting, understanding, and engaging with individuals as having expertise explicitly related to their personal experiences (Lincoln & Guba, 2004). The progression is inductive with patterns or philosophies developing during the research process (Lincoln & Guba, 2004).

Gall et al. (1996) explained the difference between qualitative and quantitative research in layman's terms through their contrast of the two studies. Quantitative investigators assess casual associations amongst social or human phenomena from a mechanical viewpoint, whereas qualitative scholars view human intents as significant roles in clarifying causal associations amongst social aspects (Gall et al., 1996). Qualitative investigators postulate an impartial social reality. However, qualitative investigators accept that social reality is erected by those participating. Quantitative investigators hypothesize that social reality is constant, whereas qualitative investigators agree that social reality is always established in social settings. Quantitative investigators take an unbiased, detached attitude concerning the participants in research and their environment, while qualitative investigators become directly involved with the study

(Gall et al., 1996). Qualitative investigations are useful when examining a larger body of participants with the intent to extend the findings to the general population.

Role of the Researcher

The researcher's role includes the identification and selection of all participants and the collection of data utilizing digital interviews, through the use of teleconferencing technology such as Zoom. The researcher will serve as an observer. As the researcher, I will also be responsible for the transcription of data, data coding, and identifying emerging themes. Professional and social-relational associations will be avoided as it pertains to research participants to aid in the production of rigor and eliminate any conflicts of interest (Temple et al., 2017). I will attempt to create a comfortable atmosphere in which participants will feel free to share personal details of their experiences by ensuring confidentiality and privacy and by allowing participants to stop the interview and participation in the study at any time.

As the researcher, acting as observer-participant, I was the primary data collection instrument used in this qualitative study (Clark & Vealè, 2018; Chang et al., 2016). Biases were put aside, as much as possible, regarding the outcome of the study through bracketing and reflexivity (Beech, 2013; Janak, 2018). Beech (2013) argued that it is important that the researcher identify their values and personal background to decrease potential bias in research. The personal biases that were put aside included the fact that I share the same ethnicity as participants in the research and the need to maintain an awareness of assumptions as to the experiences of participants during their therapeutic alliance was required. Researcher bias also stemmed from my personal experiences while

seeking services from healthcare professionals as there were some similar experiences. For example, on one occasion, while receiving healthcare services from a European American physician, my clinician utilized hurtful statements that left me confused and unwilling to continue services with that clinician. Also, researcher bias was filtered out surrounding the feeling of being left to handle my issues on my own.

I used bracketing as one of my tools to aid in the control of biased views (Molly, 2019). Bracketing has been used in phenomenological studies to increase consciousness of the researcher's ethics, viewpoints, or feelings, to methodically set aside their assumptions and prior knowledge about the phenomenon being investigated, for an objective inquiry (McNarry et al., 2019; Sorsa et al., 2015). Bracketing is a process by which the researcher decides to hold all biases and previous knowledge to understand the experience as it is (Beech, 2013). Bracketing was accomplished through reflective journaling. A reflective journal is an individual written document that is created to aid in thinking about numerous ideas or events over time to understand one's self-awareness and expand their learning (Woronchak & Comeau, 2016).

Methodology

Participant Selection

To meet the criteria of selection for this study purposeful sampling strategies were used to include time location sampling and saturation sampling. Purposeful sampling involved intentionally recruiting participants for the study based on criterion (Luciani, Campbell, Tschirhart et al., 2019). Such reasons included having had a specific experience or awareness of a certain phenomenon (Maxwell, 2013). Purposeful sampling

involved the decision to sample participants from a specific setting based on preliminary methodological dimensions (or delimitations) to meet the study's needs, which may include limitations of space, time, power, or identity. In order to meet criterion selection for this study, the study population included individuals who (a) self-identifed as African American women, (b) are between 21-65 years of age, (c) have received therapeutic counseling services from a European American clinician, (d) reside in the Atlanta Metro. Due to time constraints and limited resources, the researcher chose to utilize time location sampling which selects participants within a certain area and timeframe (Sommen et al., 2018). This study obtained participants that are in the local area and had received therapy from a European American clinicians. Recruitment flyers and emails (see Appendix A) were sent out to some community organizations such as churches, community centers, and doctor's offices to identifying and recruiting potential participants for the study who meet population inclusion. Permission to post flyers was obtained for the community organizations mentioned (leading church officials, community organization officials, and doctors) through verbal authorization. The researcher documented the organizational leaders providing authorization on a spreadsheet with the date and time authorization was approved. Lastly, social media mediums such as Facebook, Instagram, and Twitter were used to distribute information about the study.

Participants were also recruited through snowball sampling. Snowball sampling was employed to support the ability to obtain an adequate number of participants who met the inclusion criteria. In snowball sampling, participants suggested other individuals they knew by an acquaintance or otherwise as potential participants who meet the study

inclusion criteria, allowing the researcher access to others in the study population of interest (Woodley & Lockard, 2016).

A sufficient sample size, in phenomenological research, was attained as saturation of data was reached (Moser & Korstjens, 2018; Englander, 2012). Saturation sampling was obtained when there was no new information yielded and the study had reached its maximum in information obtainment (Moser & Korstjens, 2018; Kaiser and Marconi, 2017). Moser and Korstiens (2018), argued that 10 or less interviews are required to reach saturation (Moser & Korstjens, 2018).

Instrumentation

The data collection instruments used in this study include a demographic checklist (Appendix B) created by the researcher, interview protocol (Appendix C) created by the researcher, Zoom video and audio recordings, and two digital voice recorders. Interview questions were open-ended to allow for the description of the experiences of participants. Moser and Korstjens (2018) and Rubin and Rubin (2012), stated that when conducting a qualitative transcendental phenomenological interview, there should be a relatively small number of questions that are to be open-ended and conducted in a semi-structured format. The interview protocol (Appendix C) was designed to be consistent with the tenants of phenomenological research and to address the research question posed in this study.

There was no use of legal or historical documentation, observation sheets, artifacts, archived data, or other forms of data collection instruments outside of what is listed above. The demographic checklist provides demographic information about the sample without collecting any personally identifiable information. The researcher created

the interview questions that were used for this research study. The interview questions were created to answer the research question and to align with phenomenological methodology. The researcher submitted all interview questions to the committee members for evaluation of clarity and validity.

Procedures for Recruitment, Participation, and Data Collection

The most commonly used collection methods for obtaining data include interviews, observations, and focus group discussions (Moser & Korsjens, 2018). Data collection includes established activities that aid in gathering information that produces hypotheses or conclusions about the question posed (Moser & Kerstiens, 2018; Creswell & Poth, 2017). For this research, data collection through the means of electronic real-time interviews with the use of the teleconferencing platform Zoom as the medium, were completed. The data collection addressed the research question of how the endorsement of the SBW schema affects African American women's experiences and perceptions of the therapeutic alliance with European American clinicians.

This researcher submitted the study to the Walden University IRB to gain the approval of the study protocol and instruments before recruiting participants and was approved by IRB on 8/18/2020. Purposeful and snowball sampling were used to recruit participants within the research criterion. I sought to distribute flyers to church leaders, community center directors, and management staff within doctors offices and other small businesses within the Atlanta Georgia metro area. Flyers (Appendix A) possessed the appropriate contact information of the researcher for those with interest in participation to include a telephone number and e-mail address. Interested participants that contacted the

researcher were also asked to pass the flyer to friends and family members that may desire to participate. By taking these actions both purposful and snowball sampling were achieved. Social media Facebook groups that maintained a population of African American women who live within the Atlanta metro area were also used to disseminate the recruitment materials.

A pre-interview was conducted through telephone conversation, to complete the demographic checklist (Appendix B) and identify eligibility. At this point information will be provided to interested parties surrounding the studies process and purpose, and to review the consent form (Appendix D) with potential participants to answer any questions. During the pre-interview conversation, it was explained to the potential participant that their participation will be voluntary and that participants maintain the ability to opt-out at any time. Lastly, participant availability was obtained, the interview was scheduled, and the medium by which the interview took place was provided to interested parties.

Before to the collection of data, email addresses for participants were collected during the pre-interview and placed on the demographic checklist (Appendix B). Consent forms were emailed to all willing participants during the pre-interview for their initial review. Consent was attained by having participants review the informed consent document and replying to an email with a statement of understanding and consent. Data was collected through semi structured interviews by the researcher and carried out through interviews conducted on Zoom. At the onset of the interview, I identified if participants were in a safe and confidential setting through participant self-reporting and

clarifying if the participant was comfortable with completing the interview at that time. All interviews were recorded on Zoom and two digital recording devices and then transcribed by the researcher. Participants reviewed individual transcribed documents for accuracy. The researcher continued conducting interviews until saturation was reached, a point where no new themes were evident in the data collected.

Phenomenological qualitative interviews permit participants to direct or lead the conversation in ways that disclose their experiences (Walker & Shepard, 2011). Therefore, a limited number of questions were presented. Additional follow-up, probing questions were asked to entice conversation as topics of discussion were brought to the forefront (Englander, 2012). Each participant was interviewed twice. The first interview was conducted with an estimated 60-minute time frame. A second interview was conducted, if it was necessary, lasting no more than 30 minutes. The second interview was completed over the phone after participants were provided five days to review their transcripts. The review of the transcripts and conclusions for accuracy and description is commonly referred to as member checking. The researcher gave a $10 Amazon gift card to participants who completed the interview and both the initial and follow up emails to provide incentives for participation.

Participants maintained the ability to discontinue the interview at any point. At any time throughout the interview process, participants maintain the right to withdraw their participation in whole or in part. All participants were informed of their right to withdraw. Participants were debriefed at the close of the interview. During the debriefing, an explanation was provided to participants about possible uses of the study, such as to

enhance clinical outcomes in the field of clinical social work, and the phone number to the Georgia crisis and access line as a resource, should participants require additional assistance. Participants were also required to respond to follow-up emails to answer any other questions that may have arisen or to provide clarity.

Data-Analysis Plan

Moustakas used six stages in his data analysis method (Temple et al., 2017). The first is that of bracketing, which includes my ability to write about, through reflective journaling, I set aside my biases in order to focus on the research with minimal consideration of my personal experiences (Temple et al., 2017). I constantly add to this documentation of biases throughout the interviews and the process of analyzing data. Step two, horizontalization, included the highlighting of significant statements in the transcription of individual interviews (Temple et al., 2017). Each statement was treated equally in the analysis process. Third, the creation of clustered meaning included the organization of significant statements in themes. In the fourth stage, I created a textural meaning; this included a summary of what every African American woman experienced with the phenomenon (Temple et al., 2017). The fifth stage was to create a structural description, an account as to how the phenomenon occurred. In this stage, I interpreted the experiences of all participants. In the last stage, I wrote the essence and integrate the structural and textural descriptions from steps four and five. This summary represented the overall experience for all participants (Temple et al., 2017).

This process for the analysis of interview data within a phenomenological study was appropriate because it used clearly defined steps that allow the researcher to extract

the essences of the lived experiences of the participants from the data collected. Hyper Research, a qualitative software program, was purchased and provided an organized workspace used for the storage of data, the coding process, the retrieval of relevant dat0a, and then the comparing and contrasting of the data and themes developed.

Issues of Trustworthiness

Trustworthiness refers to the degree to which the outcome of a study authentically reflects individual or lived incidents of a phenomenon being studied (Curtin & Fossey, 2007). The essential elements supporting the studies trustworthiness include credibility, transferability, dependability, and confirmability (Symon et al., 2018).

Credibility

Credibility refers to the authenticity of the research findings (Liao & Hitchcock, 2018). I ensured credibility was supported through bracketing, transparency, and member checking (Moustakas, 1994; Temple et al., 2017; Whittemore et al., 2001). The tenant of authenticity was supported by assuring that I minimized my own biases. Throughout the bracketing process, I explored and clarified my own biases before, during, and after the study. This process aided in the increased awareness of my biases and assisted me in setting aside assumptions to look at the true meaning of the phenomenon experienced by the participants (Sorsa et al., 2015). The tenet of transparency of a study allows for other researchers to inspect how the data was collected and analyzed. In this study, I included a clear description of the sampling technique and the presentation of the research process (Liao & Hitchcock, 2018; Whittemore et al., 2001). I also explained the criteria for participation, recruitment strategy, the size of the required, and procedures (Liao &

Hitchcock, 2018). Lastly, credibility was established by the participants as they evaluate the transcript and confirm the accuracy of what was discussed, a process known as member checking (Moustakas, 1994). Participants completed this review after the transcription had been completed and emailed to them. If participants or the investigator possessed any questions or concerns about the transcript, follow up questions were sent by email, or a second phone interviews were conducted.

Transferability

Transferability denotes the extent to which the outcomes of a study can be transferred to other circumstances, conditions, or settings (Curtin & Fossey, 2007). To aid in transferability, I ensured that a description of participants' experiences would be fully rendered to allow other investigators to create a comparative analysis of other persons and groups. Curtin and Fossey (2007) argued that in striving for trustworthiness or genuineness, the discoveries obtained from qualitative investigation ought to be transferable. The data and findings of the research were presented in a detailed fashion. Those reading qualitative investigative studies ought to be capable of determining whether the results from a study can be useful in other situations, circumstances, or settings (Curtin & Fossey, 2007).

Dependability

The quantitative concept of reliability is translated into qualitative research to dependability (Houghton et al., 2013). Dependability contains the characteristic of consistency (Moser & Korstjens, 2018). An audit trail, member checking, and triangulation were used to support dependability in the study. Dependability is the

consistency of research outcomes over time. The audit trail consists of systematic data archiving (Nakkeeran & Zodpey, 2012); it includes audio recordings, transcriptions, and field notes. As part of member checking, participants were asked to review the transcripts of their interview as well as a summary of the findings to ensure accuracy (Houghton et al., 2013). Triangulation served to enhance the dependability of the results (Kyngäs, Kääriäinen, & Elo 2020). Triangulation consisted of the utilization of multiple sampling strategies as noted by Parás-Bravo et al., (2018) and Benoot et al., (2016). These researchers argue that triangulation in a qualitative study can be achieved through an integration of different forms of purposeful sampling. Such sampling strategies used in this study included time-location sampling, criterion-based case selection, saturation sampling, and snowball sampling.

