

2017

Therapeutic Alliance Between African American Clients and European American Providers: A Phenomenological Study

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Walden University

College of Social and Behavioral Sciences

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Pamela Johnson-Hood

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Walden University
2017

Abstract

Therapeutic Alliance Between African American Clients and European American
Providers: A Phenomenological Study

by

Pamela Johnson-Hood

MPH, Yale University, 1997

BA, California State University, Los Angeles, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

February 2017

Abstract

African Americans do not seek mental health help at the same rate, as do European Americans; furthermore, African Americans who do seek help tend to leave therapy prematurely. A poor therapeutic alliance between African American clients and European American clinicians may be one reason that African Americans do not seek therapy or leave prematurely. The purpose of this phenomenological study was to understand the lived experience of African American clients in therapeutic relationship with European American clinicians. Rogers' theory of therapeutic alliance, which included empathy as a key concept, served as the conceptual framework of this study. Through purposeful sampling methodology, 10 participants were invited to participate, based on self-report of being African American and having had therapy with a European American clinician. Participants were interviewed regarding their lived experiences in therapy with a European American clinician. Interviews were recorded, transcribed, and analyzed using thematic analysis. There were 13 thematic findings. Findings revealed that more participants reported positive experiences in therapy than did participants who reported negative experiences. Empathy, therapeutic alliance, and trust were key factors to positive outcomes. Knowing and implementing what factors lead to positive alliance has valuable social change implications for European American clinicians and their African American patients. Clinicians should be trained in the importance of empathy, therapeutic alliance, and trust, especially when working in mixed racial therapeutic dyads.

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Dedication

This study is dedicated to the countless members of African American communities across the United States of America, both present and past, who have endured psychological harm, without the promise of receiving appropriate mental health care. Help has arrived!

Acknowledgments

First, I give honor to Jesus, my Lord and Savior, who would not let me give up on my dream, to serve others as a doctor of clinical psychology. Second, I would be remiss if I did not speak of the unwavering devotion, support and kindness of my husband, Terrell, who undergirds me with his great love, and our four bright and beautiful children, Felicia, Terrell, II, Justice and Jillian, without whom I might not have maintained my joy and sanity (smile). To my beloved mother, Elaine, who is cheering from heaven, thank you for teaching me that “I can do anything, that I put my brilliant mind to!”

I would also like to say thank you to my faculty members. To My Chair, Dr. Rachel Piferi, who believed in me from the start, my committee member, Dr. Yoly Zentella, who believed in the importance of my study and also my external reviewer, Dr. Martha Giles, each who persisted with me until this valuable research and manuscript had come to fruition.

I want to give thanks for each individual that prayed for me, said an encouraging word or otherwise inspired me along my doctoral journey. A special mention of gratitude to (Drs.) Woolford, Key, French and Stephens, who lent support and guidance along the way, as well as all of the courageous individuals that agreed to participate in my study – I am grateful, indeed! For those who follow in the pursuit of academic excellence and achievement, I say “I have stayed the course and finished my race, be inspired to do the same!”

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Chapter 1: Introduction to the Study

Mental health practitioners understand that therapeutic alliance is a key factor in positive therapeutic outcomes (Webb, DeRubeis, & Barber, 2010). The American Psychological Association established therapeutic alliance and empathy as cornerstones to effective and essential treatment (as cited in Moyers & Miller, 2013; as cited in Norcross & Wampold, 2011). Yet, perceiving empathy from a therapist who represents the larger apathetic society may prove difficult for an African American patient. Several challenges exist in this racial therapeutic dyad that can prevent a therapeutic alliance from forming or continuing, once formed (Brown, Blackmon, Schumacher, & Urbanski, 2012; Carr & West, 2013; Gurpinar-Morgan, Murray, & Beck, 2014; Walling, Suvak, Howard, Taft, & Murphy, 2012). African Americans remain overburdened and underserved in receiving appropriate mental health care. Clarity as to what factors help create successful therapeutic outcomes in this racial dyad has not been well represented in literature, and therefore presents a gap in knowledge (Brown et al., 2012; Carr & West, 2013; Gurpinar-Morgan et al., 2014; Walling et al., 2012). Gaining a better understanding of the factors that can create a better therapeutic alliance between these two racially and culturally different communities can lead to better treatment amongst African American clients in the future. Stakeholders need to find what this population of clients needs to assist them in feeling more connected with their European American counselors.

Some may believe that racism and racial tensions in the United States do not occur in present U.S. society, yet it continues to persevere. Historically, slavery, a system of elitism and ownership, was the beginning of racism, followed by 100 years of

disregard for the civil and human rights of free African Americans (R. Clark, Anderson, Clark, & Williams, 1999). Racism and discrimination are associated with creating mental health pathology (Bynum, Burton, & Best, 2007; R. Clark et al., 1999; U.S. Department of Health and Human Services, 2001). This finding underscores the harm that hateful words and actions can do. Likewise it further demonstrates why African Americans may deal with more depression, suicide ideations and attempts. And further illustrates why African Americans may seek mental health help.

While some institutional and social inequalities between African Americans and European Americans have been addressed; yet, due to the lived experiences of many African Americans, tensions still persist. African Americans still experience racial discrimination. One example is the assassination of young African American men, in cities across the United States, by European American citizens and police officers, resulting in further tension and mistrust (*The New York Times*, 2014a). These assassinations often occur without cause and without penalty (*The New York Times*, 2014a). The recent outcry of the African American community and a host of other races have drawn attention to the violence against African Americans from European American private citizens and police offices (*The New York Times*, 2014b). As a result of negative actions of some ill-intentioned European Americans, cultural mistrust continues to be a factor in the lived experiences of numerous African American citizens within the United States. These feelings of mistrust often extend into the therapeutic relationship with European American therapists.

Cultural mistrust is defined as the distrust that African Americans have against European Americans (Watkins, Terrell, Miller, & Terrell, 1989). Cultural mistrust is not only present in the society, but also in the therapeutic room (Brown et al., 2012; Hollar, 2001; Nicolaidis, 2010; Torres, Driscoll, & Burrow, 2010; M. T. Williams et al., 2014). A host of challenges can affect the doctor–patient, therapeutic cross-cultural relationship, such as client expectations regarding the clinician’s credibility, cultural values, interpretation of their problem, and overall ability to connect with them (Chang & Yoon, 2011). Race is a key matter in the therapeutic relationship (Johnson & Caldwell, 2011). Thus, some have suggested that placing minority clients with minority providers is the best solution (Cabral & Smith, 2011). However, this solution is not always practical, given the underrepresentation of minority clinicians in the field of mental health (American Psychological Association [APA], 2013).

The issue of racial matching is controversial between clinician and client in mental health therapeutic relationships (Horst et al., 2012). Sterling, Gottheil, Weinstein and Serota (2001) found no significant effects in racial pairing of clients and clinicians in an outpatient addiction study of 100 participants. In contrast, Farsimaden, Draghi-Lorenz, and Ellis (2007) unearthed differences in therapeutic alliances, retention rates, and feelings of connection when the therapist and patient shared a similar racial background. Farsimaden et al. paired about half (55) of racial minority patients with racial-minority clinicians; they paired the other half with European American clinicians. The credibility of providers was greater when researchers introduced racial matching (Farsimaden, 2007). Chang and Berk (2009) noted half of their participant pool was unsatisfied in

nonmatching racial dyads. Ethnic minority clients expressed dissatisfaction because of their perceptions of European American providers as lacking knowledge about their culture, power/privilege, racism, and stigma. Similarly, Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) found that satisfaction was higher when they matched ethnic minorities with an African American provider, partly because African American providers routinely addressed ethnicity when it was a part of the current issue being addressed in therapy. This alignment positively affected the therapeutic outcome.

In a therapeutic relationship, culture may be more important than race. Horst (2012) claims that a provider's qualities are more vital than their ethnic origin. However, racial matching can extend understanding and the provider's awareness of culture. Horst et al. (2012) found that the clinicians' cultural awareness and ability to competently treat clients was important to matching. Race was not a significant factor in their study; rather, a significant factor was the clinician's awareness of how culture can impact the couple and individual (Horst, 2012). Thus, it is the therapist's multicultural skills and knowledge that were most significant when it comes to providing care that is effective with African American clients (Horst et al., 2012).

Culture and racial issues could block therapeutic alliance between people of different racial backgrounds, because it holds the potential to cloud perceptions of each other in relation to the other (Johnson & Caldwell, 2011; Laszloffy, 2000). Johnson and Caldwell (2011) looked at how similarities and dissimilarities between clinicians and patients (including race) and confidence in the clinician's ability relate to satisfaction. However, of 233 therapist-patient dyads, only two had African American clinician and

patient dyads. The rest were predominantly European American clinician–European American patient dyads. Thus, Johnson and Caldwell found no significant difference in race and determined that ethnicity was not an issue. Given the low number of ethnic therapist and client dyads, race was not the principle factor examined. However, when clients perceived that their therapist was confident, satisfaction was significantly higher, regardless of gender or race (Johnson & Caldwell, 2011).

African American clients must be understood as individuals as well as in relation to their shared experiences with the sociopolitical and sociocultural realms that help to shape their worldviews. Awareness of their environment and placement in the larger ethnocentric culture remains as important to know about as the person in the therapeutic context (Morris, 2000a). Certain assumptions are conceived from particular cultural views. Thus, when individuals use their knowledge base to understand the world, they do so from their worldview or culture-influenced perspective (Ibrahim, Roysircar-Sodowsky, & Ohnishi, 2001). Counselors who intend to help African American individuals, families, and communities must do so from the African Americans' worldview and not their own. Thus, therapists must do more than check biases before entering the therapeutic session; they must also learn about the African American culture and seek to see the African American client in the culture that inspires and influences them.

Although various reasons may exist for the therapeutic disconnection, many African Americans remain overburdened by depression, anxiety, and a host of other mental health issues (M.T. Williams et al., 2014). Thus, the ongoing search for factors that can improve the therapeutic alliance between this racial dyad continues to be an

important quest. This gap in knowledge has left many in the counseling field unable to discern practical ways to foster therapeutic alliance with their African American clients. Many African Americans abort counseling sessions prematurely and do not receive the help once sought (Westra, Constantino, & Aviram, 2011). The social implication for the clinician is a desire to help his or her African American clients but not having clear understanding and guidelines to optimize the relationship for the good of the client (Chang & Berk, 2009; M. T. Williams et al., 2014). In this study, I explored what African Americans think about the therapeutic process by inquiring into their lived experience to determine if there were any factors that cause therapeutic alliances to successfully form between an African American and European American therapeutic dyad.

In this chapter, I describe the introduction and background to the problem, problem statement, purpose of study, and the research questions. The preview of the conceptual framework, nature of the study, pertinent definitions, assumptions, scope and delimitations, limitations, and significance of this study will also be reviewed. A conclusion summary concludes this chapter.

Background of the Study

Getting treatment for mental health issues is important (National Institute of Mental Health [NIMH], 2013). African Americans are more likely to experience mental health issues like depression, suicide ideation, and suicide attempts than their non-African American counterparts. However, they are less likely to seek care (Villatoro & Aneshensel, 2014). African American men and women were less than half as likely as

European Americans to receive mental health treatment or counseling (Villatoro & Aneshensel, 2014).

When African Americans do seek help, they are more likely to prematurely abort sessions, largely, in part, due to alliance ruptures between themselves and their provider (Westra et al., 2011). Therapeutic alliance is linked with successful therapy outcomes. However, if a therapeutic alliance is never established or ruptures are never repaired in this racial dyad, many African American patients will continue to be inappropriately served or underserved. Researchers have not revealed what factors contribute to a successful therapeutic alliance between African American clients and European American clinicians, therefore revealing an empirical research gap in knowledge (Brown et al., 2012; Carr & West, 2013; Gurpinar-Morgan et al., 2014; Walling et al., 2011).

Person-centered therapy has three components: congruence, empathetic understanding, and unconditional acceptance of the client (Quinn, 2012). These three factors have the ability to create a therapeutic atmosphere and bond between the therapist and the client. The culturally competent clinician will have an awareness of the client's experience as a culturally different person, an awareness of the counselor's assumptions, and culturally appropriate therapeutic interventions and skills (Sue, 1992; Sue, Arredondo, & McDavis, 1992). These attributes are necessary to move beyond theory into immersion of a different culture (Quinn, 2012).

Quinn (2012) found that the culturally competent therapist has empathy, multicultural knowledge, and consistent awareness. When European American counselors employ empathy in therapy with African American clients, positive change

will result (Quinn, 2012). A client's satisfaction to positive regard and trust in the clinician, demonstrates multicultural competency (Quinn, 2012). When the patient perceives that the counselor is empathetic toward him or her, satisfaction levels are highest. Therefore, therapeutic alliance is key to positive therapeutic outcomes (Webb et al., 2010).

In seeking help for mental health issues, many African Americans, must, for economic reasons, or choose to, due to cultural mistrust, wait until the problem is exacerbated and a visit to the emergency room or state psychiatric facility becomes the only feasible remedy (Rosen, Miller, Nakash, Halpern, & Alegría, 2012). The wait times to see a doctor in the emergency room between 1998 and 2000 were 29.5 minutes for European American and 54.2 minutes for African Americans. Between 2008 and 2010, European Americans waited on average 49.7 minutes and African Americans waited 67.7 minutes to see a doctor in emergency rooms across the United States (Centers for Disease Control and Prevention, n.d.). These statistics highlight the disparities and inequalities that exist for African Americans in accessing and receiving proper mental and health care when compared to their European American cohorts (U.S. Department of Health and Human Services, 2001).

More people are seeking and receiving treatment for depression than in previous years (65.6% in 2005 and 71% in 2008 (NIMH, 2007). However, European Americans are more likely to be diagnosed with major depressive disorder than members of other groups (NIMH, 2007). Yet, African Americans are 56.5% more likely to suffer from more prolonged expressions of this disorder and are less likely to be treated than their

European American counterparts (NIMH, 2007). It is necessary to garner greater understanding of the factors that inhibit and foster successful treatment among African Americans.

A negative perception surrounds seeking mental health help in the general U.S. population, and in particular, the African American community (Rosen et al., 2012). This sensitivity has formed, in large part, through a historical lens of slavery and racism. Historical experiences have influenced and inspired a culture of mistrust (Benkert, Peters, Clark, & Keves-Foster, 2006) and created a need, when providing mental health to people of color, to regard how a person perceives him or herself in relation to racial identity, as this may prove important to acknowledge when attempting to provide care (Benkert et al., 2006; Cardemil & Battle, 2003; Terrell & Terrell, 1981; Townes, Chavez-Korell, & Cunningham, 2009).

Racial matching has ties to therapeutic alliance and positive outcomes due to similar understandings of culture and lived experiences (Atkinson, Bui, & Mori, 2001; Owen, Imel, Adelson, & Rodolfa, 2012). These similarities help therapists and clients establish connectedness and foster positive therapeutic outcomes, such as completing the number of recommended sessions and patients indicating treatment was a success. Because few people of color enter the mental health field, particularly at the doctorate level, patients of African American descent will likely receive treatment from European American providers (APA, 2013). According to demographic characteristics of APA members by membership status, African Americans at the doctoral level account for only 1.5% of the total body of providers (APA, 2013). European Americans, in contrast, at the

doctoral level account for over 59% of clinical providers (APA, 2013). Yet, if clinicians lack proper multicultural education and field training, African American clients may not receive appropriate care (Owen et al., 2012).

A disparity exists in mental health services in the United States, and in particular for African Americans (U.S. Department of Health and Human Services, 2001). The current training module does not meet the needs of many minorities, in particular, African American citizens (Ancis & Sanchez-Hucles, 2000; Morris, 2000b). With less than 2% of doctoral-level mental health clinicians who are African American, the need exists to examine and uncover the factors that do lead to successful therapeutic alliances between this racial dyad of African Americans and European Americans (APA, 2013). Uncovering the factors that lead to successful alliance between this racial dyad is important to address because African American clients will most likely choose to remain in therapy when therapeutic alliance is achieved.

Problem Statement

African Americans often report dissatisfaction with therapeutic care and terminate their therapy with European American providers due to this dissatisfaction (Owen et al., 2011; Rosen et al.; Westra et al., 2011). Furthermore, researchers have not uncovered what factors contribute to a successful therapeutic alliance between African American clients and European American clinicians, therefore exposing an empirical research gap (Rosen et al., 2012; Westra et al., 2011). Due to the importance of the therapeutic alliance to success in therapy, not knowing what makes for a successful alliance may be problematic for many European American clinicians who are well intentioned and seek to

provide care to this underserved population. Instead of providing care that helps, a lack of cultural competency can leave the African American client overburdened with mental health issues that might have been addressed, had appropriate culturally competent care been initiated (Constantine & Sue, 2005; Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011).

Purpose of the Study

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African American clients think about their lived experiences and to identify elements of a good alliance. Through a purposeful sampling methodology, I invited 10 participants to participate in the study, based on their self-report of being African American and having had therapy with a European American clinician. I interviewed participants regarding their lived experiences in therapy and their perceptions of a therapeutic alliance or connectedness with a European American clinician. The interviews were recorded, transcribed, and analyzed using thematic analysis (Braun & Clarke, 2006)

Research Questions

The following research questions were used for this study:

Research Question 1: What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician?

Research Question 2: From the perspective of African American clients, what was the most satisfying aspect of treatment with a European American clinician?

Research Question 3: From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider?

Research Question 4: Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

Conceptual Framework

Empathy is a key component of therapeutic alliance. In order to have a therapeutic relationship, it is imperative to employ empathy. Thus, empathy is the part of therapeutic alliance that I was interested in because of the numerous ways that factors like racism and discrimination are experienced by many African Americans and how they come into play when we consider issues that might effect therapeutic alliance between this racial dyad in therapy.

Empathy provided the conceptual lens for this qualitative study on therapeutic alliance between African American clients and European American providers. Thus, the conceptual framework for this study was based on the empathy concept from Rogers's person-centered therapy (Rogers, 1959, 1975). The empathy concept model centers on (a) genuineness or realness; (b) unconditional positive regard, which creates a climate for change and acceptance; and (c) empathetic understanding (Rogers, 1959, 1975).

Therapeutic alliance is also based on these factors.