Confirmability

Confirmability is the ability to check the results of a study based on impartiality (Korstiens & Moser, 2018; Sadeghian et al., 2018). This means the interpretation was not founded on the researcher's preferences and views but, data grounded in the participant's experiences (Moser & Korstiens, 2018). Confirmability was ascertained by keeping a reflexive journal and double-checking the data through member-checks (Moser & Korstiens, 2018; Houghton et al., 2013). A reflective journal is commonly utilized in a qualitative investigation to explain the investigators perspective and potential (Humble and Sharp, 2012; Jennings et al., 2011). Reflective journaling allows the researcher to utilize a written document to aid the thought process and decrease bias through self-

reflection and awareness of one's prejudices to expand learning (Woronchak & Comeau, 2016). This process is also referred to as bracketing.

Ethical Procedures

The ethical procedures followed in this study were aligned with the philosophy of Walden University and approved by the Institutional Review Board (IRB) to ensure a high standard of ethics. Upon the IRB's approval to complete this study, this investigator began to seek participants to participate in the study. Permission to post flyers, when needed, was obtained from proper authorities within community organizations, as mentioned previously. Information about the study was also posted on social media and distributed to professional colleagues. Informed consent was obtained from every participant through the use of a detailed consent form. The rights of all participants was safeguarded. As noted in the data collection, participants had the right to withdraw from the study at any time and also may have chosen not to answer any of the questions. The phone number for the Georgia Crisis and Access Line (GCAL) at 1-800-715-5225 was provided at the beginning of each interview.

Participant identity was maintained by the use of a pseudonym in place of participant names. Confidentiality will continue to be enforced as research data will be retained on a password protected computer for the next five years. The researcher removed any identifiable references in the final document to ensure the participant's identities were safeguarded. The investigator is the only person with access to the data. Lastly, the study was conducted online using the teleconferencing platform Zoom which

was password protected. The recordings were downloaded to a computer that is also password protected.

Summary

This chapter provided an outline for the methodology in which this study will be conducted. The introduction, design, the role of the researcher, and issues of trustworthiness were provided. This chapter also encompassed a data analysis plan and ethical considerations. Chapter 4 provides information from the study conducted. This information will include an introduction, setting, demographics, data collection, data analysis, evidence of trustworthiness, and the results from the actual study.

Chapter 4: Data Analysis

Introduction

The purpose of this qualitative phenomenological study was to examine how the endorsement of the SBW schema affects African American women's experiences of the therapeutic alliance with European American clinicians. This study of the experiences of these women may serve to provide better understanding of how the SBW schema may serve to aid or hinder the therapeutic alliance or the African American woman's ability to accept services from a clinician that does not represent her nationality. This research addressed the following research question: How does endorsement of the SBW schema affect African American women's experiences and perceptions of the therapeutic alliance with European American clinicians? Lastly, this chapter will discuss the research setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary.

Research Setting

A purposeful sample of African American women, living in the Metropolitan Atlanta Georgia geographic area, who had received therapy from European American therapists were recruited from doctor offices and the use of flyers that were distributed. Interested individuals contacted the researcher directly from information on distributed flyers (Appendix A). The researcher also used social media Facebook groups that maintain a population of African American women who live within the Atlanta metropolitan area to disseminate the recruitment materials. During this time, there were Black Live Matters (BLM) movement protest, extreme racial tension, and a controversial

presidential election, which may have contributed to the willingness to participate as African Americans were increasingly speaking out against injustice within the United States.

Demographics

The sample included six participants, all African American women. The age range was between 22 and 64 years. Two participants expressed that they were aged 19-22 years at the time of therapy. All participants were discharged from therapy and maintained no current levels of psychiatric distress. In terms of the therapeutic experience, two participants saw a female therapist and four participants saw a male therapist. As it relates to education, three participants attained graduate degrees, one held an undergraduate degree and two did not possess a degree at all, yet one did complete some college and another from high school. All therapists were European American. All participants were discharged from therapeutic services and expressed a current level of psychological distress of *None* (on a scale of None – Mild – Moderate – Severe).

Table 1

Pseudonym	Age	Education level
Dion	55	BA
Donna	61	MA
Greeny	59	MA
Hagar	64	PhD
Karen	40	High School
Sasha	22	Some College

- Dion, is an African American woman residing in Atlanta, Georgia and is 55 years of age. Dion maintains a bachelorette degree in business administration. Dion

sought therapy services during a divorce after her experience with domestic violence. Dion strongly expressed her lack of confidence in her clinician during her therapeutic experience as she stated, the clinician had no conception of what it was to be an abused Black woman.

- Donna, is an African American woman residing in Atlanta, Georgia, and is 61 years of age. Donna has a master's degree in Psychology. Donna also sought therapy while trying to obtain employment. The therapist she obtained services from was a previous college professor. Donna also is a much lighter complexion than all of the other participants and expressed that due to her skin color she didn't experience racism as others may have who were darker.
- Greeny, is an African American woman native born resident in the Atlanta, Georgia area and is 59 years of age. Greeny has a master's degree in education and sought therapy as she was going through a very traumatic divorce where she was put out of her home by her husband with no notice. Greeny denied viewing herself as a SBW until after leaving the therapist's office and having to continue to carry her problems on her own with no assistance. Lastly, Greeny explained she felt rushed out the door by her clinician with no resolution and left with trying to figure out how to move forward.
- Hagar, is an African American woman residing in Atlanta, Georgia, but is originally from a midwestern state and is 64 years of age. Hagar has a master's degree and a doctorate. Hagar acknowledges her subscription to the SBW schema but stated she did not feel very strong during the time she sought therapeutic

service. The reason Hagar sought therapy was due to past childhood abuse. One profound statement made by Hagar about her therapeutic experience was, “She referred to other Black women that she had dealt with who had similarly been abused and she said they reminded her of deer.”

- Karen, is a 40-year-old African American woman who born, raised, and currently resides in Atlanta, Georgia. Karen has a high school diploma and states she went to the “university of hard knocks”. Karen expressed her inability to connect with her clinician not because of what he said or did, but due to her perceptions of how she was treated by office staff because of her race.
- Sasha, is a 22-year-old African American woman, who is originally from an East coast state but currently resides in the Atlanta Georgia, metro area. Sasha completed three semesters of college but did not continue with her degree program. Sasha maintains a positive outlook on life and acknowledges that she is adventurous. While Sasha views herself now as a strong black woman she did not during her therapeutic experience. Sasha also maintained the opinion that by viewing SBW as superhero’s you place a stigma on them that creates loneliness and isolation as they begin to feel they are not able to ask for assistance.

Data Collection

Data were collected from 6 participants through electronic real-time interviews with the use of the teleconferencing platform Zoom. Demographic information was collected during the pre-interview telephone call. All primary interviews in Zoom were recorded on a digital recording device and transcribed, then uploaded into the qualitative

analysis software by the researcher. A limited number of questions were presented, with additional follow-up probing questions when needed for clarity (see Appendix C). Interviews were approximately 60 minutes each. Participants were asked to member check by reviewing the transcripts and conclusions to ensure the findings were an accurate reflection of their experience. Copies of the transcript were emailed directly to participants. Once participants completed their review they were returned by email. Only one participant made corrections to the context of one of her statements. There were no unusual circumstances encountered in the collection of data or variations that were previously presented.

Data Analysis

The data were analyzed using Moustakas' six stage data analysis method, as described by Temple et al. (2017) and described in Chapter 3. First, I bracketed out presuppositions and bias through reflective journaling, a process that lasted throughout the analysis. Next, I used horizontalization, which involves highlighting significant statements in each of the individual interviews (Temple et al., 2017). Third, significant statements were coded and organized into categories, revealing themes through clustered meaning. In the fourth stage, textural meaning was developed through summarizing the themes related to specific experience categories related to the phenomenon (Temple et al., 2017). The fifth stage (structural description) included interpretation of the experiences of all participants. Finally, the conclusions of the analysis are offered representing the essence of the experiences, integrating the prior steps into a conclusion.

The summary and conclusions are presented to convey the overall experience for all participants.

Through the analysis process, codes were examined and compared for overlap and redundancy, and then narrowed into broad themes or categories to form major ideas through an inductive process. Themes were revealed to address the research question. These themes and the associated responses of the participants are discussed separately in the results using verbatim examples to provide an in-depth understanding and powerful insight into the experiences of the participants and to support theme development. These themes included: Feeling uncomfortable due to demographic differences/racism, therapist's inability to relate to or understand the culture and life of African American women, poor connection and engagement with therapist, lack of confidence in the therapist, double-sided perceptions of the nature of the SBW schema, personal strength and independence as an African American woman to serve and carry on, and the SBW schema hindering the therapeutic alliance. Discrepancies arise as concepts emerge that are erratic in one participant's comparison with the experience of other participants. This discrepancy may arise during the transcription of data. To address such discrepancies, I re-examined interrelated segments of the transcripts to ensure the information was not misinterpreted. I further contacted the participant to confirm that the perception that was taken away was the message the participant was attempting to convey. I then compared the transcripts of all participants. Discrepant cases may be used in future research to aid in understanding the reason for the differences in participant experiences.

Evidence of Trustworthiness

Trustworthiness in qualitative research is supported by evidence of credibility, transferability, dependability, and confirmability. Credibility was supported by the reduction of my biases through the use of bracketing, transparency, and member checking (Temple et al., 2017; Whittemore et al., 2001; Moustakas, 1994). Bracketing was accomplished through the use of reflexive journal in which I recorded my thoughts and reactions during data collection. By bracketing I was able to explore and clarify my biases prior to, during, and after the study. Transparency was established by the inclusion of a clear description of the sampling technique and the presentation of the research process (Liao & Hitchcock, 2018; Whittemore et al., 2001). The criteria for participation, recruitment strategy, and the procedures were explained. Lastly, through the use of member checking was incorporated as participants reviewed their transcripts and agreed that I captured the experience they were attempting to convey.

Transferability discusses the ability of the information from the study can be transferred to another's circumstances, conditions, or settings (Curtin & Fossy, 2007). To ensure transferability, a description of participants' experiences were rendered to allow other investigators to create a comparative analysis, and the data and findings were presented in a detailed fashion.

Dependability contains the characteristic of consistency (Moser & Korstjens, 2018) was completed through an audit trail which included audio recordings, transcriptions, and field notes. Triangulation was also used as I used multiple sampling strategies, which included time-location sampling, criterion-based case selection, and

saturation sampling, and snowball sampling argued by Parás-Bravo et al., (2016), and Benoot et al., (2016).

Lastly confirmability, which relates to the ability to check the results of the study based on impartiality was obtained through the reviewing of a reflexive journal and double-checking the data through member-checks (Moser & Korstiens, 2018; Houghton et al., 2013).

Results

This study was conducted to address the following research question: How does the endorsement of the SBW schema affect African American women's experiences of the therapeutic alliance during clinical treatment with European American clinicians? All participants provided a description of their therapeutic experience that were received from European American clinicians. They also expressed their perspectives of whom they would seek receive services from in the future as they lacked confidence in treatment received from European American clinicians. All six participants further expressed their perceptions that European American clinicians lack the cultural competence necessary to assist them in therapy. Throughout the analysis I identified seven major themes related to the participants' experiences in therapy as listed in table 2 below.

Table 2

Themes

Theme	
Theme 1	Feelings of Discomfort in Therapy
Theme 2	Therapists inability to relate to or understand the culture and life

	of African American women
Theme 3	Poor connection and engagement with therapist
Theme 4	Lack of confidence in therapist
Theme 5	Double sided notion of SBW schema
Theme 6	Personal strength and Independence
Theme 7	SBW schema hinders the therapeutic alliance

Theme 1: Feelings of Discomfort in Therapy

All six of the interview participants in this study described feeling awkward or discomfort in therapy at some point due to the demographic differences (e.g., race, gender, socioeconomic status), cultural differences (participants stated African American's culturally do not consider therapy), and or racial discrimination and racism. Some participants described not knowing what to expect, feeling nervous or anxious, and believing the therapist might be able to empathize with them, but not truly understand them due to the demographic differences. For example, Karen described many of these feelings in detail. First, Karen described feeling nervous seeing a therapist on the advice of a European American friend, despite cultural factors that do not support seeing a therapist:

> I just looked at him as a therapist. I really didn't know what to think. I was a little nervous because I had never been to a therapist before. I didn't know what to think or what to expect. You know that's not something we do. My big momma used to tell me what goes on in the house stays in the house, so I never felt the

> need to talk to anyone. I only went because a friend of mine who is White told me that maybe I should think about it and that she goes to therapy and it helps her.

Karen continued to describe differences in experience based on race which brought about feelings of discomfort, as she did not believe the therapist could understand her. She described difficulties in understanding another person's experiences of discrimination or racism:

> I don't consider myself to be a racist or anything like that. I accept people for who they are, but when I feel discriminated against, it does something to me. I also don't believe that all White people are racist, but I do believe that it is difficult for them to truly understand me completely, that even includes my friends that are White, just like I know that there is no way possible for me to completely understand them as being White. I can empathize with them, but I don't know what it's like. I don't think they can truly understand how just having skin that looks like theirs can afford them more in life than having skin that looks like mine. It's just the sad truth about the way things are, about my reality.

Just as with Karen, Sasha, also described her feelings of discomfort during therapy. Sasha expressed that her discomfort related to a first impression, her perception of the therapist's discomfort with her, and her perceptions of potentially being judged by her race:

> This man is judging me. That was my very first impression; he is judging me. I was a little bit uncomfortable; he kind of started grabbing his personal belongings, like getting a little more personal space, like, just looking real distancing. You

know, so naturally, I just felt like he was uncomfortable, and that made me uncomfortable.

For some, the feelings discomfort stemmed from experiences of perceived racism while seeking therapy, either from the office staff or from the therapists themselves. The participants indicated that the experiences of direct or indirect racism generated discomfort and distrust, eroding any possibility for a strong therapeutic alliance. For example, Hagar described her experience of discomfort while talking with her therapist. Hagar indicated that she thought some of the questions the therapist asked and some of the statements the therapist made were rooted in racism. Hagar described experience of discomfort and how the experience of racism from the therapist made her "shut down." Hagar stated

> The reason why my experience with the European therapist stood out was because, you know we, were talking about um, my history with childhood abuse, and she referred to other Black women that she had dealt with who had similarly been abused and she said they reminded her of deer, and that statement was the turning point to me during the therapy because to say that Black women who are receiving counseling from your remind you of animals, uh I felt that indicated to me that she was a racist and was really incapable of processing my statements because she did not see Black people, specifically Black women as human beings. That kind of shut me down; I did not want to receive any more therapy from her, um of course, when I had received therapy from the Black therapist, none of this occurred. No statements comparing Black women to animals was made, and it

> also reminded me of an article that I read that said in most advertisements in America, this study was kind of old, maybe 15-20 years ago. It said that Black women were frequently depicted as animals and for her to say that Black women who are receiving counseling from her reminded her of deer, um Bambi, I just felt that was an indication of her racism and an indication of her ability to assist me.

Hagar continued to describe having positive and effective experiences with African American therapists compared to European American therapists in the following quote:

> I don't want to say that all of the black therapists were necessarily wonderful, but the other three that I saw, they were helpful, and they were concerned about me, and they weren't concerned about my appearance, and they gave me valuable insight that continues to help me to this very day. … I didn't feel any type of racial insult with the Black therapist.

Karen described a different experience of racism from the office staff. She stated that experience of racism affected her ability to connect with the therapist as well.

> I came into the office, and the staff was kind of standoffish. I noticed I did not see any other Black women in the waiting room. Actually, I was the only Black person in there at all. It made me feel a little uncomfortable, and I felt like they were talking about me because they kept looking at me whispering to each other. As a matter of fact, when they called me to the counter to make my payment, I asked them if there was any other information they required as I noticed they kept looking at me, and the receptionist tried to play it off and said no, we got everything. I was trying to be professional but wanted to ask why were you

> looking at me then. The receptionist also acted as if she didn't want to take my credit card. I was handing it to her, and she just looked at me, so I put it on the counter; that is when she reached for it. I knew the therapist was, White but didn't expect the reaction I received when I walked in. My friends tell me that I sound White over the phone and that I talk real proper, so maybe she thought I was White when I booked the appointment. Maybe it was because my name wasn't Bonquesha (laughter). Whatever the reason, it made me feel uncomfortable, and I was questioning if I even wanted to go through with the actual therapy session because of their behaviors. I thought about telling the therapist about the behaviors of the staff but decided to wait and see how he acted because I have learned that a lot of the times, the staff is a product of the head. … I was uneasy even during the therapy session even though the therapist didn't seem as if he was trying to be racist despite some of the questions he asked. He at least attempted to be concerned about my situation, but because of the way his staff treated me, it made me feel like I don't want to come back and deal with this kind of treatment every week. I get enough racism outside of the doctor's office without having to come here and deal with it too.

The participants in this study commonly reported feelings of discomfort with the notion of therapy that were worsened by experiences of racism or racial bias. Understanding cultural aspects of African American women may help to understand the trepidation surrounding beginning a therapeutic relationship. However, the inability to relate to the cultural aspects of the participants was another common theme.

Theme 2: Therapist's Inability to Relate to or Understand the Culture and Life of African American Women

Participants in this study perceived that European American therapists were unable to relate to or understand the cultural background and life experiences of African American women. Five of the six participants described this inability of the therapist to relate to African American culture, while one participant felt the therapist was able to relate to their cultural background. For example, participant "Hagar" indicated she believed "The practitioner should be aware of a person's culture, and this woman was obviously not only not aware of African American culture, but she was also not sensitive to me as a human being." Participants described the need for a therapist to be able to relate to the life experiences of the Black Woman, which they did not perceive to be the case. For example, Greeny stated:

> I think a Black person, especially a woman, would have been able to handle my situation better and give me better advice because she would have known how certain Black men, and it's not every Black man, but certain Black men act. I think I would have gotten better advice as opposed to there's nothing wrong with you, it's your husband.

Dion further acknowledged the lack of understanding of her culture, the repercussions of systemic racism, and its impact on the experiences of African Americans in general and African American women specifically:

> Again, I think it was based on whatever he was taught. I can't say that in any of the conversations I had with him, that he could even empathize with my culture,

> with how we live, you know, living in an urban community with all the limitations there were, being that he lived, not in an urban community, and with privileges, sort of speak. I don't think he could relate. I think everything that he may have in his mind, or whatever he presented, was based on what he was taught from school. … Where I lived and based on where I had to go to see him, he had no clue, our cultures weren't intermingled much back then.

Other participants more directly tied the therapists' this inability to understand or relate to Black women to racist and sexist comments, suggestions, or connotations. For example, two participants described in-depth how questions or comments made to them during the therapeutic session reveals racism and an inability to relate to the participant's cultural background. Karen described assumptions made by the therapist, that she came from a low income, single parent household, as general inability to understand her culture and background:

> Well, one of the questions he asked was like, did you grow up in a low-income area? I felt like he thought all Black people were supposed to be poor and have nothing in life based on his question. I don't feel like he would have asked a White person that question. He also asked me if my mom was a single parent, and if my dad was involved in my life. I was waiting for him to pass out when I told him that my mom and dad were married over 48 years and that my dad was always the one who worked and supplied for our house. Like Black people don't have decent families and live-in middle-class homes. … I think he tried but wasn't capable. In regard to culture, it's hard to understand someone's culture unless you

> are from that culture, and based on the questions he asked, he demonstrated his inability to understand my culture as far as I'm concerned. … I also think it was impossible for him to understand me as being a Black woman who fears for her son's life every time he goes out of the house. A woman who has to tell her son not to put on a hoodie, or where a wife-beater out in the streets, and to put the camera on his phone if he gets stopped by the police while putting his hands on the steering wheel, so he doesn't get shot. How could he understand a Black woman who has to work to be twice as educated and twice as good at her job just so you can compete with someone who is white with less education? I'm in no way prejudice, but this is my reality. I don't know how I can expect a White therapist to understand my reality.

Similarly, Sasha described that the White therapist will never really understand because the therapist will never actually feel this or have these experiences for him or herself.

> Well, the female, I could say, she may have understood a little bit more as far as the discrimination towards women in general, but as far as the race part of it, I could see that she empathized it, because, you know, I kind of got a chance to sit and talk with her for a second. She does have a couple of Black people in her life, you know, mixed kids and things like that, but I could see her ability to empathize with the issue, but I never really feel like they will truly understand it because it will never be done to them. You can be next to someone that it happened to and feel for them, but you will never really feel it for yourself. … No, I don't

> personally feel like anyone will understand how it feels to be a Black woman besides Black women.

Participant comments related to the inability to understand the lived experiences of a black woman made the participants feel like the therapist did not relate to them. It also made the participants feel uncomfortable, eroding the ability to create a connection and engage with the therapist. Due to the inability to relate or understand the culture of African American women, retention rates were diminished.

Theme 3: Poor Connection and Engagement with Therapist

Because of the feelings of discomfort, experiences of racism, and of the therapists; inability to relate culturally, there was a poor of connection with the therapist noted by five of six participants. However, the nature of the poor connection varied across participants. One participant described having an anxious connection with the therapist, ultimately not feeling a connection that felt safe. Donna noted the following of the connection with her therapist:

> I didn't have any problem connecting with him, um, I wasn't fearful, but I was anxious about it, but once I sat down with him, I didn't feel like I felt safe. … I had never been through therapy, and I didn't know what to expect. I was educated, but I didn't have any experience with therapy.”

Sasha described having no initial connection with her therapist. She indicated though that a connection eventually was formed through the therapeutic relationship. She stated:

> At first, there was absolutely no connection. As you continue through the conversation, I realized, like you know, it may be a little bit better, but at first, it wasn't really a good feeling. The first feeling I got when I walked in the room was that I really wanted to leave.

Hagar also described how her initial connection was lost after experiencing what she perceived was racism. She indicates that the experience completely removed any connection with the therapist.

> I started out feeling that she was helpful and sympathetic but, that statement about Black women being, previous black women being like deer and uh when she said that, my heart kind of went out to those Black women who had come to her expecting help but not realizing that she's viewing them as animals, you know forest animals, and uh animals they are generally viewed as feminine they are not viewed as intelligent, they are not viewed as being productive, they're like little girls or, it's not a strong animal to be compared with. It's not a lion, it's not a tiger. It's more of a victim type animal and the fact that she viewed black women as animals and was ignorant enough to make that statement to me it really was, actually it was at the end of that counseling session, and I had very little to say to her after that.

Experiences of racism were mentioned by another participant, Karen, who explained that the office staff treated her with disrespect. She felt the treatment was related to racial differences. This affected the relationship with the therapist, regardless of

the therapist’s efforts. Karen reported the impact of staff on her relationship with the therapist:

> I tried to connect with him. I wanted to, but I didn't. Based on the way that the staff treated me and his inability to ask appropriate questions, I felt as if maybe this just wasn't for me. I think that's why I didn't go back. Like I said before, he tried to be nice but, one, I was already upset about the way the staff did things, and it could have been just me at that point because I was upset. I'm not going to lie; I was upset. I tried not to allow that to interfere with my therapy, but it's always possible that some of what I was experiencing with the therapist was because of that, but I still don't feel he should have asked questions in the manner that he did. There are other ways of getting the information that you need without coming at people that way. I just felt this was a waste of my time.

The three participants described a general lack of connection with the therapist, and three described having a level of engagement in the therapeutic relationship that was based on necessity. Dion simply stated, “I just talked because I was there.” Another participant (Greeny) described being handed a diagnosis and being rushed out with no real solution to the problem. She stated:

> So, generally speaking, I felt, even though it didn't seem like an hour, it was an hour I was in there with him. When it was time for that hour to be up, I felt literally at that point rushed, cut off, and sent home with no antidote to help me get better, just a diagnosis that somethings wrong with you, and this is what's

> wrong with you and have a good day. So generally speaking, that's how I felt when I went.

The feelings of being rushed and left without a solution and no return appointment, along with the need to talk because you are simply in the room, support the lack of connection with the therapist. Dion continued to describe how she engaged with the therapist, not because of the therapist's skills, or out of necessity, but out of desperation:

> Well, I think my willingness to share was based on my desperation. Um, I needed to do it, I needed it to help my case, I was willing to share and provide whatever information about me and my situation because it was out of my own desperation, not because he was so wonderful, I needed it to be recorded, I needed it to be documented, so I can't say that my engagement, my engagement wasn't because of his great interaction with me. My engagement was out of my own desperation.

Similarly, Donna described how going through therapy was necessary for her to continue in her career, as the job she was applying for required the participation in a few therapy sessions. She stated, "He wanted to put me through therapy to make sure I was ready to work in this field without having what I was going through interfering."

Findings related to this third theme revealed that the poor connection and engagement with the resulted from participants feeling uncomfortable. Participants also expressed they felt the therapist was unable to relate to personal experiences, and experiences of racism. Participants described how poor engagement and the lack of an established connection prevented them from gaining a sense of confidence in their

therapists and the therapists' ability to help them.

Theme 4: Lack of Confidence in the Therapist

When asked about how they felt about the therapist's ability to treat them, five out of six participants discussed a lack of confidence in the ability of the therapist. Five participants described feeling a lack of confidence and five of the six participants also described feeling that therapy was ineffective. Participant Dion simply stated, "I can't say that I felt he was effective". Two of the participants described the lack of confidence in terms of their inability to be completely comfortable with the therapist or the therapist's inability to relate to their experiences as an African American woman. One participant, Karen, described how she initially felt confident, but found the therapist to lack understanding of her experience, making her reluctant to open up:

> I don't know that I was completely comfortable with him, but he did seem as if he genuinely cared about what I was going through. Before I got there, I was completely confident; my thought was that this person was a professional in his field and could definitely be able to help. That's why I was going. I just think he didn't understand me completely. He would make certain comments that he shouldn't have made, in my opinion. I didn't feel like I could really open up to him like that. I wanted to but was reluctant; you know what I mean. It was like; I wasn't intimidated by him; I just didn't feel like I would get what I needed from him. … I want to stress that he was a fairly decent person, but I just don't feel like he had the ability to help me. I don't think that applies to all White therapists, though, because I haven't been to them all, but it does to the one I went to.

Another participant echoed the notion that the therapist's inability to relate to an African American Woman's experience resulted in her being uncomfortable and having a lack of confidence in the therapist's ability to help her. Sasha explained:

> An issue as far as European Americans not really understanding certain problems that African Americans have. For, like, example, the first therapist, the male, I was explaining to him an issue as far as someone was looking at me in a store, and as far as him, he was like, why are you so upset, they were just looking at you, but he doesn't understand that this is a White person and they aren't just looking at me because they think I'm pretty. They are looking at me because they think I'm stealing, so it's uncomfortable if I'm telling you something that I know to be racist, but naturally, you don't because you haven't experienced that, so in your head, you're trying to find every other thing for what it is, but I blatantly know what it is, and that makes me uncomfortable telling you things.

The inability of the therapists to relate to the cultural experiences of the participants supported the lack of confidence felt by participants. The participants inability to obtain some form of comfortability also supported the lack of confidence in the abilities of the therapist. The inability to develop a strong confidence in the therapeutic alliance, therefore, supports feelings of ineffective treatment.