The conceptual framework for this study was also based on the work of Rogers's empathy focus. Rogers (1957, 1959, 1980) argued that healing opportunities in therapy require three components. Rogers theorized that, like the body, the mind has the ability to

heal itself. However, like the body, the right environment must be present to encourage and foster improvements that bring healing to the forefront. The following three elements establish the right climate to promote growth and healing in the psyche: (a) genuineness or realness; (b) unconditional positive regard, which creates a climate for change and acceptance; and (c) empathetic understanding, sensing the personal feelings and meanings the client is experiencing and communicating these back to the client (author, year). This process allows for better communication and relationship between the client and the clinician. These factors promote improved therapeutic alliance and therapy outcome (Crenshaw & Kenney-Noziska, 2014).

Rogers (1980) discussed communication and its role in interacting and experiencing another person on a human level. Rogers outlined how personal experiences of open and real communication lead to feeling satisfied, warm, and heard. Atmospheres, in which people are insincere with each other, and where true communication was neither allowed nor supported, often left Rogers feeling disconnected and dissatisfied. Effective communication allows for growth, whereas insincerity leads to stagnation, alienation, and discomfort (Rogers, 1980). When mental health professionals provide therapeutic environments that are inclusive of real communication and support genuine interaction, patients feel heard. Once they are heard, Rogers asserted that clients will feel satisfied, supported, and able to grow in their intention to heal, to move forward, and to move past their present obstacles.

Rogers (1980) discussed the skill of hearing and the effect it can have on another human being who needs to be heard. When a person is heard, their soul is liberated, set

free from a type of prison (Rogers, 1980). Rogers also suggested that it is the responsibility of the mental health professional to create an environment that is therapeutic. This environment will allow for equality in the relationship, where each person is seen as important and is not belittled or reduced to feeling unvalued. Creating a parent-child-style relationship with a client is not conducive to optimal therapeutic change. The clients' input must be valued, and the professional must listen for each patient to be heard. Listening starts the healing process by liberating patients from their solitude and isolation that often result in pain (Rogers, 1980).

When clinicians allow themselves to enter a room without bias and sit without judgment or preconceived notions about how communication should proceed, or how patients should act or feel, they present a therapeutic environment. In this space, restorative work can occur, and the patient can simply be (Rogers, 1980). Oftentimes having a place where a person can be free of judgments allows his or her innermost thoughts and feelings to surface. Patients are more likely to trust the person who has provided this safe zone: this environment is where they can be heard, listened to, and appreciated as a human being.

True, real, and honest listening is good for the soul for both of the people, the client and the therapist alike (Rogers, 1980). Rogers (1980) stated, "I enjoy hearing someone, I mean, of course, hearing deeply. I mean that I hear the words, the thoughts, the feeling tones, the personal meaning, even the meaning that is below the conscious intent of the speaker" (p. 8). Rogers alluded to the different ways of hearing: not mere listening to sound but listening to the heart of the matter. In this way, therapists have the

ability to reach someone, to be with them where they are. Therapists can be empathetic and to see the situation from the patient's perspective, not merely from the perspective of a theory or textbook. In this regard, therapists can do clients the most good by offering them a chance to be heard, understood, and accepted (Rogers, 1980).

The concept of empathy stresses the importance of hearing the client, and this active process requires the clinician to interpret and relate what they think the client is saying to establish accuracy. This is a key factor for European American clinicians who may interpret or perceive events or feelings differently from their African American clients. In this qualitative, phenomenological study, I explored if and how well this was accomplished from the African American client's perspective.

Empathy, the conceptual framework, is a key component of therapeutic alliance. Because I explored the lived experiences of the African American patient in regards to therapeutic alliance, a qualitative, phenomenological study approach was appropriate. In the research questions, I explored the lived experience of African American clients to discover their feelings about their connectedness and relationship to their European American clinician. The interview questions emanated from the literature and to provide a platform from which African American clients' voices can be heard through their phenomenological experiences. The interview questions were created with the intent that when discussed, the research questions will be answered. This topic of empathy will be discussed in further detail in Chapter 2.

Nature of the Study

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African American clients think about their lived experiences and to identify elements of a good alliance. The concepts studied were therapeutic alliance, empathy as a necessary component of therapeutic alliance, cultural competency, cultural mistrust, and how racism destroys the possibility of empathy and the formation of a therapeutic alliance. A review of the attitudes and beliefs of African Americans was also included to outline how the African American culture may view the world. Having this insight may increase the ability and opportunity for the European American clinicians to connect with and create a successful therapeutic alliance with their African American patients.

Methodologies give direction for the design of a research study (Creswell, 2014). A qualitative design can be described as a theoretical lens, an approach to explore a social problem through the lived experiences of the participant. Qualitative studies provide a voice to the otherwise unheard people who have experienced the challenge first hand (Creswell, 2014; Moustakas, 1994). Phenomenological research, a type of qualitative approach that involves a limited number of people through observation and in-depth interviews, is used to reveal thematic and meaningful experiences concerning the particular phenomenon being studied (Creswell, 2014; Moustakas, 1994).

Researchers recruit participants for their ability to shed light on a particular challenge because of their actual lived experience of it. With this type of approach,

researchers are not experts, but realize they must go to the source to find the authentic meaning of the experiences being studied (Moustakas, 1994). An in-depth interview allows researcher the opportunity to become enlightened about participants' lived experiences (Seidman, 2006). These interviews and interactions can advance understanding because they contain access into the lived experience being studied.

This type of study was best suited for the exploration of the lived experiences of African American clients who had European American providers in a therapeutic setting. Characteristic yes or no answers found in quantitative methods would not garner the exact feelings and emotions tied to the participants' experience of having a European American counselor. Thus, I employed a qualitative, phenomenological approach to study their personal experiences.

I had the recordings of the semistructured interviews of 10 self-identified adult African Americans transcribed, to discover the themes of each participant's experiences. The transcribed interview was the raw data. The transcripts were analyzed using thematic coding to develop themes and patterns that emerged from the data. These participants classified themselves as having had counseling with a European American counselor. These study participants were recruited from local places, such as churches, African American fraternities and sororities, and counseling clinics in the Southeastern region of the United States.

Definitions

For clarity, the definitions used throughout the study are defined here:

Attitudes and behaviors: An attitude is “a relatively enduring organization of beliefs, feelings, and behavioral tendencies towards socially significant objects, groups, events or symbols” (Hogg & Vaughan, 2005, p. 150). A behavior is typically influenced by the persons’ attitude.

Cultural competency: A collection of knowledge and awareness about cultures other than a person’s own that is applied in practice. These skills are learned through myriad of ways, such as didactic, in-field training and experience. Observation and immersion can help yield a sense of appropriate application of the aforementioned skills that evolves from time spent with people from another culture (Arredondo et al., 1996; Benkert et al., 2006; Mio, Barker-Hackett, & Tumaming, 2006).

Cultural mistrust: A tool employed by members of a minority culture in response to potential threats (physical, mental, economic, social, academic, etc.) against them, usually by a larger and different group. These heightened awarenesses and defenses come from a collective memory of lived experiences of past and current abuses enacted upon them by another group (Terrell & Terrell, 1981).

Empathy: The ability and willingness to see things and situations from the perspective of another person. Empathy involves feeling what the other person feels at that moment. To accomplish empathy, a person must be sensitive and compassionate. They must be willing to remove all judgment and preconceived notions about the other person and see them and their world from the other person’s perspective. Empathy also involves the clinician relaying a sense of their feelings and perceptions and remaining open to feedback, to ensure accuracy. The clinician becomes a trusted sounding board as

they navigate the patient's universe (Rogers, 1975). Researchers have referred to empathy as a theoretical framework, a conceptual construct (Kohl, 2008; Lux, 2010; Moyers & Miller, 2013), a critical factor, an essential variable, and a conceptual framework (A. J. Clark, 2010). Regardless of the label, it is necessary in the process of building a therapeutic alliance with patients (Horvath, Del Re, Fluckiger, & Symonds, 2011; Norcross & Wampold, 2011; Rogers, 1959).

Racism: "The practice of racial discrimination, segregation, persecution, and domination on the basis of feelings and ideas of racial superiority—is mainly a product of learned behavior" (Bell, 2014, p. 1343).

Therapeutic alliance: The collaborative efforts between therapist and client to work on mutually agreed goals. The alliance is a partnership that expands cognitive and emotional levels. Both parties consider and negotiate how they will approach the tasks. Each offers honesty and mutual respect, as each puts forth effort to be human in each other's presence, allowing for empathy and bonds to form as they engage in the process of healing (Horvath, 2001).

Assumptions

I assumed that each participant was a willing subject. Additionally, it was assumed that each person answered each question in an honest fashion and to the best of his or her recollection. Further, it was assumed that the gender of the participant did not affect their perceptions. It was necessary to assume that each participant was willing to participate in the study because they signed an informed consent and agreed to participate in the study. It was further necessary to assume that each participant answered truthfully

because they were willing to participate and understood that their documented experience is adding to a body of knowledge that will improve the chances of better mental health care for African Americans in the future.

Scope and Delimitations

African Americans do not seek or stay in mental health treatment at the same rates as their European American cohorts (Conner et al., 2010; Villatoro & Aneshensel, 2014). When African Americans do seek help, they tend to leave sessions prematurely. Exploring therapeutic alliances between this racial dyad may highlight what factors are present and allow this group of two racially and culturally different people to function in a way that leads to positive therapeutic outcomes.

In order to explore therapeutic alliance between this racial dyad, the theory of cultural competency, as described by Sue, Arredondo, and McDavis (1992), could have been used because of its ability to encompass and expose attitudes, beliefs, knowledge and skill sets that are necessary for a positive and effective interaction between this racial therapeutic dyad. However, it was discerned that empathy was most relevant because it is a component of therapeutic alliance and is most closely related to the study topic, which is that of therapeutic alliance rather than cultural competency. However, I felt that cultural competency held a role because it was a component that examined within the literature review for both its ability to add to therapeutic alliance but also subtract and distract from therapeutic alliance when there is a lack of cultural competency present.

The boundaries of the study limited the recruitment of study participants to those who self-identified as African American and had experienced therapy with European

American therapists. I did not include other populations in order to address the gap in literature concerning African American and European American dyad in therapy. Therefore, the study results may not be transferable to other minority populations.

Limitations

All research designs have flaws (Marshall & Rossman, 2010). Though a phenomenological study does provide many advantages when seeking to explore lived experiences, it still presents with some limitations. I included only 10 self-identified African American participants recruited from the Southeastern region of the United States. Therefore, due to the small unique population, the data may not be generalizable to other minority populations in other regions and may limit transferability.

Dependability is concerned with the ability to replicate the observed twice. This may be a challenging task do to the presence and relationship that one researcher may build with each participant verses another researcher's ability to do the same in the exact same ways. Thus, there must be room allowance for the human factor. Additionally, it is plausible that each participant may recall different things at particular times. Thus, what one participant recalls today may influence any secondary questions that the researcher might ask, subsequently. Therefore, dependability may be an issue in that regard. Given that the semistructured questions have been written down, a different researcher could achieve similar results, given that both researchers are asking the exact same initial interview questions.

I came to the research with the intent that any possible bias has been set aside. I had no agenda in the outcome and was only interested in learning and highlighting the

lived experiences of African Americans in therapy with European American counselors. Additionally, all researchers experience the potential to influence interviewees with voice pitch, giving direction to desired responses. The potential for bias lies in the fact that the participants and I were all African American and that I may have had preconceived concepts about what is being said or what will be said. These factors were considered beforehand, and I sought only to receive data in its purest form without influencing the participants by what was asked or how it was asked. I prepared a list of interview questions that were followed in the exact sequence, verbatim for each participant interviewed, in order to address these limitations.

Significance of the Study

Significance to Practice

The social change implications for the African American patient could include not seeking to prematurely end therapeutic sessions with his or her European American clinician before a positive therapeutic outcome was established. Additionally, for the European American clinician, social change can present in the form of garnering a greater understanding of what he or she can do to in terms of how he or she can better engage with his or her African American clients in therapy that will lead to better therapeutic alliance and improved therapeutic outcomes for his or her African American clients. This knowledge can influence positive outcomes in the practice of mental health counseling.

Significance to Theory

Identifying factors that encourage and inspire therapeutic alliance and, ultimately, positive therapeutic outcomes in a European American provider and African American

client racial dyad is important. It has significant social implications for educators, therapists, supervisors, and researchers who seek to provide therapy to the African American community, as well as the African American patient themselves.

Significance to Social Change

African Americans do not seek or stay in mental health treatment at the same rates as their European American cohorts (Conner et al., 2010; Villatoro & Aneshensel, 2014). When African Americans do seek help, they tend to leave sessions prematurely. Exploring therapeutic alliances between this racial dyad may highlight what factors are present and allow this group of two racially and culturally different people to function in a way that leads to positive therapeutic outcomes. A better understanding of the process will lead to meaningful patterns and themes that will address the gap of not knowing what factors will lead to successful therapeutic alliance between this racial dyad and the lack of practical application in the therapeutic room.

Summary and Transition

Chapter 1 provided an introduction to the field of mental health and the importance of therapeutic alliance and empathy and the role they play in positive therapeutic outcomes (Webb et al., 2010). Additionally, I provided an explanation as to why some mental health practitioners may benefit from further understanding of what factors can lead to successful therapeutic alliance between the African American patient and European American clinician therapeutic dyad (Moyers & Miller, 2013; Norcross & Wampold, 2011). I also presented a information on the background, problem statement, purpose of study, and research questions. The preview of the conceptual framework;

nature of the study; pertinent definitions; assumptions; scope and delimitations; limitations; significance of this study; and significance of practice, theory, and social change was also reviewed. A summary and transition was also provided.

Chapter 2 will provide a review of literature pertinent to the background and purpose of this exploratory phenomenological study on alliance between African American clients and European American providers. The chapter will include the literature search strategy, the conceptual framework of empathy, and a literature review of related key concepts such as therapeutic alliance, empathy as a necessary component of therapeutic alliance, cultural competency, cultural mistrust, and how racism destroys the possibility of empathy and the formation of therapeutic alliance. The chapter will conclude with a summary on the major themes in the literature, what is known and where the gap of information exist within the discipline, as well as a brief introduction to the methodology of the study.

Chapter 2: Literature Review

Therapeutic alliance between African American patients and European American mental health clinicians are routinely strained to the point of early termination (Westra et al., 2011). Yet, the relationship between the client and the clinician are imperative to the success of the treatment (Ogden, 2015). Empathy, a component of therapeutic alliance, is key when it comes to cultivating a therapeutic relationship and attempting to see the world from the client's perspective (Carr & West, 2013). A lack of empathy can lead to ruptures in therapeutic alliance and can cause the African American patient to feel that they have not been heard, understood, or supported (Owen et al., 2012).

Racism and discrimination are issues that this racial dyad has dealt with in the general society. These factors can also be issues within the therapeutic setting (Torres et al., 2010). They, in addition to a lack of cultural competency, can lead to cultural mistrust, which further impedes the therapeutic alliance between this racial dyad (Whaley & Hall, 2009). Thus, it is important to look at these components (empathy, cultural competency, cultural mistrust, and racial discrimination) when exploring the therapeutic alliance between these two races within the therapeutic setting. Additionally, having a sense of what factors influence the attitudes and behaviors of the African American patient may help the European American clinician to better comprehend how he or she feels, what he or she thinks, and how he or she copes. Finding what factors account for increased positive therapeutic alliance between this racial dyad will improve therapeutic outcomes, reduce the gap in knowledge, and was the purpose and focus of this study.

When examining the disparity in seeking and maintaining mental health services in African American clients, the therapeutic alliance is an important construct of focus, particularly when an African American client is paired with a European American clinician. Researchers have not identified what factors increase the possibility of a successful therapeutic alliance between African American clients and European American clinicians. Some African American clients who are seeking help may not find it due to early termination for lack of satisfaction with the care provided (Owen et al., 2012).

In the United States, racial issues have resulted in division within the society and can be a cause for concern even within the therapeutic setting. Many European American clinicians who seek to provide care to this underserved population may be challenged to do so. Instead of providing care that helps, they may leave the African American client overburdened with mental health issues that might have been addressed had appropriate culturally competent care been initiated (Constantine & Sue, 2005; Hook, Davis, Owen, Worthington, & Utsey, 2013). Didactically and clinically, preparing doctors in training, professors and supervisors at training facilities have interest in this process as well. It may also be to their benefit to understand what factors, according to the African American client, will best meet their needs in addressing mental health in their culture (Aymer, 2010; Brown et al., 2012; Chao, Wei, Good, & Flores, 2011; Kirmayer, 2012).

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African

American clients think about their lived experiences and to identify elements of a good alliance.

In this chapter, I will review literature that is pertinent to the background and purpose of this exploratory phenomenological study on alliance between African American clients and European American providers. The chapter will include the literature search strategy; the conceptual framework of empathy; and a literature review of related key concepts such as therapeutic alliance, empathy as a necessary component of therapeutic alliance, cultural competency, cultural mistrust, and how racism destroys the possibility of empathy and the formation of therapeutic alliance. Additionally, the attitudes and beliefs of African Americans will be explored to look at factors that affect the therapeutic alliance between this racial dyad. As a part of my discussion of empathy, I will include empathy as a concept, the history of empathy, the components of empathy, and how the concept of empathy is used in literature. As a part of my discussion of therapeutic alliance, I will be including the history and definition, the benefits of, therapeutic alliance and race, the evolution of therapeutic alliance and race, reasons for a lack of therapeutic alliance between the African American and European American therapeutic dyad, and a rationale for the selection of concepts. I will also include a lack of cultural competency, inaccurate diagnosis, and cultural mistrust as a result of inaccurate diagnosis. I will include discussions on color-blind racism, mindsets, African Americans' representation in psychological research messages of racism in therapy, and increases in microaggression related to decreases in therapeutic alliance. I will outline discussions of coping; the effect of discrimination on the attitudes and beliefs of African Americans;

attitudes; and beliefs among subgroups of African Americans such as college students, seniors, and men. The chapter will conclude with a summary on major themes in the literature, what is known and where the gap of information exist within the discipline, as well as a brief introduction to the methodology of the study.

Literature Search Strategy

I searched the following databases for this literature review: PsychINFO; PubMed, Google Scholar, PsycARTICLES, Academic Search Premier, National Institute of Mental Health, and American Psychological Association. Major key words used in the search included *therapeutic alliance, African American, empathy, cultural mistrust, cultural competency, mental health, mental illness, mental health and African American, empathy theory, discrimination and mental health, African American and therapeutic alliance, African American, and mental illness*. A variety of a combination of terms listed above were entered into the various databases to pull out potential appropriate articles and studies surrounding the topic of interest.

Conceptual Framework

The purpose of this study was to explore the lived experiences of African American clients in therapy with a European American clinician. I sought to gain a greater understanding of what factors lead to a successful therapeutic alliance between this racial dyad. Empathy, therapeutic alliance, cultural competency, cultural mistrust, racism, and discrimination in addition to the attitudes and beliefs of African Americans are factors that will be reviewed to broaden the understanding of why therapeutic alliance between this African American and European American dyad has not been successful

thus far. Of these variables, I chose empathy as the conceptual framework that best fits the formation of therapeutic alliance.

Empathy as a Concept

Empathy frames the therapeutic atmosphere between the patient and the clinician (Rogers, 1959). Empathy supports bond formation and can aid in building a connection between the African American patient and his or her European American clinician (Norcross & Wampold, 2011). Without empathy, therapeutic alliance cannot be established (Neukrug, Bayne, Dean-Nganga, & Pusateri, 2013). The following pages are a synthesis of primary writings and key contributors to the concept of empathy.

History of empathy. Lipps first introduced the concept of empathy in the late 1800s. Lipps proposed that empathy would allow people to connect emotionally with another person (as cited in Neukrug et al, 2013). In the early 1900s, others added to the definition and application of empathy in therapy and noted its significance in therapeutic outcomes. Rogers (1980) helped discern how useful empathy could be to the clinician and the patient when applied in the therapeutic process.

Rogers (1959) underscored the concept of empathy. In 1957, Rogers described the necessary conditions of therapeutic personality change. Initially, Rogers referred to this concept as the state of empathy, the ability to perceive the internal frame of reference of another with accuracy, along with emotional components and meanings. Upon reflection of previous work and with new understanding gained from others' work, Rogers (1975) referenced it as a process.

Many have hailed empathy as a necessary component to attaining a successful therapeutic alliance (A. J. Clark, 2010; Crenshaw & Kenney-Noziska, 2014; Elliott, Bohart, Watson, & Greenberg, 2011; Lux, 2010; Moyers & Miller, 2012; Moyers & Miller, 2013). Researchers have referred to empathy as a theoretical framework, a conceptual construct (Kohl, 2006; Lux, 2010; Moyers & Miller, 2013), a critical factor, an essential variable, and a conceptual framework (A. J. Clark, 2010). Regardless of the label, it is necessary in the process of building a therapeutic alliance with patients (Horvath et al., 2011; Norcross & Wampold, 2011; Rogers, 1959).

Moyers (2013) proposed that empathy and alliance were among the top relational elements that represent effectiveness in the therapeutic process. Empathy should be incorporated into the training of future mental health clinicians (Moyers & Miller, 2013; Norcross & Wampold, 2011). Moyer, Martin, Houck, Christopher, and Tonigan (2009) proposed that training can make an effective difference in the level of therapeutic empathy displayed. Over the span of many decades, controversy has surrounded the concept of empathy; however, majority of researchers have come to treasure the conceptual framework.

Most forms of therapy have adopted the empathy construct to connect with the patient. This action allows the clinician–patient team to pinpoint the core of the patient’s mental health challenges together. This teamwork is built and maintained by successful therapeutic alliance, and it allows for positive therapeutic outcomes (Neukrug et al., 2013). Empathy is a central component of therapeutic alliance allowing a climate of

acceptance that allows for greater reciprocity and therapeutic alliance between the patient and the clinician.

Components of Empathy

Empathy is a therapeutic skill (Moyers & Miller, 2011). The clinician must engage several components in creating an empathetic relationship with his or her client. These elements can include unconditional positive regard, genuineness or congruence, and empathic understanding (Rogers, 2007). Before reaching empathetic understanding, the clinician must be willing to have an unconditional positive regard for his or her client. They must show full acceptance of the client, regardless of conditions, situations, and worldviews. The client must feel accepted without fear of being judged (Rogers, 2007). Genuineness or congruence calls for the therapist to be sincere and present in the moment with the patient. This component allows clinicians to be themselves without façade (Rogers, 1980). This realness allows therapists to connect on a level that may not be possible if a barrier of pretense exists. Responsibility for the progress and advancement of the quality of healing connections in treatment rests with the psychotherapist (Moyer, 2013). Empathy, or accurate empathy as it has been referenced, is the clinician's ability and willingness to see the client's perspective of the situation from his or her worldview or frame of reference. According to Rogers (1957), the therapist must choose to be empathetic on a conscious level. This skill necessitates that the clinician employs active and reflective listening with an aptitude of exchange; the counselor reflects clients' worldviews with accuracy to the client until they reach an agreed definition or reference

(Moyers & Miller, 2013). This understanding helps the client feel that he or she is understood.

Bohart and Greenberg (1997), similar to Rogers, introduced three fundamental elements of empathy that address rapport, understanding, and communication. These three elements expound on Rogers' original concept of empathy. Some researchers focused on emotional empathy (Vinton & Harrington, 1994), whereas others considered intellectual aspects of empathy (Duane & Hill, 1997).

A. J. Clark (2010), acknowledging Rogers' previous contributions, considered empathy in the counseling process and concluded a more detailed way existed in which to view and apply empathy. A. J. Clark incorporated the concept of subjective, interpersonal, and objective empathy. In subjective empathy, the clinician is able, during a mindful state, to be present with and experience the patient's world. Interpersonal empathy allows the clinician to engage in the empathetic understanding of the lived experience of the patient. Objective empathy grants the clinician the opportunity to apply therapeutic and skilled knowledge to the situation (A. J. Clark, 2010). In whatever form, empathy remains a factor in the formation of the therapeutic alliance.

How This Conceptual Framework of Empathy Relates to This Study

A. J. Clark (2010) suggested that empathy has the power to frame the therapeutic atmosphere between therapist and client. Framing often has the ability to provide an unthreatening mental space in which the therapist accepts the patient without regard. This acceptance leaves the opportunity for the patient to feel emotionally supported and understood (A. J. Clark, 2010). A patient's perception of the therapist's empathic

understanding is a component in the success of therapy (Elliot et al., 2011; Lux, 2010; Rogers, 1957). Thus, this study will provide a platform from which African American patients can voice their perceptions of their therapeutic experience in this racial dyad.

Rogers (1980) stated, "I had to learn through hard and frustrating experiences that simply to listen understandingly to a client and to attempt to convey that understanding were potent forces for individual therapeutic change" (p. 50). Rogers's research led to a greater understanding of how to be with a client in a therapeutic and unthreatening way. Interviewing African American clients as to their perspective of how and if their therapist was able to achieve this state of being was useful, allowing for greater comprehensive appreciation and insight into how this group of people perceives the actions, behaviors, and interactions of their European American clinicians with them. This information can lead to a more informed therapeutic session between this racial dyad and may lead to more frequent and improved therapeutic outcomes.

The therapeutic relationship between the provider and patient is the single most significant indicator for treatment success (Norcross, 2011). For a therapeutic environment to exist, empathy must underlay understanding to be a reality (Rogers, 1975). Empathy is a platform on which one human being can interpret and empathize with another human being. Empathy supports an atmosphere where a bond can be formed that may facilitate a cooperative and joint partnership in the establishment of therapeutic goals in the healing process (Elliot et al., 2011). Only when a person is humble or empathetic with another can they see the inner worldview of another. This way of being with another

person allows for a frame of reference from which a person can see what and how the person has been affected by a particular thing, condition, or person (Elliot et al., 2011).

Literature Review

In this section I outline the following subjects: empathy, therapeutic alliance, cultural competency, cultural mistrust, racial discrimination, and attitudes and beliefs of African Americans. Empathy will be examined because of its unique ability to provide access to therapeutic alliance. Therapeutic alliance was investigated because it has the ability to foster the cohesiveness needed to provide positive therapeutic outcomes between the racial dyad of African American patients and European American clinicians. Likewise, discussions about cultural mistrust, cultural competency, racism and discrimination, and the attitudes and beliefs of African Americans provide a look at factors that further effect the therapeutic alliance between this racial dyad.

How Empathy is Used in the Literature

Empathy allows for better listening, understanding, and the ability to better lend support to the patient. Patients perceived level of empathy from their clinician increases patient satisfaction, improves patient compliance, and improves positive therapeutic outcomes. Empathy is the underlying factor to therapeutic alliance (Elliot et al., 2011; Horvath et al., 2011).

Moyers and Miller (2013) investigated whether low therapist empathy levels were toxic to the therapeutic relationship. Moyers and Miller considered counselor interactions and outcomes with substance abusers. Moyers and Miller indicated that the therapeutic relationship did account for differences in therapeutic alliance, increased substance use

rates, and therapy failure rates. The greater the perceived empathic level of the counselor, the greater the positive therapeutic results experienced by the client (Moyer et al., 2013).

Rogers' concept of empathy can be appropriately applied in addiction counseling (Moyer & Miller, 2013). This field of counseling has traditionally accepted attacking the patient as a form of appropriate therapy. This method accounts for the variance in outcomes. However, when the therapist applies empathic listening and understanding, patients drink less (Moyer, 2013). Agencies will need to screen potential counselors for empathy skills to increase positive therapeutic alliance and outcome, especially in addiction treatment (Moyer & Miller, 2013).

Crenshaw and Kenney-Noziska (2014) considered four different examples of how empathy can be applied into clinical practice through play therapy with children. Of note, one severe trauma case mentioned involved two children who suffered due to their mother's murder. Simply "doing" things in therapy would not have been as useful as "being" fully present with the children. Empathy and deep listening were the factors that helped to be human with the clients, as proposed by Rogers (1980), and that helped them process their mother's death in a safe manner. Researchers postulated that the quality of the therapeutic relationship and the therapeutic presence are two critical factors that help create and support the therapeutic relationship. The ability of the therapist to convey empathy, authenticity, and unconditional positive regard allowed for true restoration to follow (Crenshaw & Kenny-Noziska, 2014), based partially on Rogers' concept of empathy.

Elliot et al. (2011) conducted a meta-analysis of studies exploring the relationship between empathy and therapy outcome. The authors discussed observer, client, and therapist ratings along with empathic accuracy. They concluded the client's perception of the therapist's empathy level is a strong predictor of the therapy outcome. Empathy provides fertile soil to explore. They further posited that active listening informs the clinician about what to explore next.

Elliot et al. (2011) revealed that some studies in their meta-analytic review indicated that the client's level of brightness, lower levels of dysfunction, and ability to communicate well that were major factors in the level of empathy displayed from clinicians. This theory veered away from Rogers's (1957) and A. J. Clark's (2010) viewpoint that the clinician must create the therapeutic atmosphere, not the patient themselves. Notably, because Moyer and colleagues (2009) proposed training could create an effective difference in the level of therapeutic empathy displayed, it seems logical that it is not the client's ability but the clinician's that are in question in this regard.

Elliot et al. concluded they could make clinical recommendations, based on the evidence concerning empathy. They included (a) securing an empathetic foundation is essential for all clinicians. (b) To meet the needs of the patient, all clinicians must endeavor to understand and communicate said understanding to the patient concerning their lived experience. (c) Clinicians should attempt to validate the client's experience from the client's viewpoint. Through a display of empathic affirmations, evocations, and conjectures, the clinician can help the patient understand and represent their lived

experiences in meaningful words and thoughts that will enable them to process their emotions safely, and examine their objectives and principles (Elliot et al., 2011).

All of these research studies (Moyers, 2013; Crenshaw, 2014; Elliot, 2011) point to greater understanding and serve to further establish that empathy is a viable selection among concepts explored in this present study.

Therapeutic Alliance: History, Definition and Beyond

For positive therapeutic outcomes, the therapeutic alliance, also referred to as a working alliance, is a critical determining factor between therapist and patient (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012; Duff & Bedi, 2010; Horvath et al., 2011; Johansen, Iversen, Melle, & Hestad, 2013; Kazdin & Durnin, 2012; Porter & Ketring, 2011; Ryan, Safran, Doran, & Muran, 2012; Smith et al., 2012; Wagner, Brand, Schulz, & Knaevelsrud, 2012). Alliance has a history that dates back to Freudian days when Freud first alluded to alliance. Freud considered that patients, when first entering therapy, might conjure up feelings of resistance and anxiety that might hamper their willingness to stay. Freud posed that a “cure” for such defenses was positive transference: an atmosphere of acceptance that would allow bonding (Horvath et al., 2011). Connecting can cultivate the encouragement needed to stay long enough to experience progress in the area for which they had sought treatment. Many others, Bordin (1975, 1994), Luborsky (1976), Rogers (1974) and Zetel (1956), took the concept of alliance further to reveal different aspects of how to achieve the alliance; the varying stages of alliance, and even measures of alliance (Horvath et al., 2011).

Several characteristics are germane to successful counseling. The following are necessary components of effective treatment, if the client's needs are to be met: (a) cooperative effort from both parties; (b) defining the goals and expectations early is essential; (c) discuss realistic time frames; and (d) establish good relationships that allow for honesty and a place where the client feels comfortable. However, the therapeutic alliance has been hailed among these as the key factor that determines successful counseling (Duff & Bedi, 2010).

Horvath (2011) defined alliance as a partnership or collaboration between the doctor and the patient. In other words, a coming together of the minds, where the two included in the partnership operate with an agreement about what their focus will be. Yet, it is not simply the goal, but the environment they create that builds trust. This setting allows transparency on both participants' parts and establishes upfront that both are human beings worthy of respect, honor, and dignity. Thus, the two parties are equals and the relationship is not predicated on the usual doctor-patient or adult-child relationship.

Although the inception of therapeutic alliance is attributed to Freud in 1912, the concept continues to develop as other authors add to the conversation. For instance, Bordin (1994) acknowledged that alliance was the end result of people coming together as a team, in therapy. He suggested that alliance was created through a three phase process: (a) agreement on therapeutic goals, (b) consensus on tasks that make up therapy, and (c) a bond between the patient and the clinician. Rogers's (1974) interest in relationships in client-centered therapy lent considerable attention to the topic of alliance.

The meta-analysis conducted in 2011 by Horvath et al. (2011) revealed good insight into the field of therapeutic alliance. These authors reviewed 201 studies involving over 14,000 treatments to explore the relationship between alliance and outcomes of individual psychotherapy. Their review suggested that there were three top instruments widely used to assess therapeutic alliance levels: the California Psychotherapy Alliance Scale, Helping Alliance Questionnaire, and Working Alliance Inventory (WAI).

Findings suggested techniques that may provide better alliance in therapeutic sessions (Horvath et al., 2011). Researchers noted that clinicians play a significant role in the therapeutic alliance building and maintenance stages. These authors indicated that thoughtful consideration should be given to culture, expectations, and capacities of each individual client. When seeking a level of collaboration, consider the client's problems and available resources (Horvath). Their findings also suggested that the therapeutic alliance significantly aligns with positive therapeutic outcomes even in the presence of assorted types of psychotherapy.

Horvath and colleagues (2011) also addressed the issue of the up and down wave effect that normally occurs with alliance. Thus, they proposed it is important the clinician not rely on observation alone, but also employs active monitoring via patient feedback to ensure they are aware and equipped to address variations. Because therapeutic-alliance levels do fluctuate as patients' advance through therapy, Hovarth et al. indicated the importance that the clinician be willing to make any necessary changes to accommodate the client.

Horvath and colleagues (2011) explained that the contributions of the therapist to the therapeutic-alliance level experienced in sessions are vital. These authors suggested that non-antagonistic replies to the patient's harsh or unreceptive feelings are essential for preserving a useful bond and partnership. Alliance is a skill that can be taught, learned and applied in therapy (Hovarth, 2012).

Duff and Bedi (2010) built on this thought of alliance as a skill in their investigation of 15 patient-identified clinician behaviors and the strength of the therapeutic alliance, through a thorough examination of 79 patient–therapist relationships. Their study results indicated five behaviors moderately to strongly associated with the therapeutic alliance (a) ask questions, (b) identify and reflect the patients feelings, (c) validate the patient's experience, (d) make encouraging comments about the patient, and (e) make positive comments about the patient. Yet, three particular behaviors played a role in strengthening the therapeutic alliance:

1. Make encouraging comments about the patient
2. Make positive comments about the patient
3. Greet the patient with a smile

These three communicate positive regard toward the patient and promote the therapeutic alliance. Previous research in client-centered therapy, posited by Rogers in 1974, also found that showing positive regard toward the client is conducive to building and maintaining an alliance. These researchers' findings indicated that patients can accurately identify statistically significant experiences in the counseling process. No African Americans were represented in this population pool. However, this present study

hopes to bridge the gap in knowledge by exploring several of these aspects of therapeutic alliance from an African Americans' experience.

The benefits of therapeutic alliance. The benefits of a therapeutic alliance are many and far reaching. Wagner (2012) suggested that the therapeutic alliance is useful with different cultures. Kazdin (2012) claimed it is beneficial with child patients. Even in cases with severe mental health issues, the therapeutic alliance can help lead to positive outcomes (Johansen, 2013). Likewise, in the presence of comorbidity and challenges with attachment and interpersonal issues, alliance is key (Smith, 2012). Therapeutic alliance remains a critical factor in generating positive therapeutic outcomes regardless of what type of psychological intervention is employed (Horvath, 2011; Kazdin, 2012).

People who experience mental health illnesses may not realize their need for help. And those who do, may not seek help. Researchers indicated many barriers exist that prevent many from getting the help they need (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010). Some of these identified barriers include access to care. However, alternatives exist to seeking help in person. Internet psychotherapy provides an option for those clients who may not have time, money, or desire to meet with a therapist in person on a routine basis.

Various disorders such as anxiety and depression have been associated with Internet-based delivery of therapy (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Paxling, Lundgren, Norman, Almlöv, Carlbring, Cuijpers, & Andersson, 2013). The Internet offers cognitive-behavioral therapy through a prearranged curriculum that includes philosophies and techniques in a succession of instructions. A therapist usually

assigns homework and offers support through text, e-mails, or phone calls (Andrews et al., 2010). Researchers have disputed the appropriateness and effectiveness of online therapy (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Yet, current studies indicate that even in an online environment, patients and therapists may establish a therapeutic alliance (Paxling, 2013; Wagner, 2012).