Theme 5: Double-Sided Notion of SBW Schema

According to participants in this study, notions of the SBW schema are two sided, comprised of both negative and positive aspects of the schema. Sasha noted that "As far as the strong Black woman, it's complex, there's a good side and a bad side to it, and I

personally don't want to fit into that." Different elements of both the positive and negative sides of the BW schema were noted by the participants.

On the negative side, the participants described a negative perception of how White therapists viewed of strong black women, including the view that strong black women are angry, aggressive, and difficult. For example, Dion asserted,

> Yes, it is a very negative stigma and makes us sound aggressive, hard to deal with, having a lack of communication, skills, or makes us sound angry. That's what I think it means when you say, a strong Black woman.

Sasha described a similar idea of being angry, attributing it to the lack of understanding of the African American woman's experience, stating:

> They try to make it seem like we are angry, and I feel like even if I am I have a right to be, and there are certain things that they won't understand about it because they haven't had to live that.

Conversely, on the positive side, all six f participants acknowledged a positive side of the SBW schema presented African American women as being able to take on and handle everything, as well as portraying African American women as self-sufficient and independent. For example, Karen described her notion of the SBW schema in terms of the one who holds everything together:

> A woman of color who is always taking on more than they should. Black women who are there for the children, their significant others, family, friend, church, community, you now like a superwoman type. She is someone who can do it all, handle it all, and keep things going regardless of how bad things are. A strong

> Black woman goes above and beyond, always trying to make sure the people she cares about are OK, even if she isn't. She normally isn't going to talk about her problems or what's going on with her. She is just going to keep moving and act like everything is OK. She is the one that holds the family together, like the glue. Yes, she is the glue of the family. Whenever there is a problem in the family, everyone comes to her. She is always concerned about the care of others and making sure the house runs smoothly, even if she's doing it by herself. I think that's what I would think of when I think of a strong Black woman.

Lastly, along with descriptions of strong black women as being strong and independent, the participants described a lack of self-care as a common trait of strong black women. This was a common notion, as it was noted by four of the participants. Dion stated simply, "That's what we do. We do, and do, and do, and don't take care of ourselves enough.… We don't have time to get treatment." Sasha also described in great detail the "superhero" nature of the strong black woman, but the simultaneous needs of the strong black woman that go unmet:

> I do feel like people look at strong Black women like their superheroes, and they might be to some, but every person needs somebody, so when you put people in a category of having to be strong, I feel like one of the main adjectives that people would put with strong would probably be independent. I feel like by putting that platform and putting that word out there; you are increasing to the loneliness of Black women because now they feel more uncomfortable asking for help. Now they feel more uncomfortable letting people know that they aren't OK, because

> now they feel like I'm not strong if I let people know I'm having problems, or I'm not strong if I'm having problems, I'm not strong if I'm having help. It's a good thing for those strong women, but it's also a bad thing for them as well emotionally. I feel like that's very emotionally damaging, that word. … She is definitely able to express her needs, but it really just comes to whether or not she wants to and whether or not she sees it as a need, because the thing about strong Black women, they'll see it as a need when they are literally at their breaking point. They won't see it as a need when the problem first begins. They will go all the way to the end when they really can't handle it by themselves, and that's when they will reach for help, and that's why I say it's emotionally damaging because if they didn't feel the need to feel so strong, they could ask for help before the problem got bad. The need for independence just keeps them going.

Personal perceptions of the SBW schema as being double sided provided insight into how these participants may see themselves. Therefore, it is further important to understand how these participants see themselves in relation to the SBW schema. The next theme delves into their perceptions of themselves as Black women and their perceptions of how they fit within the SBW schema.

Theme 6: Personal Strength and Independence

In terms of their personal perception of themselves as strong Black women, the participants perceptions of themselves echoed their thoughts of the general SBW schema. All six of the participants considered themselves to be “strong Black women,” describing themselves with a number of combinations of strength, independence, and the ability to

handle adversity. Interestingly, the participants described that they did not choose to be a strong Black woman, but rather, it came as a necessity or simply “the way things are for Black women.” This participant, Karen, described this more fully:

> Not necessarily that I choose to be, but it is usually the way things are for Black women. Life throws things at us, and we have no choice but to take it. … yes, I do see myself as a strong Black woman. You know that's how we were raised growing up. Big momma would tell us to pick ourselves up and keep it going, that as a Black woman, I had to be twice as strong, twice as good. She would say I don't have time to cry about woulda, coulda, shoulda. Based on what I experienced in life, she was right, so that's what I teach my daughter. We don't have time to cry about things. It's not an easy task, but we do it because that's what we do.

Perhaps the central notion and self-perception as a strong Black woman was the attributes of strength and independence, meaning carrying a lot of weight and living up to the expectation to do so. One participant, Dion, described:

> Well, my personal perception is that we um, carry a lot of weight, and even though our backs aren't built to do that, we are expected to do so. Whether it's taught, or whether we are reared, or based on what we saw, or whatever came at us, our options were limited. If it had to be done, if it had to be cared for, we had to do it. Our strength is really a requirement to be who we are. We don't have a choice, there are not a lot of options to do anything less than that; otherwise, we are locked up in mental institutions. I just say that our strength is not optional. We

have to be what we are, and not just to take care of the people around us, but even in our careers, we don't have a choice. We have to be just that. Now I don't equate the strong Black woman with the angry black woman. I don't think those two correlate, but the strength part of it is a requirement to be who we are. That's my opinion.

This strength is not just a trait, but a requirement, according to participants in this study. Strength represents a requirement in order to be a strong black woman and take care of the people and things that need to be taken care of. Dion concluded:

> Our strength is really a requirement to be who we are. We don't have a choice, there are not a lot of options to do anything less than that; otherwise, we are locked up in mental institutions. I just say that our strength is not optional. We have to be what we are, and not just to take care of the people around us, but even in our careers, we don't have a choice. We have to be just that. …Now I don't equate the strong Black woman with the angry black woman. I don't think those two correlates, but the strength part of it is a requirement to be who we are. That's my opinion. (Dion)

Seeing themselves as aligning with the premises of the SBW schema, the participants' discussions of how their personal acceptance of the SBW schema may or may not impact the therapeutic alliance can be better understood. With a focus on personal strength and cultural factors that may hinder the development of a therapeutic relationship, participants discussed how the SBW schema affected the therapeutic alliance.

Theme 7: SBW Schema Hinders the Therapeutic Alliance

The next theme relates to the personal notions of the SBW schema, as described by participants, and the perceived negative impact on the therapeutic alliance with a European American therapist. The participants offered explanations as to how and why the therapeutic alliance was affected by the therapist and/or their own conceptions of the SBW schema. This explanation included the stigma of the need for therapy as being seen as a weakness, racism, and how the characteristic traits of black women, according to the SBW schema, may hinder the therapeutic alliance. These factors also seemed to affect their future actions in terms of whether they would seek additional therapy and from whom they would seek therapy.

One factor that seemed to hinder the therapeutic alliance is the cultural perspective related to the SBW schema of therapy seen as a weakness. Two participants described going to therapy as being seen as a weakness in the Black community. Dion explained how it is looked down upon, culturally, in the community.

> I think that culturally it's looked upon as weak when you have to have therapy or when you might want or desire therapy. I think that your looked upon as being weak when you should just do what you gotta do, sorta speak whatever that might be, or whatever that's supposed to mean. It's very unfortunate that our mental health is not a part of that strength. Our physical ability, our ability to suppress, our ability to overlook, or put blinders on to things, is the strength that helps, supposedly helps us to get through our lives, and the thought of therapy is looked

upon as weakness. That's only something White people do, and they do it because they want to have an excuse to get away with whatever it is that they do

Karen's comments supported this theme She noted she would not tell anyone she had gone to therapy because of fear of being ridiculed or others considering her "crazy."

If they do [go to therapy], that's not something I think they would be willing to tell. I know I wouldn't tell anyone I went. To me, that's like asking for ridicule. I have enough problems without people in my family or my friends calling me crazy. You know that's what they would say. They would be like, If you are going to a therapist, you must be crazy, and with the way my family likes to talk about people, it would be all over the world that I'm crazy before sunset even hits (laughter). No, I wouldn't tell anyone.

Both Dion and Karen described the need for therapy as a weakness, for which they could be ridiculed, told they are crazy, and looked down upon. Another factor reported to affect the therapeutic alliance was experiences of racism and the inability to relate to African American culture (experiences that were detailed in previous sections). As described by the participants, these were direct experiences of racism with the therapist directly or with the office staff. Although experiences of racism were discussed in relation to the therapists' ability to relate to these Black women, these experiences and inability to relate ultimately eroded the therapeutic relationship or the ability to form the relationship at all. According to Karen, the therapist tried, but was not capable of relating and forming that therapeutic alliance because he lacked the understanding of her culture and the repercussions of systemic racism.

> I think he tried but wasn't capable. In regard to culture, it's hard to understand someone's culture unless you are from that culture, and based on the questions he asked, he demonstrated his inability to understand my culture as far as I'm concerned…. I don't know how I can expect a White therapist to understand my reality.

In another example, Hagar described how her female therapist was initially connecting with her in the therapeutic relationship, but then made a racist comment that destroyed the relationship completely, removing trust, and confidence in the therapist as someone who would be able to help her.

> I felt that it did, I felt she was on my side as a strong Black woman until she made that comment until she made that comment and that kinda destroyed the alliance because she wasn't looking at me as being strong or a Black woman, she was looking at me as an animal. That's how I view it. … I basically ignored it because when people show me how ignorant they are, I believe it but I don't feel I have to fight it. I believe she said it, because it was in her heart, and there was nothing that I could say that was going to take that out of her heart. I just accepted it; I was like OK, so this is where your coming from so let me not um, you know, you don't even know what you said, so I just heard it, I processed it, and I kinda psychologically withdrew from the session.

Hagar supported the impact of racism in the relationship by acknowledging the existence of racism in the field of psychology. She stated:

> I was aware of the racism that existed in, not only in [the] program but in the field of psychology. The whole area of psychology has served as a tremendous source of racism, so I'm always going to look at a person as being fair until that person proves to me that my assumption was not warranted.

Contrary to Hagar's perception of the therapeutic alliance, Greeny perceived the SBW schema itself to hinder the alliance. Greeny discussed characteristics common to African American women that may hinder the development of a therapeutic alliance, as she felt African American women are quick to speak and slow to listen, therefore they are not always able to receive the advice being provided in therapy. Greeny described in detail:

> It may hinder because today's strong black women in my eyesight, are like if you don't give me an answer, or if you say anything that is a little bit crazy in my thinking, it might be a good thing that you're saying, but if it's not what I'm looking for, or it makes absolutely no sense, and because of the strong black woman that is quick to say something as opposed to listening to the whole thing thinking about the whole thing and then speaking on it, um yeah. The strong black woman can hinder some stuff. Uh, you going to someone to help you, and you tell them all of your issues, and then it's for you to be quiet, put your listening ears on, and hear what the person is saying. … A strong Black woman, when you're trying to help them, they are, if it's not sounding correct for a few minutes or a few seconds of the conversation, they are quick to speak, and not listen, and then if you try to calm them down some, some women, and tell them you won't even let me finish. They don't care at that point because you sounded crazy to them at the

> beginning, so therefore you have nothing else to say to me, and that will be an issue for some. Now they may not, the Black woman that has gone through enough I guess. A black woman who is really, really seeking some help, I believe after she's done the talking, she's willing to listen, and ask intelligent questions to help her understand better.

Donna was a discrepant case as she acknowledged how a previous relationship with her therapist, despite some discomfort, aided with aspects of the alliance and his ability to be somewhat competent culturally. Donna noted:

> I think that he was extremely competent to assist me, um, I thought he was competent. I knew him as a person before, so I knew that he didn't have any prejudice or bias towards me as a Black person. I didn't feel he did. I didn't think about it, and there is nothing that came up in the therapy that made me think otherwise, but anytime he brought up race, he was talking about how the medical field is prejudice towards Black people. That, a lot of Black women when they go to have babies they aren't treated like White women. He was working in the hospital with sick babies. He was telling me what I would need to watch out for. What I needed to be looking out for when I was in that environment. That's when he talked about race; he was talking about how the doctors treat Black people. He had people in his family that were Jewish. They had married someone that was a Jew, and in New York there was a lot of racism, big time, so it made him more liberal. The unknown, what he was going to ask and how far he was going to dig in was what made me uncomfortable.

Donna further expressed that she didn't experience racism as many African American women did because her skin was much lighter than many African American women, as her mother was not African American:

I didn't have a Black mother, so she didn't teach me to be racist. My mother was White

> and American Indian. But my dad is Black, and I consider myself as Black. My grandfather was Irish on my mother's side and my grandmother was Native American. I'm much lighter than a lot of Black women because of my mother, so I didn't experience racism the way that some other Black women did, but I saw them deal with it.

Lastly, in terms of the effect on their seeking out therapy in the future, five participants agreed that they likely would not seek therapy again, but if they did, they would seek out an African American, female therapist. This was because of the lack of ability to relate to and understand the experiences of African American women who relate to the SBW schema. Participants described these experiences and why they would likely seek out a Black woman therapist.

Each of the participant experiences was different, but the detailed description offered by participants provided highlights the similarities in thought, supporting the theme of the weak cultural understanding among European American male therapists with African American women seeking therapeutic help and how this weak cultural understanding served to hinder the therapeutic alliance. Karen described how the lack of understand of experiences of being an African American, as well as being woman, make

it difficult to form that therapeutic relationship; as a result, Karen will see a black woman therapist, if she ever sees a therapist again:

> I'm not sure that I would seek therapy again, but if I did, it would be from someone Black. … You know, if I did see another therapist, it would be a Black woman. I would see someone Black because I think that they would understand my culture better because they are black too. Even though I feel like we have different cultures within the black community … I believe they can understand the discrimination that you experience just from having a skin tone that looks like mine. I also feel like they would understand that there are many Black households that have two parents making things work. I say it would also have to be a female therapist because there are things that we go through as women, and I just don't believe that men are as sensitive to our needs or can understand what it is like to be a woman. Only a woman knows what it is like to be a woman. Plus, there are forms of discrimination that we experience as women that men don't, so they would not understand. … Yeah, if I chose to do it again, and that's a big if, it would have to be a Black woman.