Wagner, Brand, Schulz, and Knaevelsrud (2012) claimed therapists can establish a positive online therapeutic relationship with people who are from a different culture and who reside in a different geographical region from the provider. Their view was based on previous work of Knaevelsrud and Maercker (2006, 2007) who found that although trauma victims usually have challenges with fulfillment issues, a strong therapeutic alliance was possible through an Internet therapeutic relationship. They discovered that the alliance therapists could create online had a strong positive influence on patient adherence to goals and diminished dropout rates.

In the Wagner and colleagues (2012) study, researchers recruited 55 PTSD Arabic patients; 78% of the participants were women with an average age of 27.7 years. The researchers administered the WAI to each patient after patients completed four therapeutic sessions. Each patient received two weekly 45-minute Internet sessions based on a cognitive-behavioral interview over a 5-week period. The authors used two scales: the Posttraumatic Diagnostic Scale to assess PTSD symptoms and the WAI to assess the presence and levels of working alliance. These authors supported earlier research findings by Duff and Bedi (2010), indicating that improvement in a therapeutic alliance early in treatment is possible. Their findings of an early alliance stayed constant between Sessions

four and 10. This finding signaled the possibility of establishing a positive and stable online therapeutic relationship with clients who are situated in an enduring volatile atmosphere. Thus, the researchers illuminated the important note that health professionals who are geographically separated from their patients—even patients who experience trauma—can provide relevant psychological support.

Whether geographically separated or sharing the same physical and therapeutic space with patients, the therapeutic alliance can cultivate and promote the success of any therapeutic intervention (Johansen, 2013; Kazdin, 2012; Wagner, 2012;). Kazdin and Dubin (2012) noted that relationship motivates therapy and healing amidst a spectrum of illness, including severe cases. Increased therapeutic alliance is associated with improved treatment fulfillment, improved treatment completion, and therapeutic change (Johansen, 2013; Kazdin, 2012).

Because little was known about the therapeutic alliance and children, Kazdin and Dubin (2012) conducted a study involving 97 children referred to the Yale Parent Center and Child clinic. These children had mental health issues such as antisocial, oppositional, or aggressive behavior. Using the Therapeutic Alliance Scale for children, the researchers measured the child's alliance with their therapist. These measurements were administered at the 1/3 and 2/3 point of a core set of 12 weekly sessions. All 12 therapists were European Americans as were 83% of the children. About 11% of the children were African American and only 2.1% were Latinos. Results suggested that the child-therapist alliance aligned with therapeutic change. Additionally, the authors posited, the better the

quality of therapeutic alliance, the more therapeutic change the children experienced (Kazdin & Dubin, 2012).

Johansen, Iversen, Melle, and Hestad (2013) explored predictors and characteristics of therapeutic alliance in recent-onset schizophrenia-spectrum disorders. Previous study results indicated that the therapeutic alliance improved symptoms and pharmaceutical adherence while reducing rehospitalization, and drop-out rates in schizophrenia patients (Johansen, Iversen, Melle, & Hestad, 2013; McCabe, Bullenkamp, Hansson, Lauber, Martinez-Leal, Rossler, Salize, Svensson, Torres-Gonzalez, Van den Brink, Wiersma, & Priebe, 2012; Priebe, Richardson, Cooney, Adedeji, & McCabe, 2011). The Johansen et al. study was significant because patients with these symptoms usually have difficulty with alliance. Johansen and colleagues recruited 42 patients with between two and five years of onset of symptoms of schizophrenia-spectrum disorders. They used four neurocognitive measures to assess intellect, executive functioning, verbal and memory, and attention. The working alliance was measured by the use of the WAI-S. Previous reports indicated a 13% dropout rate for schizophrenia-spectrum disorder patients. The Johansen et al. (2013) study suggested that the therapeutic alliance was associated with better compliance, decreased dropout rate, decrease rehospitalization, decreased symptom levels, and improved outcomes.

Often clinicians will need to treat patients for comorbid illnesses. Smith and colleagues (2012) studied how attachment orientation (anxiety and avoidance) and development of a working alliance aligned with treatment outcomes among depressed women with a history of child sexual abuse. They included 70 women with major

depression and the aforementioned abuse history in their study. They assigned participants randomly to one of two groups: interpersonal psychotherapy or treatment as usual, which incorporated various techniques (cognitive-behavioral therapy, client-centered therapy, etc.).

Women with abusive past experiences may have challenges with attachment. The client–doctor relationship can be ruptured easily by vulnerable attachment orientation. Having PTSD or bipolar personality disorder can cause challenges in any relationship due to interpersonal and attachment difficulties. Although, victims of these disorders with a history of sexual abuse often have comorbid diagnoses, Smith and colleagues (2013) postulated that when the therapist establishes a working alliance atmosphere, even in the presence of PTSD or bipolar disorder, treatment progress was not disrupted. Smith et al. explained that increased working alliance and decreased attachment avoidance aligned with increased improvements in depression symptoms.

The clinician may find it necessary and valuable to employ certain multicultural standards when providing appropriate and usable mental health services to ethnic clients (Horvath, 2011). Many times, patients with cultural backgrounds that vary from that of Eurocentric cultures hold different beliefs about seeking help and ways to receive help. Thus, employing a standard approach may not be suitable or practical in the treatment of patients in the African American community (Duff & Bedi, 2010; Ryan, 2012).

Therapeutic alliance and race. It is important to examine useful and purposeful ways to interact with African American clients, when it comes to therapeutic alliance between African American and European American therapeutic racial dyad.

Applying a Eurocentric perspective in therapy may not be clinically or culturally appropriate with African American patients (Hook et al., 2013; Lindsey & Marcell, 2012; Williams, Domanico, Marques, Leblanc, Turkheimer, 2012). African Americans do not seek mental health care at the same rates as their European American counterparts in the United States (Cheng, Sevig, & Kwan, 2013; Lindsey & Marcell, 2012; Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014; Ward, Wiltshire, Detry, Brown, 2013; Williams et al., 2012). This phenomenon also exists in the Great Britain, where Blacks are less likely than Whites to seek care (Gurpinar-Morgan, 2014).

Gurpinar-Morgan, Murray, and Beck (2014), conducted a study to gain an understanding of relationships between race and mental health professionals. In this interpretative phenomenological analysis, the authors interviewed clients in the same fashion as their normal appointments, for no more than one hour. Five participants, all self-identified as Black and minority ethnic, received mental health services in northwest England. The authors posed that understanding the concept of ethnicity and the relationship of mental health may improve delivery of treatment. People whose ethnicity highly influences their psychosocial status may think the sensitivity of the therapist about their ethnicity is more important than those who do not see their ethnicity as having a major influence on their mental health.

Gurpinar-Morgan et al. (2014) suggested it is unnecessary for the therapist to have the same background as the client. However, the clinician must show empathy and appreciate how the client's background affects their struggles. The researchers found that sometimes, even though the client wants to talk about ethnicity, it is unaddressed

successfully because the professional is uncomfortable addressing its relationship to therapy. Many therapists fear such a discussion will negatively affect the trusting relationship needed in therapy. Yet, Gurpinar-Morgan et al. proposed that until the therapist brings up ethnicity, many people do not see it as important or relevant to their struggles. The authors indicated that clients did want to know the therapist's background to see if there were similarities and thus, the therapeutic rapport could be established. Benefits may accrue from raising dissimilarities between clinician and client to make a deeper connection and open therapeutic alliance (Gurpinar-Morgan et al., 2014).

When differences have resulted in racism, talking about different ethnicities can have a negative impact on therapy sessions. Yet, Gurpinar-Morgan et al. (2014) proposed that talking about ethnicity can be used as a tool to delve deeply into a client's issues. However, they cautioned this topic can be raised more comfortably toward the beginning of therapy. Some study participants reported that therapists could understand their struggle, regardless of differences, whereas others said the differences were a challenge in making a strong therapeutic alliance, but rated the therapy as still being good. Patients indicated that having the same background was a positive factor in therapeutic alliance. Similar backgrounds raised assumptions made by the therapist about the client because of how someone of that ethnicity should behave or what they should believe (Gurpinar-Morgan, 2014).

Carr and West (2013) investigated what significant factors were useful when treating African American men with a history of depression. During a 3-week in-patient stay, study participants had therapy sessions with a European American female clinician

who had a strong feminist stance. The clinician integrated a multicultural/feminist framework with the psychotherapy. In the sessions, they focused on exploring gender socialization, racial socialization, and identity development. The patient and clinician were of similar age. The therapeutic alliance between the Black male and a White therapist opened the door to conversation about differences in race and gender.

For one of the African American men in this study, experiencing frequent perceived discrimination was associated with low self-worth (Carr & West, 2013), highlighting a concept known as the invisibility syndrome. Though the invisibility syndrome alone does not automatically instigate depression, the internal struggle between self-perception and the outside world's perceptions brings negative consequences that do cause depression (Carr et al., 2013). African Americans have experienced the invisibility syndrome even in therapeutic counseling (Hook et al., 2013).

A dearth of literature exists on African American men and depression (Ward & Menegsha, 2013). When diagnosing and treating African American men for depression, the clinician should be aware of their clinical and cultural experiences. A mutual division of power in the therapeutic alliance is key to understanding the client's worldviews through a cultural lens (Carr, 2013). Because perceived racism represents a large aspect of the minority experience for African Americans, clinicians may find it useful to increase awareness, understanding, and appropriate clinical tools when attempting to properly diagnose and treat clients from this ethnic culture (Brown, Blackmon, Schumacher, & Urbanski, 2012).

To truly understand the client's symptoms, the therapist must fit current issues into the client's perspective and experiences. In their study on working alliance and ethnicity, Walling, Suvak, Howard, Taft, and Murphy (2011), found that it is important not only to have a clear understanding of symptoms in regard to race, but also to have awareness of the ever-changing levels and position of the working alliance that can develop between ethnic and racial clients and their European American clinician. Results indicated that though working alliance may be dismal at the start of therapy, due to experiences of microaggression and cultural mistrust of the ethnic patient, it is possible that an alliance can develop as time and therapy sessions continue.

Carr and West (2013) discovered the importance of helping the client feel they have a part in their therapy. The researchers suggested clients can teach the therapist about their own worldviews and seeing the issues and situations they have had to face from their perspective. In other words, the client teaches the clinician how to employ an empathetic view. Culturally responsive therapy is very important in addressing depression in African American men. The multicultural/feminist approach helps speak to issues of race and gender in the rapport between client and clinician. Aligned with this framework, a client can be made to feel empowered if they are seen as the expert in their own life (Carr et al., 2013).

Some researchers argued that certain ways of being in therapy with clients of ethnic or racial background are superior (Brown, 2012; Carr & West, 2013; Gurpinar-Morgan, 2014; Hook et al., Utsey, 2013). Rosen, Miller, Nakash, and Halperin, in their 2012 study, investigated which sociodemographic differences contributed to making the

first therapy session successful and well received between client and clinician. They revealed that initial intake, creating connection, identifying issues, and setting goals can pose difficulties, especially when differences exist in ethnicity between the therapist and client. Because of these differences and lack of bonding, premature abortion of sessions may result.

Rosen and colleagues (2012) studied 114 videotaped first sessions by trained onlookers. They assessed complementarity through varying social-identity factors such as race, gender, and age. Participants were all adults without suicidal ideation or psychotic symptoms. Researchers randomly matched clients to a clinician. The client pool included 61% women; 53% Latino; 36% European American non-Latino, and 11% African American. Of the 44 participating clinicians, 68% were women, 55% were European American, 36% were Latino, and 9% were African American.

When cultural differences are exposed more barriers must be overcome, adding levels of complexity. Rosen et al. (2012) looked at how shared social-identity factors like race, sex, and age correlated to use of services. They also examined how long sessions continued and if people left treatment. Although results were unclear and inconsistent, the researchers were able to discern that the greater the listening with empathy and understanding, the greater the impact of the provider on the client and the impact of the client on the provider.

Therapeutic alliance was established as the client became more comfortable over time (Rosen et al., 2012). The relationship developed based on positive interactions. The authors suggested that interaction, both verbal and nonverbal, could positively impact the

therapeutic alliance. The use of tears and humor also contributed to bonding between the clinician and client. Differences in race and ethnicity can be overcome by interpersonal variables early in the therapeutic alliance. Rosen and colleagues (2012) suggested that elements other than cultural variables could help gain high levels of cohesiveness between the client and the provider. Different ideas of what constitutes good therapeutic alliance vary between cultural groups (Rosen, 2012). This present study offers an opportunity to learn what African American patients think establishes good therapeutic alliance.

The evolution of therapeutic alliance and race. Multicultural competency is of great importance in communicating with and effectively treating minority clients. Multicultural competency is a gateway to building a strong therapeutic alliance. A strong therapeutic alliance aligns with increased psychological well-being.

In 2003, APA and USDHHS Department of Minority Health created a set of multicultural-competency practices and standards, in an attempt to close the gap in minority health disparities. Since then, several groups of researchers looked at health disparities and cultural competencies. However, only one considered what effect multicultural orientation had on psychotherapy outcome (Owen et al., 2011).

Plausible reasons for a lack of therapeutic alliance between the African American and European American therapeutic dyad: Rationale for selection of concepts. There are several factors that may explain the lack of therapeutic alliance between the racial dyad of an African-American patient and European American clinician during therapy. The following sections will discuss the importance of cultural

competency, and the deficiencies and implications that often resolve from a lack of cultural competency (Falender & Shafranske, 2012; Whaley & Hall, 2009). Cultural mistrust, often times, results from racism and discrimination, as well as a lack of cultural competency. The concept of cultural mistrust will be discussed because of its ability to effect therapeutic alliance and its result from a lack of cultural competency and empathy (Combs, Penn, Cassisi, Michael, Wood, Wanner, & Adams, 2006; Pieterse, 2011; Williams & Williams-Morris, 2000). Racism is another important element to study that may affect therapeutic alliance between this racial dyad (R. Clark et al., 1999; Pachter, Bernstein, Szalacha, & García Coll, 2010). There are many forms of and ways to encounter racism that will be explored in the next few pages such as colorblindness, Mind sets, Messages of racism and therapy, microaggressions and the effects of discrimination on the attitudes and beliefs of African-Americans (Bonilla-Silva, 2007; R. Clark et al., 1999; Morris, 2000b; Neville, Lilly, Duran, Lee, & Browne, 2000; Sue & Sue, 2003).

Cultural Competency

Cultural competency is a key component to establishing therapeutic alliance with an ethnically or racially different client. If a European American clinician is to understand their African American client's world-view, they must become culturally competent (R. Clark et al., 1999). Empathy is an important and necessary component to employ when attempting to truly understand and cultivate therapeutic alliance with another human being. A person's culture is integrated into who they are and how they may perceive themselves and the world around them. When it comes to the African-

American patient and the European American clinician, it is clear that they do not share the same racial culture. It is important that the European American clinician recognize that the African-American patient may have very different experiences in the society, based on their skin color. Not acknowledging this possibility may hinder the empathetic and therapeutic alliance process. Thus, having cultural competency and being culturally sensitive may serve in demonstrating appropriate interactions with people from cultures differing from their own. A lack of cultural competency can affect the reality of proper diagnosing and treatment regimens selected for the African-American client (Barnes, 2009). The lack of cultural competency can cause inaccurate diagnosis which can further the cultural mistrust felt by many African-Americans toward the healthcare system, in general, and the European American clinician, in particular.

Falender and Shafranske (2012) argued that competency in psychology training is imperative, not only in didactic but also in supervisory portions of clinical training. These authors advanced that the mere learning of knowledge is insufficient to ethically say someone is prepared to hold a position as a counselor or clinician. Rather, they reasoned that the incorporation of knowledge, along with skill, and if necessary, a shift in attitudes and beliefs about the application of such competencies in the therapeutic process are also needed. They refuted the position that once a trainee has graduated they should be considered competent perpetually. Rather, competency is ever changing with the times, demographics of society, needs of the field, and most importantly, the needs of the individual client.

Newell et al. (2010) suggested that this mindset of competency must be inclusive and not neglect cultural differences and what culture means to the diverse population of clients they may counsel. Multicultural competence necessitates that a shift in understanding, attitudes toward and beliefs about cultures that differ from the trainees own, be established, challenged, and cultivated. This shift must go beyond a mere sensitivity toward people of color, but also include an adoption of knowledge and behaviors that will allow the counselor to successfully apply their clinical abilities and, in an empathetic way, be with clients who differ from their own culture.

In 2003, APA presented guidelines calling for the inclusion of multicultural training to garner cultural competency among psychologists. Yet, 11 years later, Jones, Sander, and Booker (2013) argued that little had been accomplished to meet this goal proficiently. Most graduate programs in the United States are unclear about how to accomplish this goal. Researchers postulated that a majority of programs require only one course in multicultural psychology, and few internship opportunities that build on skills necessary for useful and skilled learning in multicultural acuity (Jones et al., 2013).

Government studies indicated that the U.S. population is shifting and those considered in the past to be in the minority will be a majority within the next two decades (U.S. Census Bureau, 2013). Yet, the majority of psychology graduate students remain overrepresented by the European American population (APA, 2013). Because training should not cease in the didactic portion of education, proper supervision in clinical training should include trainees offered salient training in multicultural skill. Yet, often, the student trainee is left to their own understanding and limited knowledge of how to

relate in culturally appropriate and meaningful ways with their patients of color. Oftentimes, the client of color is left without appropriate and useful antidotes and skills to address issues that might have been rendered in counseling by a more culturally competent clinician. In particular, when providing service to African American clients, clinicians must employ multicultural competencies to promote constructive and affirmative patient preferences and experiences (Cabral & Smith, 2011).

Lack of cultural competence. We have just reviewed why cultural competency is imperative. It is equally important to review why a lack of the same can translate into a paucity of quality mental healthcare and a failure to establish therapeutic alliance. When biases are present in the delivery of services, barriers are initiated that further diminish the road to healing (Diala et al., 2001). Effective treatment of mental health disorders in the African American community calls for culturally appropriate, sensitive knowledge and application of skills (Whaley & Hall, 2009). The expertise often taught in traditional psychology programs remains ineffective in many cultures that vary from the Eurocentric cultures that are overrepresented in psychology research (Watkins, 2011). Thus, the result can be inaccurate assessment and treatment. Gaining a truthful and correct insight and proficiency can promote efficacy in the implementation of culturally appropriate interventions (Hook et al., 2013).