Similarly, Greeny described that she would seek future therapy from a Black woman as well, noting a lack of compassion that she felt would be greater with a therapist who is both Black and a woman.

> Oh, knowing what I know now, I think I would go see a Black therapist. Only, and probably a Black female on top of that only because of the compassion level that I would need that I seemed not at all to be getting, even though he seemed to

> be caring at the very beginning of the conversation, he seemed to be into what I was saying. Writing notes and all. He seemed to be looking into my eye, but I think a Black person would have been able to comfort me a little better, and even if it was just one more appointment, because I paid, and my money is good. I know that he was interested in money because you know it's their job, but I needed help, and so, I want somebody with compassion, and I didn't get it, and I want somebody else that can experience and understand where I was coming from.

Contributing factors to the perceived failure of the development of the therapeutic alliance amongst European American therapists and African American women included the lack of personal understanding and acceptance of the SBW schema and being uncomfortable with cultural and demographic differences. Participants also noted that the therapist’s inability to relate, lack of connection and engagement, and lack of confidence in therapist, were also factors. The therapist’s ability to understanding these factors may lead to an enhanced therapeutic experience and productive alliance.

Summary

Chapter 4 provided the details and findings of the analysis of the data obtained from the research question: How does the endorsement of the SBW schema affect African American women’s experiences of the therapeutic alliance during clinical treatment with European American clinicians? Findings revealed seven themes related to: feeling uncomfortable due to demographic differences/racism; therapist’s inability to relate to or understand the culture and life of BW; poor connection and engagement with

therapist; lack of confidence in the therapist; double-sided perceptions of the nature of the SBW schema; personal strength and independence as a SBW to serve and carry on; the SBW schema and the therapeutic alliance. These themes and the associated responses of the participants were discussed providing verbatim examples to allow the reader insight into in-depth understanding of the experiences of the participants related to the phenomenon of the SBW and the therapeutic alliance. These findings are further discussed in Chapter 5, relating the findings back to the research question and to the prior literature. Chapter five will provide an introduction, interpretation of findings in the context of literature, and interpretation of findings in the context of the conceptual framework.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore how endorsement of the SBW schema affected African American women's experiences of the therapeutic alliance during clinical mental health treatment with European American clinicians. Transcendental phenomenology was used as the framework to explore how the endorsement of the SBW schema related to the clinical experience of African American women. Six African American women were interviewed after the completion of an interest conversation and completion of a demographic checklist to provide basic information surrounding their background. Once the interview was completed, all participants were requested to review a word-for-word transcript of their interview to ensure accuracy. Participants were able to make changes as need to the transcript for resubmission to this researcher. Themes were then obtained from the data collection. Such themes included feeling uncomfortable due to demographic differences and/or racism, therapist's inability to relate to or understand culture and life of African American women, inability to connect, lack of confidence in the therapist, double-sided perceptions of the nature of the strong Black woman (SBW)s schema, personal strengths, and independence of SBW, and independence as a SBW to serve and carry on, and the SBW schema and the therapeutic alliance.

In this chapter, the findings will be compared with the results of prior studies. I will also analyze and interpret the findings in the context of the Strong Black woman schema. Then, I will present the limitations of the study, the recommendations for future research, the implications for positive social change, and the conclusion of the study.

Interpretation of the Findings in the Context of the Literature

In this section, the findings and how they confirm, disconfirm, or extend knowledge will be presented. All participants indicated feelings of discomfort in therapy at some point. For example, participants felt uncomfortable due to cultural differences between them and their therapists. The theme related to feelings of discomfort supported findings by Williams et al. (2014) who reported that African American women held feelings of distrust toward European American clinician's due to past discrimination experiences that existed before or during any distressing events they may have experienced.

Participants in this study reported feeling discriminated against and perceived racism from staff members or their clinicians, which lead to discomfort in therapy. The feeling of discrimination was supported by the findings of Cuevas et al. (2016), as their study showed that African American women often noted discrimination not only from their clinicians but also from the office staff upon entering the facility. One participant expressed that she felt discriminated against during a payment transaction with the staff as they refused to take her credit card out of her hand. Another participant expressed her feelings that she was compared to an animal which made her identify the therapist as racist.

The second theme noted was that of therapist's inability to relate or understand the culture. Participants articulated that their therapist could not relate to them or that the therapists had weak understanding of culture and life of Black women. Five out of the six participants felt the therapist's "Book knowledge" did not match their life experiences.

The feelings of participants are consistent with the findings of Williams et al. (2014) and Davis et al. (2015). Williams et al. noted the need for cultural adaptation in treatment for African Americans, as they discovered that the failure to encompass cultural differences and trauma's that were related to racism could possibly minimize the therapy outcomes for African American's receiving services. Davis et al. (2015) contended that African American women reported perceptions that European American clinicians lacked pertinent skills of cultural awareness. This lack of cultural understanding was further identified by participants as they shared how the way in which language and use of metaphors can be perceived as discrimination based on culture, which leads to a disconnect in the therapeutic relationship and creates increased feelings of lack of resolution and heightened dropout rates. Participants expressed that European American therapists were unable to connect the information that was learned through their education with the actual life experiences of African American women.

The third theme that emerge from the data was, poor connection and engagement with therapist. Five out of six participants described some form of inability to connect with the therapist due to perceptions of racism and/or lack of cultural competency that lead to decreased retention. This lack of cultural competence aligns with Davis et al. (2015) as they suggest, a common reason for lower retention among African American women receiving treatment from European American clinicians was tied to clinicians' adverse perceptions toward the client. Williams et al. (2014) also supported this as their research identified that factors related to the delivery of treatment such as issues of interactions and inability to connect with the clinician, serve as barriers to the retention of

African American women in mental health treatment. Despite the poor connection and engagement with the therapists, participants sought therapy out of necessity.

Lack of confidence in the therapists was the fourth theme that emerged from the data. Participants indicated that the lack of confidence adversely affected their ability to be completely comfortable with their therapist or the therapist's inability to relate to their experiences as an African American woman. The research coincides with the findings of Cuevas et al. (2016) as they discovered that mistrust of healthcare clinicians was associated with undesirable experiences. Five out of six participants also stated therapy was not helpful, which supported the findings of Meyers et al. (2017) as they reported, 25% of African Americans receiving mental health therapy, deemed treatment received as not helpful at all. Participants identified treatment as not being helpful. They also indicated that upon leaving therapy, they left carrying the hurt and stress that they came into therapy and also the perceived negative experiences received from therapy.

Interpretation of the Findings in the Context of the Conceptual Framework

The strong Black woman (SBW) schema was the conceptual framework used to interpret the findings. The SBW schema holds that there are expected standards of behavior and beliefs for African American women (Haynes, 2019). Such expectations and standards are identified by the ability to advocate for self, display self-reliance, and take care of those surrounding them to include within the community. Woods-Giscombe (2010) proposed that characteristics of SBW included an obligation to suppress emotions, an obligation to show strength, resistance to being vulnerable or dependent, a determination to succeed, and an obligation to help others. There were three themes that

emerged from the data that related to this conceptual framework. The first theme in this section expressed that there was a double-sided notion of the SBW schema. Two of the participants noted a perception that SBW are viewed as angry, difficult, and aggressive, however this was not noted within the literature. All six of the participants expressed that they perceived the strength of a SBW as one who is able to ensure those, she cares about are OK and have all they need, event when she is lacking in her own needs. Comments from participants were in line with the premise of the SBW schema which poses that African American women are obligated to show strength. Both Etowa et al. (2017) and Nelson et al. (2016) expressed that the expectancy and epitome of a SBW is to undergo and tolerate everything. Their research argued that SBW are autonomous and invulnerable, willing to carry immeasurable burdens, and inclined to sacrifice everything at the cost of their own health. Participants also expressed that being a SBW meant they would go without at times and lack in self-care. All of the participants acknowledged that African American wome take care of everyone around them, but often give so much that they don't have enough left to give to themselves even when they are tired from all they do for others. Watson and Hunger (2016) argued that while African American women maintain self-efficiency (the ability of one to execute personal obligations and handle their own affairs), they have unhealthy insinuations for self-care, which are consistent with findings regarding self-care from this study.

The next theme related to the context of the conceptual framework was that of personal strengths and independence. Participants expressed that at the onset of therapy, they did not see themselves as SBW. They felt they were forced to become SBW as they

were leaving their therapy sessions as becoming strong was necessary for their survival. The findings of this research supported the findings of Etowa et al. (2017), and Watson and Hunter (2016) as they argued SBW schema creates adaptive reactions to ecological stressors while creating burdens that many African American women are forced to endure. Wood-Giscombe (2010) speak to the notion that African American women adopted the superwoman schema as way of combatting negative views and stereotypical images of African American women. Etowa et al. (2017) and Nelson et al. (2016) contended that African American women engage in an engulfing load of duties that they are accountable for, with little to no alternatives. This supports participants expression that SBW serve and carry an abundance of weight as evidence of a statement made by Dion, "We carry a lot of weight, even though our backs aren't built to do so." This phenomenal fortitude was supported by Watson and Hunter (2016) as they refer to the weight that is carried by SBW as being a form of "superhuman strength." Nelson et al. (2016) referred to this strength as being that of a superwoman.

The last perception expressed by participants pertains to the conceptual framework of the SBW schema and its hinderance to the therapeutic alliance. Three of the participants expressed concerns as to how the SBW schema hindered their alliance. Participants discussed their need to be strong and push themselves forward as if they were superwomen, as they left their therapy sessions feeling worse than when they began. Due to such feelings, participants articulated a diminished alliance, which hindered therapeutic retention. Participants further noted their need to seek treatment, would not be shared with family and friends within the African American community due to the stigma

they felt from their family, friends, and the broader community. They also communicated that doing anything less would affect their view and that of others in the community as to what a SBW looks like, as they were expected to hold it together. This stigma and the need to hide their mental health needs forced them to once again, display a persona of strength. This was supported by Cheng and Lo (2015), Poleschuck et al. (2014), and Watson-Singleton et al. (2017) as they all argued stigma and being seen as weak were barriers within the African American community. This also aligns with findings from Davis et al., (2015) and Polseschuck et al., (2014) who found in their research that some reasons provided by African American women for discontinuance of therapy services include adverse perceptions of clinician towards the client.

Limitations of the Study

A limitation is that the collection of data was limited to participants self-identified as being African American. There were four others who contacted me with the desire to participate. These individuals were excluded from the study because they did not identify themselves as African American and they had been born outside of the United States, therefore the results may not be transferable to women of color hailing from other areas of the world.

The second limitation of the findings from this study was that this research may not transfer across the African American culture. All participants identified as female. There were no African American men who provided their individual experiences with obtaining counseling services from European Americans. The third limitation was that the results only included women currently residing within the Atlanta metro area.

Because of the limited geographical range in which participants were recruited for the study, results from the study may not be transferable to African American women living in other parts of the United States. The data may not represent the totality of experiences of African American women throughout the United States being that there were only six participants.

The final limitation would be that of researcher bias. While it was my intention to control my bias through the use of bracketing, it is possible that my bias may have influenced the collection of the data and its interpretation. Such bias may exist, as I am an African American woman who has previously received treatment from a European American clinician. Because I have had, while not the same, similar experiences with European American clinicians, my belief and experiences may have influenced the collection of data and findings.

Recommendations for Further Research

In this study, I explored how the endorsement of the SBW schema may have affected African American women's experiences of the therapeutic alliance during clinical mental health treatment with European American clinicians. Despite participants hailing from different areas around the United States, all six participants currently reside within the Atlanta, Georgia. metro area. Based on the narrowed geographic location in which participants were chosen, transferability of the results may not possible. Due to the studies small sample size of participants, it is suggested that a quantitative study be conducted to further examine the experiences of African American women throughout the U.S. as it may aid in the generalizability.

Only the perceptions of African American women were obtained for this study as I have not been able to identify any research that has evaluated their lived experiences in the therapeutic alliance with European American clinicians through the lens of the strong Black woman schema. Experiences of European American clinicians were not obtained to identify their perceptions of how the SBW schema may have hindered the therapeutic alliance. Due to the one-sided nature of the investigation, it could be useful to follow up with a phenomenological study that would include the encounters of European American clinicians to determine if their experience within the therapeutic alliance parallels to that of African American women or if it different. Understanding the perception of the therapist as well as African American women may bridge the disconnect within the therapeutic alliance.

All participants self-identified as being African American. Throughout this research, potential participants declined participation in the research as they stated they did not ascribe to being African American, but viewed themselves as Black, as they hailed from such areas as Virgin Islands, Jamaica, and Africa. Further research evaluating all women of African descent and the therapeutic alliance with European American clinicians may also prove beneficial as it may provide further avenues to explore as women of color hailing from different regions of the world may yield a different perception of what it is to be a SBW and its impact on the therapeutic alliance.

The last two recommendations for future study would be to obtain data based on the complexion of African American women and identifying how the use of metaphors can hinder or aid the therapeutic alliance. This study was based on a diverse sample of

African American women. Within this group there is a broad range of skin complexion that may produce different outcomes. For example, one participant expressed that due to her lighter complexion, she did not experience the racism that other African American women who were of a darker complexion experienced in life. While research in this area may prove to be controversial, there are indications for further study. Understanding this concept can inform practice as African American women of different complexions may maintain different perceptions of an experience.

Within this study it was noted by Hagar that she found the use of metaphors to be racist as the clinician referred to her and all African American women as deer. Upon the use of this metaphor, Hagar identified that she disconnected from the clinician and was unable to receive the help she required. Identifying how the use of metaphors are viewed based on the perception of African American women, whether positively or negatively can inform practice as it relates to the therapeutic alliance.