Inaccurate diagnosis. Inaccurate diagnoses can impede accurate and useful treatment. Researchers indicated that African Americans are over diagnosed with schizophrenia (Barnes, 2008). This misdiagnosis therefore puts this population at higher risk for mistreatment that may include wrong medication and therapy. In a

groundbreaking study, Barnes (2008) sought to examine the issue of ethnicity and diagnosis of schizophrenia from several different perspectives: (a) Does a relationship exist between race and diagnosis of schizophrenia by under diagnosis of mood disorders? (b) Does a relationship exist between race and schizophrenia influenced by comorbid substance-related disorders? and (c) In addition to race, what other variable predicts diagnosis of schizophrenia?

Barnes (2008) conducted a retrospective study, reviewing the records of 2,404 adults over 18 years of age with a single admission to a state psychiatric hospital during 1988–1996. The adults had a diagnosis of schizophrenia or mood disorder. The majority of those diagnosed with schizophrenia were involuntarily admitted. Less than 18% had a prior admission, whereas most did not have hospital insurance. Of the 2,404 patients sampled, more than half were diagnosed with schizophrenia. Although only 19.5% of the admitted population was African American, this population accounted for 82.7% of those diagnosed as schizophrenic. These numbers are staggering and should be cause for major concern.

The strengths of Barnes' (2008) study stems from the use of a large database of all state psychiatric hospital admissions over a 9-year period to explore the relationship between race and over diagnosis of schizophrenia for African American patients. The findings suggested that young African American males with less than 12 years education and prior admission were 4.29 times more likely than their European American counterparts to be diagnosed with schizophrenia. However, this study did not indicate whether the prior admission influenced the current diagnosis, nor did it speak to what

diagnosing techniques were employed. Yet, it does underscore that ethnicity and bias were both factors.

Cultural mistrust: A result of inaccurate diagnosis. It is usually a given that healthcare professionals can and should be trusted because patients have to rely upon their opinions and diagnoses for the purposes of getting healthy and staying healthy. Yet, when healthcare professionals create a diagnosis that is inaccurate, especially if based from racism or cultural bias, cultural mistrust can form and subsequent therapy can be thwarted. Much evidence exists that African Americans do not seek mental health due to cultural mistrust (Nickerson, Helms, & Terrell, 1994; Nicolaidis et al., 2010; Terrell & Terrell, 1984). Equally important, confirmation exists that this perception is not unfounded nor an inappropriate survival response. Researchers revealed that medical and mental health providers are less likely to detect, refer, and treat African American patients with appropriate care (Browsky et al., 2000; Carrington, 2006).

The results of many studies indicated that due to cultural and racial bias, as well as a lack of cultural competence; many clinicians' incorrectly diagnose African American patients, compared to European American patients (Moore, 2000). In many settings—mental health clinics, state psychiatric hospitals, and emergency rooms—African Americans continue to be over diagnosed as having schizophrenia, paranoia, and other debilitating and serious disorders (Gross, 1969; Moore, 2000; Whaley, 2002).

Studies have been conducted, presenting vignettes to doctors of psychiatry with identical symptoms. A majority of doctors assigned diagnostic errors with African American patients always viewed clinically as have more severe disorders and deserving

of a more serious diagnosis. Likewise, when real patients presented with similar characteristics and behaviors in the emergency room, Black patients were seen as more dangerous and were more likely to be diagnosed as psychotic (Moore, 2000, p. 158).

Cultural Mistrust

Many reasons exist why African Americans do not seek mental health services: of those, cultural mistrust may be the most prominent. The 1932 Tuskegee syphilis experiment is an example of why this mistrust is present in the minds and community of this population. A medical experiment originally inducted 600 African American men into a study to examine the effects of untreated syphilis. Although, 15 years later (1947) penicillin was established as the known drug of choice to treat the disease, not one of the study participants was informed of the cure.

The study continued for 40 years until a public protest (1972) called for an advisory board to investigate. The panel concluded that, although all of the study participants had given their consent, the men were tricked and not given all of the facts when they gave informed consent. The panel exclaimed that the study of these African American citizens was “ethically unjustified” (CDC, 2011).

Discrimination continues to require attention (R. Clark et al., 1999). In addition to realized discrimination, perceived discrimination can also effect the interactions between the African American and European American populations (Combs, Penn, Cassisi, Michael, Wood, Wanner, & Adams, 2006; Pieterse, 2011; Williams & Williams-Morris, 2000). Numerous studies indicated that African Americans receive inferior medical care when compared to European American counterparts presenting with the same or similar

medical issues (Hollar, 2001; Peters, 2006; Sanders Thompson et al., 2004). Typically, healthcare offices typically put African Americans on lists to see a doctor; therefore, African Americans are more likely to use the hospital or institution as a source of help rather than a primary-care physician. They are less likely to be aggressively diagnosed, referred for evaluation, or aggressively treated. Separate from the clinical criteria, it appears that the cultural origin of the client influences the treatment choices of the clinician (Hollar, 2000). Race continues to matter and the treatment offered by providers may be influenced by the ethnicity of the patient (Bach, Crammer, & Warren, 1999). Thus, cultural mistrust remains, and perhaps not only from historical presence, but including current experiences as well.

Racism and Discrimination

Racism and discrimination are being reviewed because of its ability to impede the development of a successful therapeutic alliance between this racial dyad. Racism is the conglomeration of negative attitudes, beliefs and behaviors that yield an adverse impact upon its' intended victim. It is based solely on the color of skin and assumes that one is superior or inferior simply because they were born with a certain hue (Pachter, Bernstein, Szalacha, & García Coll, 2010). It has been linked with creating mental health pathology (R. Clark et al., 1999). Thus, it should be considered among the factors that may hold influence and impact behaviors by both the African American patient as well as the European American clinician.

In this chapter, I reviewed racism and discrimination as a potential barrier to the success of therapeutic alliance between this racial dyad. Although cultural competency

has the potential to garner empathy and therapeutic alliance, racism and discrimination has the potential to do the opposite. Color-blind racism, mindsets, African Americans represented in psychological research, racist messages in therapy and microaggressions are all facets of racism and discrimination that must be discussed in order to gain a better, and more balanced, view of why the lack of therapeutic alliance and empathy is seen between the African American patient and European American clinician dyad during therapy.

Color-blind racism. Color-blind racism is being reviewed because of its potential to create a barrier to successful therapeutic alliance between this racial dyad. Color-blind bias is the new racism of the 21st century (Neville, Lilly, Duran, Lee, & Browne, 2000). It no longer represents the old form that was overt and blatant. In fact, this new form of racism can dwell with otherwise benevolent Euro-Americans without their conscious awareness (Neville et al., 2000). A 1997 APA pamphlet discussed color-blind racial attitudes: “Color-blindness ignores research showing that even among well-intentioned people, skin color, figures prominently into everyday attitudes and behavior” (Neville et al., 2000, p. 60). Group ideals continue working to maintain power and advantage (Bonilla-Silva, 2007; Morris, 2000b; Sue, & Sue, 2003).

Color-blind racism is a belief that race does not matter (Neville et al., 2000). When people hold this view, they inadvertently deny the fact that race and racism has historically and currently causes undue stress, unequal opportunities, and increased exposure to violence, incarceration, and poverty. Physical and mental distress are some of

the negative outcomes that result from discriminatory practices, established and maintained in many of North American institutions (R. Clark et al., 1999).

Racism and discrimination manifest in various ways today: Blacks, in particular, are significantly poorer than Whites; receive inferior education, even when attending the same institution; and pay more for same housing, despite being often excluded from certain areas of the housing markets through the use of voting boards (McIntosh, 2007). Failed attempts to hail taxicabs when standing near their European American cohorts, discriminatory treatment in restaurants, stores, hospitals, and other business and social dealings, also account for continued racism in today's society (Bonilla-Silva, 2007). The effects of racism are possible precursors to psychological pathology (Bynum, Burton, & Best, 2007; R. Clark et al., 1999). Therefore, it is important to look at the many ways that African Americans experience racism in the present society.

Mindsets. Certain mindsets can continue the legacy of color-blindness and racism. Mindsets that have the potential to lead to racism is being reviewed because of it's potential to create a barrier to successful therapeutic alliance between this racial dyad. The following are some portions of interviews that took place with White interviewees. When a student at an American university was asked about having Black friends, the student stated,

Most of my friends don't ... I don't have many close Black friends. It's not like we exclude, I don't feel like we exclude people. I don't think we go out of our way to include people either. ... It just seems that's the way it works out (Bonilla-Silva, 2007, p.134).

When the same student, who was a business major, was asked if the way things were set up in the business school were racist, the student answered accordingly. After first acknowledging that most of the business students were White males, the student said,

I don't really think its racist. ... I just think its an example ... or just things aren't set up in such a way where I wouldn't say it favors Whites. That's just the way it happens, in the business school. That's all (Bonilla-Silva, 2007, p.134)!

This quotation exemplifies the naturalization or normalizing actions that might otherwise be interpreted as racially inspired or oppressive; a term used to frame ways of thinking by some Euro-Americans (Bonilla-Silva, 2007).

In effort to expose and explain examples of ways some people may minimize racism, another individual was asked to comment on reasons African Americans' trail behind European Americans and to discern if it was because African Americans are lazy. The student replied:

Yeah, I totally agree with that. ... You now they're all like that. I mean if it weren't that way why would there be so many Blacks living in the projects? Why would there be so many poor Blacks? If they all worked hard, if they just went to college and just worked hard as they could they would ... they could make it just as high as anyone else (Bonilla-Silva, 2007, p.137).

These few quotations show a framework that often transcends individuals into policies that have negative and oppressive implications for those who are not considered to "belong" to the "normal" larger Eurocentric culture.

Many Whites hold a Eurocentric worldview that minorities are solely responsible for racial problems (Bonilla-Silva, 2007). Many deny that racism, whether in philosophical or operational form, does exist. This denial is held by well-meaning individuals but perpetuates the existence of racism because it denies or refuses to acknowledge its existence and the negative effects and deleterious claims on many people of color, including African Americans (Dunn & Nelson, 2011). This belief is dangerous when maintained by the general public, but even more devastating when it is a part of the beliefs and behaviors of well-intentioned psychologists who sit in a seat of potential therapeutic promise.

Color-blindness has also been associated with White privilege. McIntosh (2007) in the article "White Privilege: Unpacking the Invisible Knapsack," described acknowledging having White privilege after first realizing that men had a privilege that women did not. These privileges were maintained at the expense of women's disadvantages. Similarly, White people such as the author had been taught not to recognize their privilege consciously, although it existed. This denial of privilege also allows for dismissal of the possibility of disadvantage that others, especially solely based on ethnicity or gender, may be addressing on a daily basis. These advantages often provide "blank checks and special provisions, codebooks," claimed McIntosh. The author averred that most White people operate from an unacknowledged basis of privilege and do not consciously see themselves as oppressive.

McIntosh (2000) described acknowledgment of White skin being an asset that allowed the author to have the self-perception of "belonging in major ways" and

therefore, had the confidence to make decisions to move in directions unavailable to others. The author understood that membership in this main and dominant culture allowed privileges “such as being comfortable, belonging, and feeling confident.” At the same time, these privileges caused other human beings from different, minority ethnicities to feel uncomfortable, unconfident, and alienated. When one does acknowledge the presence of racism and privilege, one must ask themselves what actions will they take to end it? (McIntosh, 2000). This poignant question is salient to the core of social change.

Counselors must stand ready to assist people of color with their mental health needs, becoming aware and acknowledging that racism does continue to exist in the greater society. Also, racism and advantages for some means disadvantages for others. Each must acknowledge his or her own biases, which do impact the therapist–patient relationship. Counselors’ awareness of racism is fundamental to multicultural counseling (Burkard & Know, 2004). “Without such awareness, therapist’s’ own biases may perpetuate oppression against racial-ethnic minority patients during the psychotherapy process” (Burkard, 2004; Helms, 1984). Clinicians must take a stand for professionalism and leadership in this crucial area that has the power to accelerate change and promote healing a broken people, field, and world.

African Americans’ representation in psychological research. Psychological research is important because it often leads to a better understanding of the needs of the people the mental health community seeks to serve. Thus, it is exceedingly appropriate to recognize that cultures can and often do influence how people think and behave. It

follows logically that if people are from different cultures, research that is applicable to them is also imperative. But, often times when African Americans and other marginalized cultures are represented in psychological research it is associated with drugs or excessive pathology, giving the readers an unfair and biased perspective of these cultures of color. These actions serve to continue the racism and discrimination even within the healthcare system that seeks to teach and prepare clinicians to provide appropriate and useful care to African American patients.

In 2003, APA, a major contributor of research findings in the field of mental health, argued that cultural competency should be incorporated into education and practice (APA, 2003). Since then, very few graduate programs in psychology have made great leaps toward developing and instituting multicultural training. Most programs only require one course in multicultural psychology (Chao et al., 2011). Likewise, steps to increase research participation of minorities have been scarce (Watkins, 2012).

Watkins (2012) investigated the level of representation in the findings of psychodynamic-psychotherapy-treatment research in non-White participants. The author conducted a meta-analytic review of eight psychodynamic-treatment research studies over the past 10 years. The researcher reviewed the race/ethnicity of participants in each study and took note of the absence or presence of age, gender, and socioeconomic information included in the study.

Watkins (2012) studied how data were reported for over 9,000 participants in 104 studies. Of the 9,000 participants, only 2,629 were identified by race. The majority (1,959) were identified as European American; 553 as African American; 42 as Latino,

six as Asian, and only one as American Indian; 20 participants were classified as “other” and 48 were documented as “unspecified.”

Because race and ethnic population growth are the new reality, accurate reporting of racial and ethnic participants would increase the understanding of these cultures and improve clinician practice in the field with ethnic clients (Watkins, 2012). It is important to be cognizant the degree of inclusivity of research in regard to race and ethnicity. Also, if the information is not reported on race, one could assume the pool was homogenous, comprised of nonminority participants (Watkins, 2012).

Watkins’s (2012) meta-analysis findings were as follows: 75% had no racial or ethnic information; 75% of participants were White, 21% Black, and 4% a mix of Asian, Latino, Indian, and unspecified. Although ethnic minorities only represented 25% of the total 9,000 participants, over 80% of these 25% came from studies addressing primarily cocaine and opiate addiction. Until 4 years ago (1990–2010), 75% of studies still had unreported racial information. Socioeconomic and education levels continued to be underreported. As demographics change, recruiting practices should also change in psychodynamic-treatment research. “Psychodynamic psychotherapies are not ‘for whites only’ but unless samples are better categorized and more ethnic minorities are represented in samples it will continue to appear that way” (Watkins, 2012). This is a problem for all minorities and in particular, current and potential African American mental health clients.

Do Messages of Racism Continue in Therapy. Messages of racism can threaten any relationship. It is particularly detrimental in a therapeutic relationship between a

client and a clinician. Therefore, it is important for the mental health clinician to create an environment that is free from such deleterious communications. Racism has a long and deleterious past in U.S. history. African Americans have been at the forefront and have felt the brunt of countless discriminatory acts against them. Race has played a large role in how others view and treat African Americans. Race has also affected how African American view themselves internally and externally as a part of the larger society. Oftentimes, the effects of racism have rendered psychological pathology on its targets (R. Clark et al., 1999). As a result, a person of African American heritage may choose to seek mental health help. The question remains to be answered, how is race handled in therapy?

Brown, Blackmon, Schumacher and Urbanski (2012), looked at demographic variables and how those correlated with the likelihood of racial socialization in sessions with African American patients. They compared which socialization messages were more apt to be used and the therapist age and experience. They also examined racial socialization tools used in the community to see how they could be used in therapy. Brown et al. used two tools: a 39-item survey based on racial-socialization literature and the Teenager Experience and Racial Socialization scale, and the Scale of Racial Socialization. The researchers used an ANOVA test to examine the impact of race, gender, age group most worked with, and how important it was to show concern when talking about race and discrimination.

The Brown et al. (2012) findings suggested that therapists are socializing agents by sharing messages about race and racial struggles. A relationship may exist between race of the therapist and age group of the client when turning a “blind eye” to racism.

Perceived racism weighs heavily on the psyche of African Americans. Therefore, a special definition of mental health is needed for this group. Racism or discrimination takes place not only in daily interactions but also when seeking mental health help. Mistrust and poor treatment by healthcare professionals are major factors in explaining why African Americans often do not seek help.

Racism by clinicians may be exercised by not addressing race at all, as though there is no issue. Avoiding or failing to emphasize race issues does not help in building a therapeutic alliance with African Americans. It is counterproductive to employ avoidance or downplay that racism still exists. These actions have been associated with low empathy and with therapists faulting African Americans for their own problems. Brown and colleagues (2012) proposed that talking about race and racism in the lives of African Americans should be included in therapy. They further concluded that racial socialization can help combat racism. Brown et al. concluded that racial socialization should be included as a viable part of treatment with African American clients. Such inclusion can help build strong therapeutic alliances and help eliminate factors that keep African Americans from seeking help.

Brown et al. (2012) argued that many clinicians did not talk about race until it was shown to be part of the mental health issue. Clinicians should address race because in a short-term treatment it is usually related to the problem at hand. African American clinicians were more apt to use spiritual coping than their European American counterparts. Clinicians have different ways of talking about race in therapy, showing the

decision to do so relates to context. Racial socialization may be a social-justice tool to be used with African American clients.

If a patient has reduced hopes concerning the efficacy of therapy, they will often be more attuned to encounters that validate their beliefs (Westra, Constatino, & Aviram, 2011). Many African Americans do not like to seek help (Conner et al., 2010; Villatoro & Aneshensel, 2014). This attitude is often associated with perceptions of being stereotyped and misunderstood by the clinician (Walling, Suvak, Howard, Taft, & Murphy, 2011). When they do introduce the topic of race, clinicians must be cautious about how race is handled. How a therapist handles issues of race and discrimination is important in building and maintaining a therapeutic alliance. Study results indicate that when a therapist does practice racial socialization in sessions, it is something that already happens in the real world and therefore promotes African American mental health (Brown et al., 2012).

Increases in microaggression relate to decreases in therapeutic alliance.