Implications

The results from this study have strong implications for positive social change. By improving the cultural competency of European American clinicians, this may, in turn, help improve engagement with African American women and thus increase the effectiveness of the therapeutic experiences. African American women may establish better alliances with their clinicians promoting a trusting environment and leading to improved overall outcomes. One such outcome may be an increase in retention rates amongst African American women in therapeutic services. By improving retention, African American women will stay in therapy longer and will reap the benefits to their

own mental health. Stronger, healthier African American women make for a better outcome for themselves, their family, and their community.

Results from this investigation contribute to the existing literature on the therapeutic alliance with African American women. This study demonstrates the need for culturally competent and sensitive professional practices in order to promote therapeutic retention leading to better mental health outcomes for African American women. The findings suggest the need for improved training for European American clinicians in cultural competence and cultural sensitivity. Advocating for policy changes that increase cultural competency and training within clinical practice are strong implication from the findings of this study. By promoting awareness of the need for cultural competency in clinical practices that provide services to diverse populations, it may provide supportive information required for the continuance of cultural competency training.

Conclusion

This study sought to understand the role of the Strong Black Woman schema on the therapeutic alliance between African American Women and European American clinicians. To understand this dynamic, 6 African American women were interviewed about their experiences in therapy. The findings revealed that participants-maintained feelings of discomfort in therapy, participants felt therapists maintained an inability to relate to or understand the culture and life of African American women, there were poor connection and engagement with therapist, and participants-maintained lack of confidence in their therapist. Findings also revealed double sided notions of SBW schema, personal strengths of independence, and that SBW schema hinders the

therapeutic alliance. The first four themes relate to the therapeutic alliance, while the last three focus on the SBW schema. The finding cannot be generalized to all African American women due to the small sample size and the differences in encounters with European American clinicians. This research serves as a call to action to not only further studies surrounding the therapeutic alliance, but also to prepare clinicians to successfully engage and treat African American women, as implications lean toward improved cultural competency of European American clinicians to increase their understanding of the SBW in order to increase retention rates. This research also supports the need for change in practice policy and potentially that of local licensing boards.

References

Ahrnsbak, R., Bose, J., Hedden, S. L., Lipari, R. N., & Park-Lee, E. (2017). Key substubstance use and mental health indicators in the United States: *2016 national survey on drug use and health*. Center For Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/data/

Anderson, K. N., Bautista, C. L., & Hope, D. A. (2019). Therapeutic alliance, cultural competence and minority status in premature termination of psychotherapy. *American Journal of Orthopsychiatry*, *89*(1), 104–114. https://doi.org/10.1037/ort0000342

Anyikwa, V. A. (2015). The intersections of race and gender in help-seeking strategies among a battered sample of low-income African American women. *Journal of Human Behavior in the Social Environment, 25*(8), 948-959. https://doi.org/ 10.1080/10911359.2015.1047075

Bacon, K. L., Stuver, S. O., Cozier, Y. C., Palmer, J. R., Rosenberg, L., & Ruiz-Narvaez, E. A. (2017). Perceived racism and incident diabetes in the Black womans health study. *Diabetologia, 60*(11), 2221-2225. https://doi.org/10.1007/s00125-017-4400-6

Bagić, A. I., Barkley, G. L., Chung, C. K., De Tiege, X., Ebersole, J. S., Funke, M. E., Kyosuke, K., Stefan, R., Douglas, F. R., Southerling, W. W. (2018). Clinical practice guidelines or clinical research guidelines? *Clinical Neurophysiology, 129*(9), 2054-2055. https://doi.org/0.1016/j.clinph.2018.06.015

Balsam, K. F., Molina, Y., Blayney, J. A., Dillworth, T., Zimmerman, L., & Kaysen, D. (2015). Racial/ethnic differences in identity and mental health outcomes among young sexual minority women. *Cultural Diversity and Ethnic Minority Psychology, 21*(3), 380-390. https://doi.org/10.1037/a0038680

Bardol, O., Grot, S., Oh, H., Poulet, E., Zeroug-Vial, H., Brunelin, J., & Leaune, E. (2020). Perceived ethnic discrimination as a risk factor for psychotic symptoms: a systematic review and meta-analysis. *Psychological Medicine*, *50*(7), 1077–1089.

Beech, Ian. (2013). Bracketing in phenomenological research. *Nurse Research, 6*(3), 35-51.

Belgrave, F. Z., & Abrams, J. A. (2016). Reducing disparities and achieving equity in African American women's health. *American Psychologist, 71*(8), 723-733. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=edsgea&AN=edsgcl.480567201&site=eds-live&scope=site.

Bell, D. (1994). Confronting authority: Reflection of an odent protester. *Beacon Press*.

Bell, D. (1995). Who's afraid of critical race theory? *University of Illinoise Law Review, 4*(1), 893-910.

Bell, D. (2008). *Race, racism and American law (6th ed.). Aspen*.

Bell, D. A. (1980). Brown v board of education and the interest convergence dilemma. *Harvard Law Review, 93*(3), 518-533.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open, 2*(1), 8-14.

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative

evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC medical research methodology*, *16*(1), 21. https://doi.org/10.1186/s12874-016-0114-6

Berk-Clar, C., Myerson, J., Green, L., & Grucza, R. A. (2018). Past trauma and future choices: Differences in discounting in low-income, urban African Americans. *Psychological medical, 48*(16), 2702-2709. https://doi.org/10.1017/S0033291718000326

Bordin, E. S. (1979). The generalizablility of the Psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16*(1), 252-260. http://dx.doi.org/10.1037/h0085885

Calabrese, S. K., Meyer, I. H., Overstreet, N. M., Haile, R., & Hansen, N. B. (2015). Exploring discrimination and mental health disparities faced by black sexual minority women using a minority stress framework. *Psychology of Women Quarterly, 39*(3), 287-304. https://doi.org/10.1177/0361684314560730

Ceballo, R., Graham, E. T., & Hart, J. (2015). Silent and infertile: An intersectional analysis of the experiences of socioeconomically diverse African American women with infertility. *Psychology of Women Quarterly, 39*(4), 497-511. https://doi.org/ 10.1177/0361684314560730

Chan, Z. C. Y., Fung, Y., & Chein, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *The Qualitative Report,*

18(59), 1-9. Http://www.nova.edu/ssss/QR/QR18/chan59.pdf

Cheng, T. C., & Lo, C. C. (2015). Racial disparities in intimate partner violence and in seeking help with mental health. *Journal of International Violence, 30(18)*, 3283-3307. Https://doi.org/10.1177088626051455011

Cho, J. Y., & Lee, E. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *The Qualitative Report, 19*(32), 1-20. Complementary Index database (97566331). https://doi.org/10.46743/2160-3715/2014.1028

Clark, K. R., & Vealé, B. L. (2018). Strategies to enhance data collection and analysis in qualitative research. *Radiologic Technology*, *89*(5), 482CT-485CT. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=rzh&AN=129386154&site=eds-live&scope=site.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S. B., Morgan, C., Rüsch, N., Brown, J. S. L., Thornicroft, G. (2015). What is the impact of mental health-related stigma on on help-seeking? A systematic review of quantitative studies. *Psychological Medicine, 45*(1), https://doi.org/10.1017/S0033291714000129

Coley, S. L., de Leon, C. F. M., Ward, E. C., Barnes, L. L., Skarupski, K. A., & Jacobs, E. A. (2017). Perceived discrimination and health-related quality-of-life: gender differences among older African Americans. *Quality of Life Research*, *26*(12), 3449-3458. https://doi.org/10.1007/s11136-017-1663-9

Creswell, J. (1994). *Research design: Qualitative and quantitative approaches.* Sage.

Creswell, J. (2014). *Research design: Qualitative, quantitative, and mixed methods approach.* Sage.

Creswell, J. W. & Poth, C. N. (2017). *Qualitative inquiry research design: Choosing among five approaches* (4th ed.). Sage.

Cuevas, A. G., Obrien, K., & Saha, S. (2016). African American experiences in healthcare: "I always feel like i'm getting skipped over". *Health Psychology, 35*(9), 987-995. https://doi.org/10.1037/hea0000368

Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*, *54*(2), 88-94. https://researchoutput.csu.edu.au/ws/portalfiles/portal/8616637/CSU264363.pdf

Curley, N., & Johnson, C. (2014). Exploring treatment preferences for psychological services after abortion among college students. *Journal of Reproductive and Infant Psychology, 32*(3), 304-320. https://doiorg/10.1080/02646838.2013.879566

Curtis-Boles, H. (2017). Clinical strategies for working with clients of African descent. *Best Practice in Mental Health, 13*(2), 61-72. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=edsgea&AN=edsgcl.582635313&site=eds-live&scope=site

Danzer, G., Rieger, S. M., Schubmehl, S., & Cort, D. (2016). White psychologists and African Americans' historical trauma: Implications for practice. *Journal of*

Aggression, Maltreatment and Trauma, 25(4), 351-370. https://doi-org.ezp.waldenulibrary.org/10.1080/10926771.2016.1153550

Davis, T. A., Ancis, J. R., & Ashby, J. S. (2015). Therapist, effects, working alliance, and African American women substance users. *Cultural Diversity and Ethnic Minority Psychology, 21*(1), 126-135. https://doi.org/10.1037/a0036944

Delgado, R., & Stefanic, J. (2012). *Critical race theory : An introduction (2nd ed.).* Press.

Dellette, A. K., Benjamin, S., & Carpenter, D. (2018). Tweeting the black travel experience: Social media counter narrative stories as innovative insight on #travelingwhileblack. *Journal of Travel Research*, 1-16. https://doi.org/10.1177/0047287518802087

Dixon, A. R., & Telles, E. E. (2017). Skin color and colorism: Global research, concepts, and measurement. Annual Review of Sociology, 43, 405–424. HTTPS://Doi.org/10.1146/annurev-soc-06116-053315

Donavan, R. A., & West, L. M. (2015). Stress and mental health: Moderating role of the strong black woman stereotype. *Journal of Black Psychology, 41*(4), 384-396. https://doi.org/10.1177/0095798414543014

Dörnyei, Z. (2007). *Research methods in applied linguistics: Quantitative, qualitative, and mixed methodologies.* Oxford University Press.

du Plessis, J., & Naude, L. (2017). "Carrying the culture...": ethnic identity development in black African adolescents. *Journal of Psychology in Africa, 27*(2), 159-164. https://doi.org/10.1080/14330237.2017.1303106

Ebede-Ndi, A. (2016). A critical analysis of African-centered psychology: From ism to praxis. *International Journal of Transpersonal Studies, 35*(1), 64-77. http://dx.doi.org/10.24972/ijts.2016.35.1.65

Endale, L. (2018). The multidimensional model of Black identity and nigroscence theory: A philosophical comparison. *Journal of Pan African Studies, 12*(4), 509-524. https://www.semanticscholar.org/paper/The-Multidimensional-Model-of-Black-Identity-and-A-Endale/a4c7e0b9406e7a2b7280c4daf7e66acff301f7f3?p2df

Espino, M. M. (2012). Seeing the "truth" in the stories we tell: The role of critical race epistemology in higher education research. *Journal of the Associationfor the Study of Highe Education 36*(1), 31-67. https://doi.org/10.1353/rhe.2012.0048

Etowa, J. B., Eghan, B. L., & Bernard, W. T. (2017). "You feel you have to be made of steel": The strong Black woman, health, and well-being in Nova Scotia. *Health Care For Women International, 38*(4), 379-393. https://doi.org/10.1080/07399332.2017.1290099

Evans, N. J., Forney, D. S., Guido, G. M., Patton, L. D., & Renn, K. A. (2010). Racial identity development. *Student development college: Theory, research and practice,* 260-261. https://doi.org/10.1037/a0031684

Farooq, M. B., & de Villiers, C. (2017) Telephonic qualitative research interviews: when to consider them and how to do them. *Meditari Accountancy Research, 25*(2), 291-316. https://doi.org/10.1108medar-10-2016-0083.

Fazli, A. I. (2018). Faculty members' experience of student ethical problems: A qualitative research with a phenomenological approach. *Electron J Gen Med, 15*(3), 2-9. https://doi.org/10.29333/ejgm/84952

Freedman, A. A., Cammack, A. L., Temple, J. R., Silver, R. M., Dudley, D. J., Stoll, B. J., Barbara J.; Varner, W., Saade, R., Conway, D., Goldenberg, L., Hogue, J. C. (2017). Maternal exposure to childhood maltreatment and risk of stillbirth. *Annals of Epidemiology, 27*(8), 459-465. https://doi.org/10.1016/j.annepidem.2017.07.005

Fripp, J. A., & Carlson, R. G. (2017). Exploring the influence of attitudes and stigma on Participation of African American and Latino Populations in mental health services. *Journal of Multicultural Counseling & Development,* 45(2), 80-94. https://doi.org/10.1002/jmcd.12066

Fuertes, J. N., Toporovsky, A., Reyes, M., & Osborne, J. B. (2017). The physician-patient working alliance: Theory, research, and future possibilities. *Patient Education and Counseling, 100*(4), 610-615. https://doi.org/10.1016/j.pec.2016.10.018

Gall, M., Borg, W., & Gall, J. (1996). *Education research.* Longman.Gayathri, A. R., Balachandran, D., & Muraleedharan, K. S. (2018). Objectification of African American Women in the bluest eye. *International Journal of Pure and Applied Mathematics*, *119*(12), 2769-2777. https://acadpubl.eu/hub/2018-119-12/articles/7/1812.pdf

Gibbons, F. X., Stock, M. L., O'Hara, R. E., & Gerrard, M. (2016). Prospecting prejudice: An examination of the long-term effects of perceived racial discrimination on the health behavior and health status of African Americans. In *Drug use trajectories among minority youth* (pp. 199-232). Springer, Dordrecht. https://link.springer.com/chapter/10.1007/978-94-017-7491-8_11

Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation.* Sage.