Microaggressions have been known to create upset and harm within the targeted. These microaggressions can therefore take away from any previously established connections. Perceived discrimination can be associated with mental health problems (Pieterse, Todd, & Neville, & Carter, 2012). Thus, discrimination is a factor of concern in providing culturally appropriate and useful counseling to people of color. Microaggression is a type of covert and shrewd racial prejudice that racial minorities routinely agonize about (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011). Wang, Leu, and Shoda (2011) argued that microaggressions are commonplace, everyday experiences that occur in

public. They suggest that aggressions convey subtle forms of discrimination and racism that, although minimal, can impact the emotional well-being of the targeted individual or group. These stressors can be factors in poor mental health and have been associated with major depression, panic disorder, PTSD, and substance abuse (Chou, Asnaani, & Hoffmann, 2012; Torress & Dricoll, 2010).

Microaggressions take place in public as well as in the therapeutic setting of counseling (Torres & Driscoll, 2010). They can lead to ruptures in the therapeutic alliance, if left unattended (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011). Thus, microaggressions should not be overlooked. Owen and colleagues (2012) conducted research to see if clients thought microaggressions took place based on differences in ethnicity between them and clinicians. They also wanted to explore if microaggressions would ruin the usefulness of therapy and if the positive therapeutic alliance could overrule the microaggressions.

The authors sent a survey electronically to willing participants (Owen et al., 2012). This survey was made up of questions using the Racial Microaggressions in Counseling Scale, the Schwartz Outcome Scale-10, Initial Emotional State and Individual Treatment Alliance Revised-Short Form. A total participant pool of 232 clients was comprised of 171 women and 74 men with an average age of 22. Only 1% were African American, 20.3% Asian, 8.6% Hispanic, 16.3% multicultural, and 49.4% European American. By professional, 29 therapists participated: three African Americans, two Latinos, seven Asians, and 17 European Americans).

Owen and colleagues (2012) concluded that microaggressions do have a negative effect on a therapeutic alliance, thereby influencing treatment. These microaggressions may lead to broken bonds between the client and clinician and also serve to shift the focus away from therapeutic goals. These authors suggested therapists may have subconscious or deeply rooted prejudice against members of certain cultures. Tending to biases before entering the counseling room will help create a therapeutic setting. Thus, Owens et al. (2012) posited that a strong therapeutic alliance does help cancel out microaggressions and serves to maintain a positive view of the therapist by the client.

Attitudes and Beliefs of African Americans

To better understanding the world-view of any group of people, a review of their attitudes and behaviors is imperative. African-Americans do not seek mental health help at the same rate as their European American cohorts. But when they do seek help, they routinely cease attending sessions; some authors agree that ruptures in therapeutic alliance are the cause for the early termination (Owen et al., 2011 & Westra et al., 2011). It has been established that in order to have successful therapeutic alliance, empathy must be employed. In order to have empathy for the patient the clinician must have an understanding of the attitudes and behaviors of the patient that presents for treatment. Attitudes and behaviors are often cultivated at least in part, by culture. Personal experiences are impacted by societal influences.

The well-informed and culturally sensitive clinician should have an understanding of attitudes and beliefs of their African-American patient in order to better comprehend how the patient's ideas, mindsets and behaviors are influenced. A problem does exist

with garnering a successful therapeutic relationship between the European American clinicians and African-American patients. Examining the coping styles of African-Americans, the effects of discrimination on the attitudes and beliefs of African Americans, and the attitudes and beliefs among specific subgroups of African-Americans, will help to foster a better understanding of what factors contribute or take away from this success.

The attitudes and beliefs of many African American members have a long and deep connection to their treatment in the greater U.S. society (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). The history of abuse has left enduring scars on the psyche and spirits of Black people (Pieterse, Todd, Neville, & Carter, 2012); thus, many attitudes toward the larger society can be negative, even when receiving medical and mental health help (Gonzalez, Algeria, Prihoda, Copeland, & Zeber, 2011). Social and institutionalized discrimination from the larger society has caused stigmatization associated with seeking mental health support to be even greater for African Americans than that felt or experienced by non-minorities (Cheng, Kwan, & Sevig, 2013; Lindsey & Marcell, 2012).

Coping. The way people cope with problems is important to their mental health. According to a USDHHS report (2001), African Americans suffer more chronic physical health and mental health disorders than their European American cohorts. More than 10% of depressed Americans are African American. Close to 19% of those affected by mental illness overall are African American. This minority group carries an unusually high

burden of disability compared to other ethnic groups in the United States and compared to the majority European American group (Ward, Wiltshire, Detry, & Roger, 2013).

Research results vary about attitudes of African Americans seeking mental health help (Cheng, Kwan, & Sevig, 2013; Ward et al., 2013). Some studies indicated that African Americans are confronted with unusually high levels of stigmatization and thus seek care less than other groups. Other results suggested African Americans have positive attitudes toward seeking support, though these positive attitudes have not caused a higher occurrence of seeking traditional professional mental health support (Ward et al., 2013).

Many barriers face African Americans seeking help (Cabral & Smith, 2011; Carr & West, 2013; Ward, Wiltshire, Detry, & Brown, 2013). Stigma—personal and public—hold a high concern for many. Access to care and concerns about receiving culturally appropriate and empathetic care continue to be barriers (Abdulla & Brown, 2011; Cheng et al., 2013; Ward et al., 2013). Thus, many African Americans are left to cope on their own. Because some African Americans feel that mental health is a sign of weakness, many will not confide in others. Some studies indicate other reasons for self-concealment; such as lack of confidence in and perceived discrimination and stigmatization from the European American mental health professionals they would be seeking care from (Wallace & Constantine, 2005).

Ward and colleagues (2013) posited that religion is a major source of preferred coping technique in the African American community. The researchers conducted an exploratory cross-sectional survey with 272 African Americans between the ages of 25 and 72. The study aim was to discern the preferred coping behaviors of this ethnic group

in addressing mental health issues. The authors found that study participants were not willing to admit to mental health issues for fear of stigmatization. Although, slightly willing to seek help, they had a preference toward seeking out help in the form of prayer and building a relationship with God (Ward, Wiltshire, Detry, & Brown, 2013). Notably, the results for this study indicate that African Americans were somewhat hesitant even about engaging in informal acts of seeking help from others, for fear of stigmatization. This differs from other literature results regarding this topic (Conner, Lee, Mayers, Robinson, Reynolds, Albert, & Brown, 2010; Gonzalez, Algeria, Prihoda, Copeland, & Zeber, 2011).

The effect of discrimination on the attitudes and beliefs of African Americans.

Discrimination is a conglomerate of adverse actions toward a specific group based on their ethnic or racial background. These deleterious actions result in unfair treatment and a disparity in experiences encountered by those marginalized (Pieterse, Todd, Neville, & Carter, 2012). The life-time prevalence of both overt and covert prejudice in the lives of many African Americans, have left many of them resistant to future experiences (Lindsey et al., 2012; Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). Fear of discrimination in therapy can often translate into a refusal to accept professional support (Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014). Many African Americans suffer from psychological burdens caused by discrimination (Chou, Asnaani, & Hoffmann, 2012; Pieterse, Todd, Neville, & Carter, 2012). Whether emanate or perceived, racial biases have been linked to psychological distress. Through a racism-related stress model, R. Clark and colleagues (1999) postulated that racism and psychological distress were

associated. These Psychological distresses are often diagnosed in the form of anxiety, PTSD, major depression, suicide, homicide, OCD and substance abuse (Chou et al., 2012; Williams, Domanico, Marques, Leblanc, & Brown, 2012).

Discrimination can produce cultural mistrust and often prevents many minorities, including African Americans, from seeking mental health help (Williams & Sternthal, 2010; Gonzalez, Algeria, Prihoda, Copeland, & Zeber, 2011). However, if an African American does decide to receive professional support, discrimination or biases that are revealed in the form of microaggressions from the clinician can also cause premature aborting of therapeutic sessions (Owen, Imel, Adelson, & Rodolfa, 2012; Rosen, Miller, Nakash, Halperin, & Algeria, 2012).

Attitudes and beliefs among specific subgroups of African Americans. The attitudes and beliefs of ethnic and racial minority groups, in particular African Americans, concerning seeking mental health support, are usually different from the larger European American culture within the United States (Cheng, Kwan, & Sevig, 2013; Hunt & Eisenburg, 2010; Lindsey & Marcell, 2012; Ward, Wiltshire, Detry, & Brown, 2013). Their values and norms are usually cultivated from their history, and origins as well as their assimilations within the United States. In the next few paragraphs, a small subset of African American college students, seniors and African American men, within the minority community are reviewed for their perspectives on how they deal with mental health issues and seeking care.

African American college students. Though a variety of college students have been noted to have many recognizable and diagnosable mental health issues, most never

pursue assistance from professionals (Cheng, Kwan, & Sevig, 2013; Hunt & Eisenburg, 2010). People of color, African Americans in particular, are amidst those groups who do not regularly employ nor as a result get to benefit from counseling. Yet, they are among the hardest hit by psychological distress (Lindsey & Marcell, 2012; Ward, Wiltshire, Detry, & Brown, 2013). This creates a disparity in utilization and a problem for minorities.

In a recent study Cheng, Kwan, and Sevig (2013) explored how stigma correlated with help-seeking behavior among people of color. Previous studies have yielded mixed results concerning minorities and attitudes toward mental health (Abdulla & Brown, 2011; Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011). Looking at 609 racial and ethnic minorities college students in the Midwest, they conjectured that both self and public stigma would be linked with higher levels of psychological distress. Their study results confirmed their hypothesis. They found that perception of public stigma did influence their self-stigmatization concerning seeking help for mental health issues. Perceived discrimination was highly correlated with perceived stigmatization from others. However, the more closely a participant related to their ethnicity the more secure they felt psychologically and thus were less likely to be influenced by others ideas towards them (Cheng, Kwan, & Sevig, 2013). In contrast, authors Nickerson, Helms, and Terrell (1994) concluded that African Americans who indicated more racial identity were more inclined to have more cultural mistrust and would be less likely to seek help from counselors, who are predominantly European American. Likewise, Townsend, Chevez-Korell, and

Cunningham (2009) found that strongly internalized racial identity with one's African American culture causes African Americans to prefer African American counselors.

According to Cheng (2013), as psychological distress increases, perceived public or social stigmatization and self-stigmatization associated with seeking help for mental health also increases within the ethnic and racial groups. Double stigmatization occurs for these marginalized minority students struggling with prejudice or bias and stigma concerning seeking mental health support. Because One's identity may be intrinsically tied to a minority group this may promote cumulative feelings of discrimination for them personally and perceived discrimination from mental health professionals, in particular (Cheng, 2013). This is especially true for African American college students who have Afrocentric cultural values. Thus, African American students are more likely to hold negative attitudes toward seeking mental health help and are more likely to exhibit self-concealment behaviors (Wallace & Constantine, 2005).

African American seniors. National records indicate that the growing senior population is not without its' share of mental health disorders. The projected numbers of mental health disorders among this population could potentially reach 8 million by 2030 (Institute of Medicine, 2012). Similarly noted with college students, seniors have to address individual and community stigma as hindrances to seeking mental health support (Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014). For many members of the aging African American community, stigma carries more negative impact when seeking support than for their aging European American cohorts. This greater impact is probably associated with past abuses in institutionalized medicine (Sirey et al., 2014).

In a recent study on senior citizens with an average age of 82, Sirey and colleagues (2014) explored ethnic and gender differences in reporting expected social stigma connected with seeking support for a mental health issue. Of a total of 732 elder subjects, 26% (190) were African American and 74% (542) were European American. The researchers found that African American were more likely to be referred for nutritional counseling than mental health counseling. Only 11 African Americans were referred to a psychologist, compared with 32 of their European American cohort.

Referrals for mental health support are regulated by anticipated stigma. Those with depression and elevated expectations of stigma were less likely to receive a referral for help. Even when people were not depressed, African Americans tended to hold the heaviest burden of anticipated stigma from their network of friends and family, with regard to seeking psychological help. Having mental health issues is seen as a weakness in the African American community (Sirey, 2014; Ward, Wiltshire, Detry, & Brown, 2013).

African American men. African American men are among the most resistant in the African American community to seek support for their mental health burdens (Lindsey & Marcell, 2012). Researchers suggested that this minority group might be severely underrepresented in research and clinical practice (Carr & West, 2013; Ward, Wiltshire, Detry, & Brown, 2013). When researchers include African American men in mental health research, they are usually associated with topics of substance abuse (Watkins, 2012). Researchers posited that many untreated psychological issues presage drug and alcohol misuse for this ethnic minority group (Lindsey et al., 2012). Unattended

mental health burdens have also been linked with chronic diseases such as obesity, cardiovascular disease, and diabetes (Lindsey & Marcell, 2012). African Americans are at the top of most chronic disease lists in the United States (National Vital Statistics Report, 2013).

Lindsey and Marcell (2012) examined facilitators and barriers that impacted the help-seeking behaviors of African American men. A trained moderator conducted four focus groups with a total of 27 African American men with an average age of 20.4 years. Three major themes emerged: handling their emotional and mental health issues by themselves, seeking informal help, and specific times when they realized they were on the verge of a serious breakdown. These factors helped highlight reasons for delays in seeking help and when making a decision to seek support.

The African Americans in this study described a sense of autonomy, lack of knowledge about mental health knowledge and resources, and deep concerns about whether they could trust someone with their personal and intimate mental health issues. The relationship, bond, and quality of interactions between them and a person they would trust to help them was noteworthy (Lindsey & Marcell, 2012). According to these authors, help-seeking attitudes and beliefs of African American men align with compassion, understanding, and relationship. These characteristics also align with empathy and therapeutic alliance. These studies reveal a link to why this researcher is asking the following research questions: What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician? From the perspective of African American clients, what were the most satisfying aspect and the

most difficult part of treatment with a European American clinician? And based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

Summary and Conclusions

It has been well established that therapeutic alliance delivers positive therapeutic outcomes. Empathy, a component of therapeutic alliance, is a key element that may be lacking in the therapeutic relationship between African American patients and their European American clinicians. Study results (Barnes, 2008; Moore, 2000) indicate that cultural mistrust can form from a lack of cultural competency as well as perceived racism and discrimination. To better understanding the world-view of any group of people, a review of their attitudes and behaviors is imperative. The well-informed and culturally sensitive clinician should have an understanding of attitudes and beliefs of their African-American patient in order to better comprehend how the patient's ideas, mindsets and behaviors are influenced. The attitudes and beliefs of African American community members concerning seeking mental health support are usually different from the larger European American culture in the United States (Cheng, Kwan, & Sevig, 2013; Hunt & Eisenburg, 2010; Lindsey & Marcell, 2012; Ward, Wiltshire, Detry, & Brown, 2013). A gap remains because researchers are unclear as to what factors are necessary for a successful therapeutic outcome between this racial dyad. This current study seeks to explore the lived experiences of African American patients having had mental health

counseling with a European American clinician. Additionally this study will investigate which factors are needed for a successful therapeutic alliance between this racial dyad.

In this chapter, in addition to providing a literature-search strategy and the conceptual framework of empathy, I have provided a compilation of literature reviews on the following subjects: therapeutic alliance, cultural mistrust, cultural competency, racial discrimination, and attitudes and beliefs of African Americans. Empathy was examined because of its' unique ability to provide access to therapeutic alliance. Therapeutic alliance was investigated because it is the main subject of this study and has the ability to foster the cohesiveness needed to provide positive therapeutic outcomes between the racial dyad of African American patients and European American clinicians. Likewise, discussions about cultural mistrust, cultural competency, racism and discrimination and the attitudes and beliefs of African Americans provided a look at factors that further effect the therapeutic alliance between this racial dyad. As part of my discussion of empathy I integrated empathy as a concept, the history of empathy, the components of empathy and how the concept of empathy is used in literature. As part of my discussion of therapeutic alliance, I included the history and definition, the benefits of, therapeutic alliance and race, the evolution of therapeutic alliance and race, plausible reasons for a lack of therapeutic alliance between the African American and European American therapeutic dyad: Rationale for selection of concepts. As part of my discussion of cultural competency, I included discussions on lack of cultural competency, inaccurate diagnosis, and cultural mistrust: a result of inaccurate diagnosis. As part of my discussion of racism and discrimination, I incorporated discussions on color-blind racism, mindsets, African

Americans' representation in psychological research, do messages of racism continue in therapy and, increases in microaggression relate to decreases in therapeutic alliance. As part of my discussion of Attitudes and beliefs of African Americans, I discussed coping, the effect of discrimination on the attitudes and beliefs of African Americans, attitudes and beliefs among specific subgroups of African Americans such as college students, seniors and men.

The chapter has included a literature search strategy, the conceptual framework of empathy, empathy as a concept, the history of empathy, components of empathy, as well as how this conceptual framework relates to this study. Also included are a literature review of related key concepts such as therapeutic alliance, empathy as a necessary component of therapeutic alliance, cultural competency, cultural mistrust and how racism destroys the possibility of empathy and thus the formation of therapeutic alliance. A review of attitudes and beliefs of African Americans have also been included in this chapter not as an after thought but, due to its ability to shine further light on our understanding of how the African American culture may view the world. Having this insight may increase the ability and opportunity for the European American clinician to connect with and create a successful therapeutic alliance with their African American patients. Ensuring that European American clinicians, as the majority of psychologists and psychiatrists, come to the therapeutic process prepared with culturally appropriate and useful knowledge and skills that can be applied in therapy is important (Cabral & Smith, 2011).

Exploring the lived experiences of African American clients in therapeutic relationship with European American clinicians is necessary for increased comprehension and empathetic application. This study holds potential to lend improved understanding of the factors that contribute to successful therapeutic alliance between this racial dyad. Exploration of this relation is best approached through the a phenomenological qualitative design, due to researchers' ability in using this design to discover the patterns and themes associated with African American participants' lived experience in therapy with a European American counselor. Study results may yield useful knowledge that can translate into culturally appropriate and applied skills. Chapter 3, which will include major sections such as: introduction, research design and rationale, role of the researcher, methodology, and issues of trustworthiness, will follow this chapter.

Chapter 3: Research Method

Chapter 3 provides the methodology for the present study. Topics of discussion include an introduction to review, the study purpose, research design, and rationale for the study design. Additionally, the role of the researcher, methodology, and the instrumentation used is provided. Issues of trustworthiness are also discussed. The research questions and the interview protocol as it relates to the research questions are also addressed. Chapter 3 provides a data analysis plan, as well as issues of trustworthiness and ethical procedures. The chapter concludes with a summary.

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African American clients think about their lived experiences and to identify elements of a good alliance.

Research Design and Rationale

The following research questions were used for this study:

Research Question 1: What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician?

Research Question 2: From the perspective of African American clients, what was the most satisfying aspect of treatment with a European American clinician?

Research Question 3: From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider?

Research Question 4: Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

The central phenomenon of the study concerned the lived experiences of African American patients who had mental health counseling with a European American clinician. The following concepts were studied for this research: therapeutic alliance, and the collaborative efforts between the therapist and client to work on mutually agreed goals. A relationship that includes honesty and mutual respect allows for empathy and bonds to form as they engage in the process of healing (Horvath, 2001): Empathy is a necessary component of therapeutic alliance, cultural competency, cultural mistrust, and how racism is mainly a product of learned behavior and destroys the possibility of empathy and the formation of therapeutic alliance. A review of attitudes and beliefs has also been included to shine further light on the understanding of how the African American culture may view the world. Having this insight may increase the ability and opportunity for the European American clinician to connect with and create a successful therapeutic alliance with their African American patients.

African Americans do not seek help at the same rates as their European American cohorts (Villatoro & Aneshensel, 2014). When they do seek help, African Americans often leave sessions before they have had a chance to receive care that is empathetic, culturally competent, and useful (Westra et al., 2011). I explored the lived experiences of this ethnic population to increase understanding as to how the needs of this community can be better met.

Research Tradition: Qualitative Versus Quantitative

Various methods exist to create a study in social science research. All valid methodologies entail inquiry, collecting and analyzing the data to draw conclusions, creating a better understanding, and adding to the scientific conversation. Some possible approaches include quantitative, qualitative, and mixed-method methodologies (Marshall & Rossman, 2010).

Quantitative designs are useful when researching a larger pool of participants with the intent to broaden the findings to the general population. Experiments conducted usually involve assigning certain participants to certain conditions. In a quantitative survey design, researchers employ questionnaires for data collection (Creswell, 2013).

Research Rationale

A qualitative study design is the best choice when the researcher desires to learn about the lived experiences of a particular group of people. The researcher conducts interviews with a small number of willing participants to collect pertinent information. Types of qualitative designs include grounded theory, narrative, case studies, ethnographies, and phenomenological studies. The phenomenological design is useful when the researcher desires to learn the quintessence of the encounter (Moustakas, 1994). When looking at the relationship of the phenomenon to the individual, their behavior and their experience are closely tied. Moustakas (1994) saw this approach as particularly key in learning about a phenomenon. The phenomenological design provides a platform for the voices of those directly affected by the phenomenon to describe their lived experience,

immersing the researcher in the experiences from the participants' worldview (Creswell, 2013).

I chose to employ a qualitative study design using a phenomenological approach to discover the patterns and themes associated with African American participants' lived experience in therapy with a European American counselor. Through confidential and in-depth interviews with a small number of participants, I sought to better understand this phenomenon and add to the social scientific conversation surrounding therapeutic outcomes in this racial and ethnic dyad.

Role of the Researcher

I was successful in minimizing my role in this study. I did not occupy the role of the observer, participant, or observer-participant. Rather, I conducted two telephone or in-person interview with each participant. I served only as a recipient of the information, as told by the participant. I had no personal or professional relationship with participants and had no supervisory or instructor relationships involving power over any participants. There were no power relationships to be managed. No other ethical issues needed to be considered, as there were no conflicts of interest. This study was not conducted in my workplace. There were no power differentials to be considered between and the participants. As with any researcher conducting a study, it was possible that I came to the study with preconceived notions about how a study will conclude. Additionally, having a similar ethnicity with the participants could have caused me to make assumptions about what the participant may believe, think or feel. However, I entered the interview process acknowledging this possibility and having considered this intentionally sought to hear

what the participant was saying and not assume that I already knew what the participant would say. I made a decision that whatever the facts indicated was what I would report.

I am African American, which may have aided me in the research as far as being with the participants (Walker, 2011). Many African Americans do not routinely engage in research, considering the unethical practices upon members of the African American community in past research studies, for example the Tuskegee Experiment (R. Clark et al., 1999). I had the ability, sharing similar culture and ethnicity with the participants, to put the participants at ease and allow them to speak freely (Walker, 2011). There was no resistance to building therapeutic alliance between the participants and me because of the shared experiences in the world. I had no agenda in the outcome and was only interested in learning and highlighting the lived experiences of African Americans in therapy with European American counselors. Additionally, all researchers experience the potential to influence interviewees with voice pitch, giving direction to desired responses. These factors were considered beforehand. I sought only to receive data in its purest form without influencing the participants by what was asked or how it was asked.

Methodology

Participant Selection Logic

I drew participants from a population of self-identified, adult, African Americans. These same participants identified themselves as having had counseling with a European American therapist. I sent out e-mails to chapter presidents of African American fraternities and sororities and did appear before groups of people at organized meetings of churches and African American sororities and fraternities, as well as put up flyers at

local mental health clinics in the Southeastern region of the United States (see Appendix A). The purpose was to ask for willing participants who were African American adults (18 and older) who had therapy with a European American clinician, and who lived in the southeastern geographical area to participate in this study.

Sampling strategy. Through a purposeful sampling methodology, I invited 10 participants to participate in the study based on their congruence with the study's aforementioned requirements. Purposeful sampling is guided by the concepts in the qualitative study design (Creswell, 2014). I used purposeful sampling to explore the lived experiences of African American adults who had mental health counseling with a European American therapist. These conditions established that the participants met the study's criteria.

Random sampling is usually not a good fit for a qualitative study (Seidman, 2012). Randomly sampling involves selecting people from the larger population to generalize back to the larger population. However, for this study, random sampling from the larger U.S. population would not guarantee that either requirement, being African American or having had therapy with a European American counselor, of the study would be fulfilled. Therefore, I did not use random sampling in this study.

Snowball sampling occurs when the researcher builds on insights from earlier connections. Originally, I thought I might have to employ snowball sampling if needed. However, there was a show of support for this type of study from the African American community I conducted purposeful sampling with people I had spoken to about the study who may know of others who fit both of the study's requirements. Snowball sampling

was not employed in this study because initial recruitment strategies were successful in yielding enough eligible participants.

Rationale for participants. An ample sample size, in phenomenological studies, is achieved when the saturation of information has been achieved (Englander, 2012). Thus, I could not be conclusive concerning the exact amount of participants needed before the study was conducted. However, it was estimated that a total of eight to 10 participants would be invited to engage in an in-depth interview. Due to the high response to initial recruitment efforts, 10 participants were recruited to participate in the study. Saturation of ideas was achieved. In phenomenological studies, the sample size is usually small, ranging from as little as one participant to over 100 in some cases (Creswell, 2014). However, 10 participants are usually seen as significant and sufficient number (Creswell, 2014).

I drew participants from a population of self-identified, adult, African Americans who had identified themselves as having had counseling with a European American therapist. I sent out e-mails to chapter presidents of African American fraternities and sororities and appeared before groups of people at organized meetings of churches and African American sororities and fraternities. I also posted to my personal Facebook as well as an organized closed group Facebook page. I received institutional review board (IRB) permission prior to posting flyers or electronic post of any kind. Flyers were also made for placement in local mental health clinics and church within the Southeastern region of the United States for purposes of recruitment.

I made personal contact by telephone, e-mail, or face-to-face with each participant initially to make introductions and to reveal the purpose of the study. Seidman (2012) posited that the researcher should make initial contact to help to establish the groundwork of an interviewing relationship. Proper and useful interviewing is based on a relationship between the interviewee and the interviewer. Mutual respect is necessary for the interview to be truthful, useful, and purposeful. The contacts between the parties are essential (Seidman, 2012).

Instrumentation

A researcher-developed instrument was used to capture the demographic information of each participant (see Appendix B); an interview protocol (see Appendix C) was used to collect the data in this study. Through the use of audiotape, the information was recorded and then transcribed. There were no historical or legal documents that were used as a source of data. Sufficiency of data was established through saturation of the data. When the information being presented by the participants' ceased to yield new information, saturation had been accomplished (Strauss & Corbin, 1998).

Researcher-developed instruments. The interview protocol emanated from the literature in terms of informing the questions that I asked (Creswell, 2007; Englander, 2012). However, I created the actual questions for this study. According to Creswell (2007), qualitative study questions should be open-ended, be few in number, and become more detailed as they progress. These series of interview questions (see Appendix C) were used to answer the four research study questions. To explore this study's aim, four research questions guided the information collected. Data collection included

demographic information and interviews with participants. Appendices B and C include the information that was gathered. The interview questions were created for this study. However, they were tested for understandability and comfort ahead of time. Saturation established sufficiency of data collection to answer the research questions. Saturation occurred when no additional information was present or became available (Strauss & Corbin, 1998).

Content validity was established through the interview process (Creswell, 2007). Qualitative researchers must establish whether or not they have interpreted the information correctly. One way to do this is through a series of interviews. I asked the same probing, open-ended questions of each participant. The interviews were audiotaped and then transcribed by a professional transcriber. I created codes and summarized them and looked for themes. A second interview lasting no more than 25 minutes was conducted, allowing the participants to see the summarization of their answers and to allow them to indicate whether this was what they were intending to communicate. These efforts were accomplished to assure accuracy.

Procedures for assessing interview questions. I contacted the IRB prior to submitting the proposal for the purpose of obtaining guidance on the process that I should follow in order to assess the validity of the interview questions. I inquired of the IRB if it was permissible to ask African American adults who had not been in therapy of any kind to get their feedback on the (a) the understandability and if they would cause the participant to begin talking without hesitation and (b) and comfort of the interview questions and whether or not the interview questions caused any distress. No data were

collected nor analyzed. No individual had the potential for vulnerability issues or being harmed in any way. I tested the questions, with adult African Americans that would not be included in the study and who had not had counseling with a counselor, to assess if the questions were understandable before using them to collect data. On December 16, 2015, the IRB gave me permission to test if the interview questions were understandable enough to elicit conversation and comfortable enough not to cause any distress to an adult African American who had not engaged in therapy. I invited three African American adults who had identified themselves as never having counseling before to give their opinions on the questions being asked. This resulted in a few minor adjustments to the questions. Those revised questions were then used in this study.

Procedures for Recruitment, Participation, and Data Collection

Recruitment procedures. To qualify for inclusion in this study, the participant had to have self-identified as an African American, an adult, aged 18 years or older, and have had counseling from a European American clinician. These study participants were recruited from local places, such as churches, African American fraternities and sororities, and counseling clinics in the Southeastern region of the United States. I sent out e-mails to chapter presidents of African American fraternities and sororities and appeared before groups of people at organized meetings of churches and African American sororities and fraternities, as well as created flyers for recruitment purposes at mental health clinics and churches within in the Southeastern region of the United States (see Appendix A). These steps were accomplished for the main study. I submitted the study to the Walden University IRB to gain approval of the study protocol and instruments.

Data collection. The data were collected via interviews. I conducted interviews with the use of a small, general, semistructured interview protocol that had been inspired by the literature (Chang & Berk, 2009). For continuity sake, the same written format was followed when conducting all interviews. However, it is customary in phenomenological interviews to listen to and allow the participant to guide the conversation to reveal their lived experience (Walker, 2011). Thus, I initiated a limited amount of semistructured questions. For the purposes of distinguishing the necessary and fundamental configuration of the experience, participants were given freedom to speak about their experiences in regard to receiving counseling from a European American clinician. Based on what each participant described, other follow-up, probing questions (that flowed naturally from what the participant stated) were asked to get them to talk more about the particular subject that they chose to bring up in the interview that was related to the research question (Englander, 2012). I interviewed each person twice. The first interview took no more than 60 minutes. The second meeting, lasted no more than 25 minutes, allowed the participant to review the interpreted themes for accuracy. This is also referred to as member checking, which is the most significant method for verifying credibility, according to Creswell (2007). Each initial interview was taped (audio recording) with the prior consent of each participant. The audiotapes were transcribed verbatim by a professional transcription service. No historical or legal documents served as a source of data. The same steps were carried out for all 10 volunteer participants.

The researcher e-mailed each participant a copy of the consent form in advance and set a time for the interview. At the beginning of the telephone or face-to-face

interview, each participant was asked for his or her verbal permission to record and use his or her data. Each participant was also required to sign a written agreement of permission to participate in the study. This was done via email or in person. Participants were also asked for their demographic information before initiating the interview. The researcher made it clear to all participants that they reserved the right to stop the interview at any point. Each participant was offered the study results, if they wanted to know outcomes. Each participant was debriefed at the end of the second and final interview. Each participant was informed that their participation would be useful in addressing the lack of clarity in what and how factors help to create barriers or facilitate therapeutic alliance or connectedness between African American clients and potential European American therapist. After the second interview and the debriefing, they were instructed that there were no further requirements for returning to any subsequent interviews. Debriefing a study participant included thanking them for participating in the study and reviewing the study purpose and how their answers may highlight what factors facilitate and hinder successful therapeutic alliance between the racial dyad of African Americans and European Americans.

Data-Analysis Plan

The connection of the data to the specific interview questions were accomplished through the linking of each of the four research questions to the different interview questions (see Appendix C): (a) What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician? (b) From the perspective of African American clients, what was the most satisfying aspect of

treatment with a European American clinician? (c) From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider? (d) Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad? Although the interview questions are semi-structured in nature they were developed to elicit the thoughts of each participant that has lived the phenomenon of having a European American mental health clinician during therapy. The interviews served this very purpose of gathering the data, which were the participants voice and experiences (Ajjawi & Higgs, 2007).

According to Creswell (2007), qualitative analysis involves arranging and categorizing data for examination. This information is then condensed into idea patterns through coding. Many qualitative approaches exist to analyze data. Thematic analysis is a common skill and practice in qualitative and phenomenological studies to examine factors and yield rich details of the data collected (Braun & Clarke, 2006). Moustakas (1994) indicates that there are six steps to phenomenological data analysis that should be considered. These steps include: data managing; reading; describing; classifying; interpreting and representing.

Managing the data simply refers to the creation of such data and the organization of the data. This study's data was created through the use of interviews. Reading of the data includes making notes about the lived experiences obtained through the interviews and forming codes to represent the larger meanings that emerge. Describing the "essence of the phenomenon" (Creswell, pg156) is best accomplished when the researcher brackets

or suspends their beliefs and judgments about the experiences in order to give a clean description of the personal experiences of each participant. Classifying can be established through the creation of meaningful statements and then arranging these testimonials into divisions or codes. The creation and use of codes was accomplished by hand. Creating a depiction of what happened and how the participant experienced it occurs during the interpreting stage. And finally, there is the stage referred to as representing. This is how the researcher presents the essence of the experience, whether it is displayed in a table or discussion (Creswell, 2007).

This study's analysis was drawn upon phenomenological and hermeneutical principles, which are both well-known and discussed in literature (Kafle, 2011; Walker, 2011; Ajjawi & Higgs, 2007). Phenomenology is the branch of learning within qualitative research that centers on the lived experience. Hermeneutics is a type of phenomenology that describes the lived experiences of and the development of meaning of the phenomenon (Kafle, 2011).

The goal of the researcher was to provide a rich description of the phenomenon through gathering detailed information from the participants who actually lived the experience. Several authors such as Desecrates, Immanuel, Kant and Hegel have discussed phenomenon in the form of duality. This speaks to seeing the world from more than one perspective, your personal perspective and another person's perspective. Different people have different experiences of reality. Therefore, phenomenon was a perfect fit for this intended study. This type of research allowed the voice of the African American client to be highlighted, better understood when it comes to how and what

factors affect therapeutic alliance between them and their European American mental health clinician.

The analysis strategy included the following steps: The conducting of each interview by the researcher was audiotaped and then transcribed by a professional transcribing company. The researcher then read the transcribed data multiple times, while listening to the audiotaped version to ensure accuracy, and to search for significant statements to underscore an awareness of how the participants experienced the phenomenon. Codes were developed and then the development of groups of meanings into themes. Accounts of what the participants experienced was composed. From these descriptions paragraphs were written that incased the *spirit* of their experience (Creswell, 2007). According to Creswell (2007), the treatment of discrepant cases can be addressed through meeting with the contributors to resolve the incongruity.

Issues of Trustworthiness

Credibility

When considering quality research, validation strategies are paramount. Issues such as credibility, transferability, dependability, confirmability, reflexivity and intra and intercoder reliability are important, according to Creswell (2007) because they can offer accuracy in documentation of the study. When discussing phenomenological qualitative research, the purpose is to gain a greater understanding of the phenomenon. This is accomplished through learning about the participants' personal experience of the phenomenon. Thus, the participant is the only legitimate one that can judge the results. Therefore, one of the best ways to establish credibility is to have the participants check

the data for accuracy. The researcher did allow the interviewees to review the summation of the transcripts for correctness. This is also referred to as member checking, which is the most significant method for verifying credibility, according to Creswell (2007). This study did address credibility through saturation of data, mentioned earlier.

Transferability

Transferability refers to the degree to which the results can be transferred to other populations or settings (Tromisch, 2000). Transferability was addressed through purposeful sampling and through descriptive documentation of the population and setting. Though it is a specific sample it may be applicable to other African American populations within the Southeastern and other parts of the United States.

Dependability

Reliability in quantitative research can be seen as dependability in qualitative research. This research did establish dependability through the use of auditory taped interviews. These audiotapes were professionally transcribed. I then reviewed them numerous times accuracy, along with my field detailed notes of each interview.

Confirmability

Confirmability is the degree to which the results can be confirmed by others (Morse, Barrett, Mayan, Olson, & Spiers, 2002). This can be easily established by documenting the procedures for checking and rechecking the data. This was accomplished through the second interview with the participants when they were asked to re-check accounts of their experiences via the summation of their initial interview responses. Confirmability is also addressed in the discussion of the data. The researcher

did address any biases so that the reader will better understand what perspective the researcher may hold.

Reflexivity, according to Creswell (2007), deals with the awarenesses of the researcher of their biases. It is important for the researcher to be conscious of the experiences that she brings to the study, since she shares a similar background and culture with the participants. Bracketing allowed the researcher to “table” her personal views, experiences, and see the information gained through the study as new material to be studied.

Intra- and intercoder reliability is accomplished when there are two or more coders. Intra coder is when only one person is coding. This researcher did intra-code in a systematic manner to ensure that all coding was consistent (Creswell, 2007; Van den Hoonaard, 2008).