Hahm, H. C., Cook, B. L., Ault-Brutus, A., & Alegria, M. (2015). Intersection of race-ethnicity and gender in depression care: Screening, access, and minimally adequate treatment. *Psychiatric Services, 66*(3), 258-264. https://doi.org/10.1176/appi.ps.201400116

Harris, C. (1993). Whiteness as property. *Harvard Law Review 106(1)*, 1709-1975. https://doi.org/10.2307/1341787

Haskins, N. H., & Singh, A. (2015). Critical race theory and counselor education pedagoy: Creating equitable training. *Counselor Education and Supervision, 54*(4), 288-301. https://doi.org/10.1002/ceas.12027

Hauff, N. J., Fry-McComish, J., & Chiodo, L. M. (2017). Cumulative trauma and partner conflict predict post-traumatic stress disorder in postpartum African American women. *Journal of Clinical Nursing, 26*(15), 2372-2383. https://doi.org/10.1111/jocn.13421

Hayes, C. M., & Casstevens, W. J. (2017). Everyday racism in lack mothers' lives: Implications for Social Work. *Social Work Chronicles, 6*(1), 11-27. https://search-

ebscohostom.ezp.waldenulibrary.org/login.aspx?direct=true&db=edb&AN=1248477011&site=eds-live&scope=site

Hayes, J. A., Owen, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients. *Psychotherapy, 52*(3), 308-314. https://doi.org/10.1037/a0037957

Haynes, T. R. (2019). Dropping the cape of Strength: A phenomenological exploration of black superwomen's lived experiences and perceptions of help-seeking for psychological distress. https://repository.lib.ncsu.edu/bitstream/handle/1840.20/36532/etd.pdf?sequence=1

Holden, K. B., Hernandez, N. D., Wrenn, G. L., & Belton, A. S. (2016). Resilience: Protective factors for depression and post traumatic stress disorder among African American women. *Health, Culture and Society, 9*(10), 1-18. https://doi.org/10.5195/hcs.2017.222

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigor in qualitative case-study research. *Nurse researcher*, *20*(4). https://journals.rcni.com/nurse-researcher/rigour-in-qualitative-casestudy-research-nr2013.03.20.4.12.e326

Howard, T. C., & Navarro, O. (2016). Critical race theory 20 years later: Where do we go from here? *Urban Education, 51*(3), 253-273. http://doi.org/10.1177/0042085915622541

Hudson, D. L., Neighbors, H. W., Geronimus, A. T., & Jackson, J. S. (2016). Racial discrimination, John Henryism, and depression among African Americans.

Journal of Black Psychology, 42(3), 221-243. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4903152/

Hughes, M., Kiecolt, K. J., Keith, V. M., & Demo, D. H. (2015). Racial identity and well-being among African Americans. *Social Psychology Quarterly, 78*(1), 25-48. https://doi.org/10.1177/0190272514554043

Jacoby, S., & Gonzales, P. (1991). The construction of expert-novice in scientific discourse. *Issues in Applied Linguistics, 2*(2), 149-181. Retrieved from https://escholarship.org/uc/item/3fd7z5k4

Janak, E. (2018). Bracketing and bridling: Using narrative reflexivity to confront researcher bias and the impact of social identity in a historical study. *Philanthropy & Education*, *1*(2), 82-93. https://doi.org/10.2979/phileduc.1.2.04

Johnson, A. A., & Quaye, S. J. (2017). Queering Black racial identity development. *Journal of College Student Development, 58*(8), 1135-1148. https://muse-jhu-edu.ezp.waldenulibrary.org/article/678950

Johnson-Hood, P. (2017). Therapeutic alliance between African American clients and European American providers: A phenomenological study. Minneapolis, MN: Walden University. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=4556&context=dissertations

Joint Committee on Health Education Terminology. (2012). Report of the 2011 joint committee on health education and promotion terminology. *American Journal of Health Education, 43(2)*, 1-19. https://doi.org/10.1080/1932503.2012.11008225

Jones, E., Huey, S. J., & Rubenson, M. (2018). Cultural competence in therapy with African Americans. In E. H. Jones, & M. Rubenson, *Cultural Competence in Applied Psychology* (pp. 557-573). Los Angeles, CA: Springer Ineternational Publishing. https://www-proquest-com.ezp.waldenulibrary.org/docview/1696255307?accountid=14872

Jones, E., Huey, S. J., & Rubenson, M. (2018). Cultural competence in therapy with African Americans. *Cultural Compotence in Applied Psychology*, 557-573. https://doi:10.1007/978-3-319-78997-2_22

Kennedy, B. R., & Jenkins, C. C. (2018). African American women and depression: Promoting the need for culturally competent treatment. *BRK Global Healthcare Journal, 2*(1), 1-25. https://doi.org/10.35455/brk123456

Kleinsasser, A. M. (2000). Researchers, reflexivity, and good data: Writing to unlearn. *Theory into practice, 39*(3), 155-162. https://doi:10.1207/s15430421tip3903_6

Kolivoski, K., Addie, W., & Constance-Huggins, M. (2014). Critical race theory: Opportunities for application in social work practice and policy. *The Journal of Contemporary Social Services, 95*(4), 269-276. https://doi.org/10.1606/1044-3894.2014.95.36

Korstjens, I., & Moser, A. (2018). Series: practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Kugelmass, H. (2016). "Sorry, I'm not accepting new patients" An audit study of access to mental health care. *Journal of Health and Social Behavior, 57*(2), 168-183. https://doi.org/10.1177/0022146516647098

Kyngäs, H., Kääriäinen, M., & Elo, S. (2020). The Trustworthiness of Content Analysis. In *The Application of Content Analysis in Nursing Science Research* (pp. 41-48). Springer, Cham. http://dl1.tarjomac.com/nursing-ebooks/TPC202203.pdf#page=45

Landor, A. M., & Barr, A. (2018). Politics of respectability, colorism, and the terms of social exchange in family research. Journal of Family Theory & Review, 10, 330–347. https://doi.org/10.1111/jftr.12264

Landor, A. M., & McNeil Smith, S. (2019). Skin-tone trauma: Historical and contemporary influences on the health and interpersonal outcomes of African Americans. *Perspectives on Psychological Science*, *14*, 797-815. https://doi.org/10.1177%2F1745691619851781

Liao, H., & Hitchcock, J. (2018). Reported credibility techniques in higher education evaluation studies that use qualitative methods: A research synthesis. *Evaluation and Program Planning*, *68*, 157–165. https://doi.org/10.1016/j.evalprogplan.2018.03.005

Lenz, A. S., Dell'Aquila, J., & Balkin, R. S. (2018). Effectiveness of integrated primary and behavioral healthcare. *Journal of Mental Health Counseling, 40*(3), 249-265. https://doi.org/10.17744/mehc.40.3.06

Lishner, D. A. (2015). A concise set of core recommendations to improve the dependability of psychological research. *Review of General Psychology, 19*(1*)*, 52-68. https://doi.org/10.1037/gpr0000028

Luciani, M., Campbell, K., Tschirhart, H., Ausili, D., & Jack, S. M. (2019). How to design a qualitative health research study. Part 1: Design and purposeful sampling considerations. *Professional infermieristiche*, *72*(2), 152-159. https://www.profinf.net/pro3/index.php/IN/article/view/632

Mahmud, R., Kotagiri, R., & Buyya, R. (2018). Fog computing: A taxonomy, survey and future directions. In *Internet of everything* (pp. 103-130). Springer, Singapore. https://arxiv.org/pdf/1611.05539.pdf

Marshall, E. (2016). Counter-storytelling through graphic life writing. *Language Arts, 94(2)*, 79-93. https://www.jstor.org/stable/44809884

Marx, S. (2006). *Revealing the invisible:: Confronting passive racism in teacher education.* Routledge.

Mays, V. M., Jones, A. L., Delany-Brumsey, A., Coles, C., & Cochran, S. D. (2017). Perceived discrimination in health care and mental health/substance abuse treatment among Blacks, Latinos, and Whites. *Medical Care, 55*(2), 173-181. https:// doi.org/10.1097/MLR.0000000000000638

McGee, E. O., & Stovall, D. (2015). Reimaging critical race theory in education: Mental health, healing, and the pathway to liberatory praxis. *Educational Theory, 65*(5), , 491-511. https://doi.org/10.1111/edth.12129

McLeod, Bryce D.; Tully, Carrie B.; Southam-Gerow, Michael A.; Kendall, Philip C.; Jensen-Doss, Amanda; Weisz, John R (2016). The role of setting versus treatment type in alliance within youth therapy. *Journal of counsulting and clinical psychology, 84*(5), 453-464. https://doi.org/10.1037/ccp0000081

McMaster, G., Lum, J., & McCormick, K. (2018). The Entangled Gaze: Indigenous and European Views of Each Other. *ab-Original*, *2*(2), 125-140. https://doi.org/10.5325/aboriginal.2.2.0125

McNarry, G., Allen-Collinson, J., & Evans, A. B. (2019). Reflexivity and bracketing in sociological phenomenological research: researching the competitive swimming lifeworld. *Qualitative Research in Sport, Exercise and Health*, *11*(1), 138-151. https://doi.org/10.1080/2159676X.2018.1506498

Meshberg-Cohen, S., Presseau, C., Thacker, L. R., Hefner, K., & Kvikis, D. (2016). Posttraumatic stress disorder, health problems, and depession among African American women in residential substance use treatment. *Journal of Womens Health, 25*(7), 729-737. https://doi.org/10.1089/jwh.2015.5328

Mills, J. (2005). A critiqe of relational psychoanalysis. *POaychology, 22*(2), 175-193. https://doi.org/10.1037/0736-9735.22.2.155

Moerer-Urdahl, T., & Creswell, C. (2004). Using transcendental phenomenology to explore the "Ripple effect" in a leadership mentoring program. *International Journal of Qualitative Methods, 3*(2), 19-35. https://doi.org/10.1177/160940690400300202

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part

3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*(1), 9-18. https://doi.org/10.1080/13814788.2017.1375091

Moustakas, C. (1994). *Phenomenological research methods.* Sage. https://dx.doi.org/10.4135/9781412995658

Moustakas, C. (2011). *Phenomenological research methods.* Sage.

Mouzon, D. M., Taylor, R. J., Woodward, A. T., & Chatters, L. M. (2017). Everyday racial discrimination, everyday non-racial discrimination, and physical health among African Americans. *Journal of ethnic & cultural diversity in social work*, *26*(1-2), 68-80. https://doi.org/10.1080/15313204.2016.1187103

Nakkeeran, N., & Zodpey, S. P. (2012). Qualitative research in applied situations: Strategies to ensure rigor and validity. *Indian journal of public health*, *56*(1), 4. https://doi.org/10.4103/0019-557X.96949

National Alliance on Mental Health. (2018). African American Mental Health. https://www.nami.org/Find-Support/Diverse-Communities/African American-Mental-Health

Nelson, T., Cardemil, E. V., & Adeoye, C. T. (2016). Rethinking strength: Black women's perceptions of the "Strong Black Woman" role. *Psychology of Women Quarterly, 40*(4), 551-563. https:// DOI: 10.1177/0361684316646716

Nguyen, A. W. (2018). African American elders, mental health, and role of the church. *Generations, 42*(2), 61-67.

Nijenhuis, E. R., & Van der Hart, O. (2011). Dissociation in trauma: A new definition and comparison with previous formulations. *Joural of Trauma & Dissociation, 12*(4), 416-445. https://doiorg/10.1080/15299732.2011.570592

Niolon, P. H., & Center for Disease Control and Prevention (2017). Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices. *Goverment Printing Office*, 1-64. https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

Onwuegbuzi, A., & Leech, N. (2005). On becoming a pragmatic researcher: The importance of
combining quantitative and qualitative research methodologies. *International Journal of Social Research Methodology, 8*(5), 375-387. https://doi.org/10.1080/13645570500402447

Oshin, L. A., & Milan, S. (2019). My strong, Black daughter: Racial/ethnic differences in the attributes mother's value for their daughters. *Cultural Diversity and Ethnic Minority Psychology, 25*(2), 179-187. https://doi.org/10.1037/cdp0000206.

Parás-Bravo, P., Paz-Zulueta, M., Santibañez, M., Fernández-de-las-Peñas, C., Herrero-Montes, M., Caso-Álvarez, V., & Palacios-Ceña, D. (2018). Living with a peripherally inserted central catheter: the perspective of cancer outpatients—a qualitative study. *Supportive Care in Cancer*, *26*(2), 441-449. https://doi.org/10.1007/s00520-017-3815-4

Percival, J., Donovan, J., Kessler, D., & Turner, K. (2017). "She believed in me". What patients with depression value in their relationship with practitoners. A second

analysis of multiple qualitative data sets. *Health Expectations, 20*(1), 85-97. https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12436

Poleschuck, E. L., Cerrito, B., Leshoure, N., Finocan-Kaag, & Kearney, M. (2014). Underserved women in a women's health clinic describe their experiences of depressive symptoms and why they have low uptake of psychotherapy. *Community Mental Health, 49*(1), 50-60. https://doi:10.1007/s10597-012-9500-7

Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries, W. L. (2016). The impact of racism on the sexual and reproductive health of African American women. *Journal of Womens Health, 25(7)*, 664-671. https://doi.org/10.1089/jwh.2015.5637

Quinn, C. R., & Grumbach, G. (2015). Critical race theory and the limits of relational theory in social work with women. *Journal of Ethnic and Cultural Diversity in Social Work, 24*(3), 202-218. https://doi:10.1080/15313204.2015.1062673

Rahman, M. S. (2017). The Advantages and Disadvantages of Using Qualitative and Quantitative Approaches and Methods in Language" Testing and Assessment" Research: A Literature Review. *Journal of Education and Learning*, *6*(1), 102-112.

Ravitch, S. M., & Mittenfielder Carl, N. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Thousand Oaks, CA: Sage.

Resko, S. M., Brown, S., Mendoza, N. S., Crosby, S., & Gonzalez-Prendes, A. (2016). Perceived treatment needs among women with co-occurring substance use disorders and PTSD. *Journal of dual diagnosis, 12*(3-4), 271-281. https://doi.org/10.1080/15504263.2016.1248309

Sadeghian, S., Rahimnia, F., Shirazi, A., & Kaffashpoor, A. (2018). Investigating the Effect of

Prosocial Voice on Psychological Empowerment of Employees. *European Journal of Sustainable Development*, *7*(2), 191-191. http://ecsdev.org/ojs/index.php/ejsd/article/view/652

SAMHSA. 2020. *2018 National survey on drug use and health: African American.* Rockville, MD: US Department of Health and Human Services. Retrieved from http://www.samhsa.gov/data/

SAMHSA. 2020. *Racial ethnic differences in mental health service use among adults.* Rockville, MD: Health and Human Services, SMA-15-4906. Retrieved from http://www.samhsa.gov/data/

Sibrava, N. J., Bjornsson, A. S., Pérez Benítez, A. C. I., Moitra, E., Weisberg, R. B., & Keller, M. B. (2019). Posttraumatic stress disorder in African American and Latinx adults: Clinical course and the role of racial and ethnic discrimination. *The American Psychologist*, *74*(1), 101–116. https://doi.org/10.1037/amp0000339

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: lessons from low-and middle-income countries. *Annual review of clinical psychology*, *13*, 149-181..org/10.1146/annurev-clinpsy-032816-045217.

Sklet, S. (2006). Safety barriers: Definition, classification, and performance. *Journal of Loss Prevention in the Process Industries, 19*(5), 494-506. https://doi.org/10.1016/j.jlp.2005.12.004.

Slade, J. L., Holt, C. L., Bowie, J., Scheirer, M. A., Toussaint, E., & Saunders, D. R. (2018). Recruitment of African American churches to particpate in cancer early detection interventions: A community perspective. *Journal of Religion and Health, 57*(2), 751-761. https://doi.org/10.1007/s10943-018-0586-2.

Smith, B., & McGannon, K. R. (2018). Developing rigor in qualitative research: Problems and opportunities within sport and exercise psychology. *International review of sport and exercise psychology*, *11*(1), 101-121. https://doi.org/10.1080/1750984X.2017.1317357

Smith, M. L. (1987). Publishing qualitative research. *American Educational Research Journal, 24*(2), 173-183. https://doi.org/10.3102/00028312024002173

Smith, T. (2019, August 10). Qualitative and quantitative research. Salem Press Encyclopedia. https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=ers&AN=89164394&site=eds-live&scope=site

Smith, T. B., & Trible, J. E. (2016). Participation of clients of color in mental health services: A meta-analysis of treatment attendance and treatment completion/attrition. In T. B. Smith, & J. E. Trible, *Foundations of multicultural psychology: Research to inform effective practice* (pp. 95-114). Washington, DC: American Psychological Association. https://doi.org/10.1037/14733-005

Solorzano, D., & Yosso, T. J. (2001). Critical race and LatCrit theory and method : Counter storytelling Chicana and Chicano graduated school experience.

International Journal of Qualitative Studies in Education, 4(1), 471-495. https://doi.org/10.1080/0951839011006336

Sommen, C., Saboni, L., Sauvage, C., Alexandre, A., Lot, F., Barin, F., & Velter, A. (2018). Time location sampling in men who have sex with men in the HIV context: the importance of taking into account sampling weights and frequency of venue attendance. *Epidemiology & Infection*, *146*(7), 913-919. https://doi.org/10.1017/S0950268818000675

Sorsa, M. A., Kiikkala, I., & Åstedt-Kurki, P. (2015). Bracketing as a skill in conducting unstructured qualitative interviews. *Nurse Researcher*, *22*(4), 8–12. https://doi.org/10.7748/nr.22.4.8.e1317

Stockman, J. K., Hayashi, H., & Campbell, J. C. (2015). Intimate partner violence and its health impact on ethnic minority women. *Journal of Women's Health, 24(1)*, 62-79. https://doi.org/10.1089/jwh.2014.4879

Sue, D. W. (2015). Therapeutic harm and cultural oppression. *The Counseling Psychologist, 43*(3), 359-369. https://doi.org/10.1177/0011000014565713

Sullivan, J. M., & Platenburg, G. N. (2017). From black-ish to blackness: An analysis of Black information sources' influence on Black identity development. *Journal of Black Studies, 48*(3), 215-234. https://doi.org/10.1177/0021934716685845

Taha, F., Zhang, H., Snead, K., Jones, A. D., Blackmon, B., Bryant, R. J., . . . Kaslow, N. J. (2015). Effects of a culturally informed intervention on abused, suicidal African American women. *Cultural Diversity and Ethnic Minority Psychology, 21*(4), 560-570. https://doi.org/10.1037/cdp0000018

Taylor, E., Gillborn, D., & Landson-Billings, G. (2009). *Foundations fo critical race theory in education.* Rutledge.

Temple, J., Miller, M. M., Banford Witting, A., & Kim, A. B. (2017). “We walk on eggshells”:

A phenomenological inquiry of wives’ experiences of living with active-duty Marine husbands with PTSD. *Journal of Family Social Work*, *20*(2), 162-181. https://doi.org/10.1080/10522158.2017.1279579

Terrell, F., & Terrell, S. (1981). An inventory to measure cultural mistrust among Blacks. *The Western Jouirnal of Black Studies, 5*(1), 180-185.

U.S. Department of Health and Human Services Office of Minority Health. (2019). *Mental and behavioral health - African Americans*. Retrieved from HHS.gov: https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24

Van Manen, M. (2016). *Researching lived experience: Hunan science for an action sensitive pedagogy.* Rutledge.

Vargas, S. M., Huey, S. J., Jr., & Miranda, J. (2020). A critical review of current evidence on multiple types of discrimination and mental health. *American Journal of Orthopsychiatry*, *90*(3), 374–390. https://doi.org/10.1037/ort0000441

Verissimo, A. D., & Grella, C. E. (2017). Influence of gender and race/ethnicity on perceived barriers to help-seeking for alcohol or drug problems. *Journal of Substance Abuse Treatment, 75*(1), 54-61. https://doi.org/10.1016/j.jsat.2016.12.013

Wainryb, C. (1991). Understanding differences in moral judgments: The role of informational assumptions. *Child Development, 62(4)*, 840-851. https://doi.org/10.2307/1131181

Warner, K. B., Cunningham-Williams, R. M., Sewell, W., Agrawal, A., McCutcheon, V. V., Waldron, M., & Bucholz, K. K. (2018). The impact of traumatic experiences on risky sexual behaviors in Black and White young adult women. *Women's Health Issues, 28*(5), 421-429. https://doi.org/10.1016/j.whi.2018.04.011

Watson, N. N., & Hunter, C. D. (2015). Anxiety and depression among African American women: The cost of strength and negative attitudes toward psychological help-seeking. *Cultural Diversity and Ethnic Minority Psychology, 21*(4), 604-612. https://doi.org/10.1037/cdp0000015

Watson, N. N., & Hunter, C. D. (2016). "I had to be strong" tensions in the strong black woman schema. *Journal of Black Psychology, 42(5)*, 424-452. .org/10.1177/0095798415597093

Watson-Singleton, N. N., Okunoren, O., LoParok, D. H., & Hunter C. D. (2017). Emotional benefits and barriers of psychological services scale: Initial construction and validation among African American women. *Journal of Counseling Psychology, 64*(6), 684-695.

Weist, M. D., Kinney, L., Taylor, L. K., Pollitt-Hill, J., Bryant, Y., Anthony, L., & Wilkerson, J. (2014). African American and White women's experiences of sexual assault and services for sexual assault. *Journal of Aggression Maltreatment and*

Trama, 23(9), 901-916. Retrieved from https://doi.org/10.1080/10926771.2014.953715

Werner, K. B., Sartor, C. E., Mc Cutcheon, V. V., Grant, J. D., Nelson, E. C., Heath, A. C., & Bucholz, K. K. (2016). Association of specific traumatic experiences with alcohol initiation and transitions to broblem use in European American and African American women. *Alcoholism: Clinical and Experimental Research, 40*(11), 2401-2408. https://doi.org/10.1111/acer.13220

Wertz, F. J. (2005). Phenomenological Research Methods for Counseling Psychology. *Journal of Counseling Psychology, 52(2)*, 167-177.

Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African AMericans. *Professional Psychology: Researc and Practice, 32*(1), 555-562.

Wharton, T., Watkins, D. C., Mitchell, J., & Kales, H. (2018). Older, church-going African Americans' attitudes and expectations about formal depression care. *Research on Aging, 40*(1), 3-26. https://doi.org/10.1177/0164027516675666

Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative health Research, 11*(1), 522-537. https://doi.org/10.1177/104973201129119299

Williams, M., Malcoun, E., Sawyer, B., Davis, D., Nouri, L., & Bruce, S. (2014). Cultural adaptations of prolonged exposure therapy for treatment and prevention of post-traumatic stress disorder in African Americans. *Behavioral Sciences), 4*(2), 102-124. https://doi.org/10.3390/bs4020102

Wing, A. K. (2016). Is there a future for critical race theory. *J. Legal Education, 66(44)*, 44-54. https://heinonline.org/HOL/LandingPage?handle=hein.journals/jled66&div=9&id=&page=

Woodley, X. M., & Lockard, M. (2016). Womanism and snowball sampling: Engaging marginalized populations in holistic research. *The Qualitative Report*, *21*(2), 321-329. https://nsuworks.nova.edu/tqr/vol21/iss2/9/

Woods, S. (2019). Commentary 1: The role of ethical reflexivity in conducting ethically challenging qualitative research. *Journal of Empirical Research on Human Research Ethics*, *14*(5), 462–465. https://doi.org/10.1177/1556264619857856a

Woronchak, M., & Comeau, G. (2016). The value of reflective journaling with advanced piano students. *Reflective Practice*, *17*(6), 792–805. https://doi.org/10.1080/14623943.2016.1220937

Woods-Giscombé, C. L. (2010). Superwoman schema: African American women's views on stress, strength, and health. *Qual Health Res,* 20(5), 668-683. https://doi.org/10.1177/1049732310361892

Wu, I. H., Bathje, G. J., Kalibatseva, Z., Sung, D., Leong, F. T., & Collins-Eaglin, J. (2017). Stigma, mental health, and counseling service use: A person-centered approach to mental health stigma profiles. *Psychological services, 14*(4), 490. https://doi.org/10.1037/ser0000165

Wu, L. T., Zhu, H., & Swartz, M. S. (2016). Treatment utilization among persons with opioid use disorder in the United States. *Drug and Alcohol Department, 169*(1), 117-127. https://doi.org/10.1016/j.drugalcdep.2016.10.015

Zauszniewski, J. A., Picot, S. J., F., Debanne, S.M., Roberts, B. L. et al. (2002). Psychometric characteristics of the Depressive Cognition Scale in African American women. *Journal of Nursing Measurement, 10,* 83-95. https://doi.org/10.1891/jnum.10.2.83.52557

Appendix A: Flyer

Attention: All African American Women

Q: Are you an African American woman between the ages of 21 and 65?
Q: Have you ever received therapeutic services from a European-American clinician?
Q: Have you been discharged from therapy and no longer receiving therapeutic services?

If your response to all these questions is yes, you are invited to partake in an academic research study. This study is being conducted to allow your voice to be heard while adding to knowledge to the field of clinical social work. A token of appreciation will be presented in the form of a $10 Amazon gift card to all participants chosen for the study upon completion of their research task. **This study is being conducted by a doctoral student as a part of a dissertation at Walden University in the Barbara Solomon School of Social Work.** If interested, form more information please contact Tonia Nixon at 404-247-6259 or email at tonia.nixon@waldenu.edu. IRB approval #08-18-20-0577689

Appendix B: Demographic Checklist

Name ____

Participant pseudonym ____________________________________

Email Address: ______________________ Phone Number_________________

Race/Ethnicity:

________ African American/Black

________ Black/Other: ____________________________________

Age _________________________

Therapeutic Services

Were you released/discharged from therapeutic services _____Yes _____No

Current level of psychological distress _______Mild _____Moderate _____Severe

Appendix C: Interview Protocol

Thank you for taking the time out of your busy schedule to participate in this study My name is Tonia Nixon and I am a doctoral candidate with Walden University. This research is being completed to fill the requirements of my degree but, it is a topic of great importance and passion for me. I am researching the view of African American women regarding their therapeutic experiences with European American clinicians. I will do my best not to take up too much of your time. This interview will likely take approximately 60 minutes, give or take a few minutes. Are you ok with the amount of time you have in case we run over a few extra minutes if needed? Ok, thank you for that feedback. I will do my best to be timely. I am going to ask you a few questions and I ask you to respond to the best of your ability. If there is a question you do not understand, please do not hesitate to let me know and I will rephrase it for you. If any of the questions make you uncomfortable for any reason, let me know and I will stop the questions. I will end the session at any time at your request. I will have a list of telephone numbers accessible to you that you can call at your convenience, allowing you to reach a crisis line or further counseling, should you feel that is needed. Do you have any questions for me? Ok, lets begin.

RQ: What are the lived experiences of the therapeutic alliance of African American women who receive mental health treatment from European American clinicians?

Interview Protocol:

I. Please describe your general experience in therapy with your counselor?

II. Please discuss your comfort level and confidence in your therapist's ability to assist you with your problems?

III. Please describe your ability to connect with your therapist.

IV. Describe how you think your clinician understands you in terms of your culture, background, and being a black woman.

V. Do you feel that your clinician had a strong, moderate, or weak understanding of your culture and how it relates to your experiences and therapy? Please explain your answer.

VI. How do you relate to the strong black woman persona and do you think the strong black woman persona and what are your perceptions about SBW?

VII. Please tell me how your idea of a strong black woman may or may not hinder the therapeutic alliance.