Ethical Procedures

The researcher did follow ethical procedures aligned with Walden University’s direction and approval was sought through the Institutional Review Board (IRB). Upon the IRB’s granted approval (IRB# 05-23-16-002712) for the study, the researcher began to ask people to participate. Institutional permission will be unnecessary, as no interviews will take place at a work site. There are no ethical concerns regarding the recruitment procedures. Recruitment was accomplished via Facebook, and through presentation to small groups at churches and African American Sororities and Fraternities and through word of mouth. Confidentiality about who was in the study was strictly enforced. The only agreement put in place was to allow the researcher access to the participants, as

there is no previous data that needed to be accessed for this study. This was documented through a signed consent stating that each participant's desire to be included in this study. The recruitment material (see Appendix A) did not pose any ethical concerns.

The interviewer did not inquire about the context of the therapy. The only interest was in finding out about the relationship with the therapist (the therapeutic alliance in this racial dyad). Each participant was asked to give permission to use his or her information for the study. At any time during interview, participants had the right to withdraw from the study. At no point during the entire study did it become necessary to replace the exiting participants. Each participant was treated with the utmost respect. The researcher has successfully completed the National Institutes of Health (NIH) training course "Protecting Human Research Participants." Each participant included within this study was treated fairly and the protection of his or her rights was maintained at all times. As mentioned previously, it is the right of any participant to refuse participation or early withdrawal from the study. Each participant was informed of this through spoken word and the informed consent.

The researcher did not anticipate the interview process would cause any stressful emotions. However, the researcher was prepared to provide the number of the local mental health crisis line, should anyone have felt extreme duress as a result of the interview. The Rappahannock Area Community Services Board offers a 24 hour, 365 days a year, emergency services line, for crisis intervention. After the initial interview, a second interview was conducted to show the summary of the themes the researcher

interpreted from the initial interview. The participant checked for accuracy. Following the second interview, participants were debriefed as they exited the study.

Confidentiality was strictly enforced. The researcher will keep all data in locked storage during the study and afterward for a period of 5 years, after which it will be destroyed through use of a shredding device. No one will have access to the data storage except for the researcher. Numbers were assigned to each participant to keep them anonymous to everyone other than the researcher. Not even the transcriptionist had knowledge about each participant. Per the IRB guidance, the transcriber did not have to sign a confidentiality agreement due to the fact that the transcriber was never allowed access to the participant's names. While recording, the researcher gave special care to only address each interviewee by patient number 1, 2, 3, etc. This study was not conducted in the researchers workplace.

Summary

This chapter outlined the methodology for the conducted study. An introduction, research design and rationale for the design were presented. The role of the researcher, methodology and issues of trustworthiness were also included in this chapter. A data-analysis plan and ethical considerations were also provided. Chapter 4 followed as the study proceeded. It includes an introduction, setting, demographics, data collection, data analysis, evidence of trustworthiness and the study results.

Chapter 4: Results

Introduction

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African American clients thought about their lived experiences and to identify elements of a good alliance. I also explored the factors that lead to and detract from an effective therapeutic alliance.

Through a purposeful sampling methodology, I invited 10 participants to participate in the study, based on their self-report of being African American and having had therapy with a European American clinician. I interviewed the participants regarding their lived experiences in therapy and their perceptions of their therapeutic alliance or connectedness with a European American clinician. I recorded and had the interviews transcribed, analyzing the data using thematic analysis (Braun & Clarke, 2006).

The following research questions undergirded this study:

Research Question 1: What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician?

Research Question 2: From the perspective of African American clients, what was the most satisfying aspect of treatment with a European American clinician?

Research Question 3: From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider?

Research Question 4: Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

This chapter includes the reintroduction of the study's purpose and the research questions answered in the study. The setting, demographics, data collection, data analysis, and evidence of trustworthiness are also discussed here. The results and a summary conclude this chapter.

Research Setting

As described in the methods section, after obtaining IRB approval (#05-23-16-002712), I posted flyers (see Appendix A) in an African American church, posted on Facebook, and circulated them in the community. Potential participants voluntarily contacted me upon hearing about the study. I determined if they met the eligibility criteria of self-identifying as an African American adult and having had the experience of counseling with a European American clinician.

Each interview took place using the same initial interview questions discussed in Chapter 3. However, based on comments from each interviewee, I introduced additional questions to gain a greater understanding of what the participant raised during the interview. The interviews took place in a private space with a closed door to allow for complete privacy and no interruptions. No personal or organizational conditions influenced participants or their experience at the time of study. Therefore, no conceivable influence existed of the interpretation of the study results (e.g., changes in personnel, budget cuts, and other trauma).

Demographics

A total of 10 participants took part in this study. Nine (90%) African American women and one (10%) African American man volunteered. Ages ranged from 26 to 65, with 80% of participants being between the ages of 36 and 55 years. Eight of the 10 (80%) participants had an average income of \$71,000 to more than \$100,000. Seven of the 10 (70%) had completed a master's or doctorate degree. Three (30%) were high school graduates. Four (40%) were married, four (40%) were divorced, and two (20%) had never been married.

- Participant 1: African American woman; divorced; income \$71,000–\$100,000+; education: master's degree; between the ages of 36 and 45
- Participant 2: African American man; married; income \$71,000–\$100,000+; education: master's degree; between the ages of 36 and 45
- Participant 3: African American woman; single; income \$71,000–\$100,000+, education: doctorate, between the ages of 56 and 65
- Participant 4: African American and Asian American woman; married; income \$71,000–\$100,000+; education: high school graduate, between the ages of 36 and 45
- Participant 5: African American woman; single; income \$0–\$30,999; education: high school graduate; between the ages of 26 and 35
- Participant 6: African American woman; divorced; income \$71,000–\$100,000+; education: master's degree; between the ages of 46 and 55

- Participant 7: African American woman; divorced; income \$31,000–\$39,999; education: high school graduate; between the ages of 46 and 55
- Participant 8: African American woman; married; income \$71,000–\$100,000+; education: master’s degree; between the ages of 46 and 55
- Participant 9: African American woman; married; income \$71,000–\$100,000+; education: master’s degree; between the ages of 36 and 45
- Participant 10: African American woman; divorced; income \$71,000–\$100,000+; education: master’s degree; between the ages of 46 and 55

Data Collection

Data accrued from 10 willing African American adult volunteers. I recruited each participant using the strategies mentioned in Chapter 3. All 10 participants signed an informed consent form and had ample time to read and ask questions, if needed. After they completed the informed consent, they filled out a demographics sheet. I asked no identifying information. However, I collected race/ethnicity, age range, income range, education, and marital status on the demographic form (see Appendix B). I interviewed each participant twice. The first interview lasted no longer than 45 minutes. The second interview lasted no longer than 25 minutes, conducted for the purposes of member checking after the data were transcribed and analyzed, to establish credibility. Most initial interviews took place at a local library in a private room with a closed door to ensure privacy. Other interviews took place either in a private home office or by telephone on a secure line. In each initial interview, participants completed the demographic sheet, and I used the interview protocol with open-ended interview questions, as described in Chapter

3 (see Appendices A and B). I recorded the interviews on a digital recording device and made handwritten notes during the initial interview. No variations occurred in data collection from the plan presented in Chapter 3. Likewise, no unusual circumstances emerged in data collection.

Data Analysis

In this phenomenological study, I captured the lived experiences of participants. I read the transcribed data multiple times while listening to the audiotaped version to ensure accuracy and to begin the process of identifying codes and themes that would emerge from the data. After a study of analysis, as suggested by Moustakas (1994) and Creswell (2007), I established the codes and themes.

Data analysis occurred as described in Chapter 3. The analysis strategy included the following steps: I conducted and audiotaped each interview. A professional transcription company transcribed the audiotaped data. I read the transcribed data multiple times, while listening to the audiotaped version to ensure accuracy. Next, I searched for significant statements to underscore an awareness of how participants experienced the phenomenon. The next step included developing groups of meanings into codes and then themes. I composed accounts of what participants experienced. From those descriptions, I wrote summaries that encased the spirit of their experiences into themes (Creswell, 2007). The following are the codes used along with short definitions, with examples of direct statements taken from interviews with study participants that embrace the meaning of each code.

Code 1: Empathy

The code of empathy emerged when the participants described genuineness or realness, unconditional positive regard, or a sense of feeling what the other person was feeling and relating it back to them. Participant 7 demonstrated this code in the statement, “I felt like maybe she felt my pain.” Another example of this code was stated by Participant 5: “She was really compassionate and really met me where I was.”

Code 2: Lack of Empathy

The code of lack of empathy emerged when the participants described that they perceived as no genuineness or unconditional positive regard or when participants reported no sense of communicating personal feelings back to the patient. This code was exemplified by Participant 2’s statement, “Sometimes I feel like the goal is to just get me better and not focus on the day-to-day problems. There’s obviously some benefit for him getting me better for the government. It’s almost like they’re forgetting about me.”

Code 3: Cultural Competency

The code of cultural competency emerged when the participants described the therapist as having a collection of knowledge and awareness about cultures other than his or her own that was applied in practice. This code was demonstrated by Participant 4’s statement,

I think she used inclusive language, that’s very important. I don’t remember her using language that was offensive. She never used “those people or these people.” I don’t remember her pointing out cultural difference. I just remember her being

very sensitive. I just don't remember her isolating me or making me feel like an outsider. I think those are really important.

Code 4: Lack of Cultural Competency

The code of lack of cultural competency emerged when the participants described their therapist as having or displaying little knowledge and awareness about cultures other than his or her own. Participant 3 exemplified this code in the statement,

This is what I thought, If she thinks that all African Americans were raised in the ghetto, and their whole life story's been a climb out of the ghetto, and they don't have a framework for people who were not raised in the ghetto, or whatever the other kinds of stereotypical or maybe even common things that are maybe part of the public perception of African Americans. I felt that it was really difficult for her to look at me through my experience and through their experience of what they thought the African American experience was.

Code 5: Cultural Mistrust

The code of cultural mistrust emerged when the participants described a viable and sometimes necessary tool employed by members of a minority culture in response to potential threats (physical, mental, economic, social, academic, etc.) against them, usually by a larger and different group. Participant 3 exemplified this code in the statement,

I did not feel that she had the background to even understand what I was talking about. ... I felt like she didn't understand culturally what I was saying. She didn't

have a framework, I don't believe, for what I was actually going through and the interactions I was having within my community.

Code 6: Cultural Trust

The code of cultural trust emerged when the participants described a sense or perception by members of a minority culture that, although (historical and current) reasons may exist to engage in mistrust, the person at that moment decided he or she can trust the person, usually through some display of cultural understanding or empathy conveyed. Participant 4 exemplified this code in the statement, "I was a single mother and she still treated me with dignity. She didn't make me feel ashamed, especially with the stigmas that are attached to single mothers, Black single mothers."

Code 7: Trust

The code of trust emerged when the participants described a sense of trust, in general, on a human-to-human level, not necessarily based on culture. Participant 4 exemplified this code in the statement, "I was very confident that she gave me the care that I needed. I trusted her. I think she genuinely cared that I got better."

Code 8: Mistrust

The code of mistrust emerged when the participants described a sense of mistrust in general, on a human-to-human level, not necessarily based on culture. Participant 2 exemplified this code in the statement, "Sometimes I feel like the goal is just get me better and not focus on the day to day problems. There's obviously some benefit for him getting me better for the government. It's almost like they're forgetting about me."

Code 9: Positive Contributing Factors

The code of positive contributing factors emerged when the participants described factors that facilitate a therapeutic alliance. Participant 5 exemplified this code in the statement “She really helped me through the process of getting the support that I needed at that time.” Participant 8 also exemplified this code in the statement “I think they understood what my concerns were. I think they were able to provide some solid advice.”

Code 10: Negative Contributing Factors

The code of negative contributing factors emerged when the participants described factors that created a barrier to alliance. Participant 2 exemplified this in the statement, “I just don’t think he’s giving me his full attention.” Participant 6 also exemplified this code in the statement, “He could not relate to us.”

Code 11: Positive Resolution

The code of positive resolution emerged when the participants described the ability to come to a resolution or resolve the issues at hand. Participant 9 exemplified this code in the statement, “She allowed me to look within and get the strength that I knew was there and balance it.”

Code 12: Negative Resolution

The code of negative resolution emerged when the participants described the inability to resolve issues for which the patient sought counseling initially. Participant 6 exemplified this code in the statement,

Oh, confidence was definitely lowered. If you can’t keep us in counseling, its almost like I said, the whole buy in. Even if you go to the doctor and the doctor

says you have cancer, for the most part, most people are still going to go back. Even if its negative that the doctor tells them. They are still going back. He couldn't keep us in session and nor did he do anything to try to regain control. Maybe he kind of lost control of the sessions.”

Code 13: Desire for an African American Clinician

The code of desire for an African American clinician emerged when the participants described their desire for an African American clinician but were unable to gain access to one. Participant 6 exemplified this code in the statement,

If we'd have had probably an African American male or female they would've been more compassionate and understood where I'm coming from as Black woman. ... They would've been able to relate to us. I think that probably the folks that were coming to him were probably more European American and maybe more blue collar.

Code 14: Difficult

The code of difficult emerged when the participants described it difficult to hold sessions with their European American counselor. Participant 2 exemplified this code in the statement, “The sessions are almost programmed. I don't think you should be able to tell they're programmed and you can.”

Code 15: Initial Feelings

The code of initial feelings emerged when the participants described how they felt about the counselor in the initial meeting. Participant 7 exemplified this code in the

statement, “In the beginning, I didn’t think she could help me because, she couldn’t identify personally with what I was going through.”

Code 16: Change in Feelings Over Time

The code of change in feelings over time emerged when the participants described how they felt about the counselor as they continued in their therapeutic relationship with the counselor over time. Participant 6 exemplified this code in the statement,

When we first started, I thought of course he’s the counselor so hopefully he can help us. There were only three sessions. I think that you have to build rapport. That was not enough time to build rapport as well as if he was concerned for me, he would really want my marriage to work. I feel like not only did he not reach out to my husband and talk to my husband and try to bring him back, he also pushed me out of counseling.

Code 17: Moving Forward

The code of *moving forward* emerged when participants described the ability to resolve issues for which the patient sought counseling. Participant 7 exemplified this code in the statement,

I felt I could trust her. I felt that I could take her help. I could use what she was giving me. Her suggestions, or her advice, I could take that. I did, and it was really helpful. It gave me the courage to do what I needed to do, and stop some of my madness.

Code 18: Stuck

The code of *stuck* emerged when participants described feeling they were unable to move forward to resolution: Participant 2 exemplified this code in the statement,

That was one of the situations where I felt bad, because he thought he was helping me, but I'm like, "Dude, you're not going to convince me with probability." I felt like he wasn't listening to me, because I'm like, "Dude, you're telling me to control my breathing." I think that's rookie. Everybody tries to sit back and try to take a deep breath when they're kind of stressed out. He's giving me these rookie tactics and things that I've already thought about, and that's his treatment. I feel like some of the things he's giving me are common sense that I think most people would do under those certain circumstances. Those were the situations where I felt he wasn't helping me at all.

Code 19: Anxiety or Frustration

The code of *anxiety or frustration* emerged when participants described feeling their clinician's inability to create therapeutic alliance or help them move forward or ability to help. Participant 3 exemplified this code in the statement,

I grew more frustrated because it did not feel like we were getting to what I needed to get to. I got a level of frustration. On top of the reason I was going, I experienced frustration of not even getting to what I wanted to get to. Again it felt like a waste of time and I'm spending money.

Code 20: Doctor had the Ability to Help

The code of *doctor had the ability to help* emerged when participants described their perception that the clinician had the ability to help them. Participant 9 exemplified this code this in a statement:

She helped me peel back the layers as to where all of those thoughts were coming from and get to the core, not causing me to lose who I am at my core. But, helping me to relearn that things that weren't healthy for me to make better decisions and choices to get me to where I am now.

Code 21: Doctor Lacked the Ability to Help

The code of *doctor lacked the ability to help* emerged when participants described their perception that the clinician lacked the ability to help them. Participant 6 exemplified this code in the statement,

Sometimes, when we would talk to him and he would ask questions but he didn't come back with a follow up. I didn't know what we were saying we needed to work towards. You don't know if you're going west when you should be going east. The counselor was not telling you. I think that going to counseling, the counselor should tell you the purpose, why you are here once you tell him the problem he should tell us what the goal is, what were working towards, establish some type of goals. Also, get some type of commitment that there will be no aborting this counseling. Were here for the duration until we agree that we have resolved the issues.

Code 22: Therapeutic Alliance

The code of *therapeutic alliance* emerged when participants described strong collaborative efforts between their therapist and themselves to work on mutually agreed goals. The alliance is a partnership that expands cognitive and emotional levels. It includes both parties purposefully considering and negotiating how they will approach the tasks at hand. It also includes when each offers honesty and mutual respect, as each puts forth good effort to be human in each other's presence, allowing for empathy and bonds to form as they engage in the process of healing (Horvath, 2001). Participant 5 exemplified this code in the statement,

She was really compassionate and really met me where I was. I really liked her she's actually someone I will never forget. When I realized that I was dealing with certain issues for the first time but never was really able to put a name on it. She really helped guide me through that process of getting the support that I needed at the time.

Participant 9 also exemplified this code in the statement, "I think I felt really connected because she validated which I later would learn validation is really important in that type of relationship." Again Participant 5 said,

I think it goes back to what I said before, the validation. Her, now that I'm thinking about it, her being relatable, I remember at a particular time, where when we were talking about the pressure in society and stuff like that and her being a little but transparent about her own walk and just making me feel like I'm not the only one that struggled in this area.

Code 23: Lack of Therapeutic Alliance

The code of *lack of therapeutic alliance* emerged when participants described a lack of cognitive and emotional levels of connection, no mutual respect felt, and a lack of agreement on goals to work on. Participant 6 exemplified this code in the statement, “I don’t feel like he connected with us as an educated African American family. I believe he was not use to our level of class that we were coming from. He could not relate to us.”

Similarly, Participant 3 stated,

I felt like we did not connect. I wanted to end the relationship and she was really upset that I wanted to end the relationship because she felt that we hadn’t gone far enough. She felt as though it was me giving up on myself. [The European American clinician] turned the situation into a shortcoming for me.

The 23 codes translated into 13 thematic findings. Six findings describe positive resolutions and seven describe negative resolutions. Previous studies indicated that this racial dyad usually have negative therapeutic outcomes; therefore, the discrepant cases were the seven of 10 participants who described a positive outcome.

Evidence of Trustworthiness

Credibility

As noted previously in the methods section of Chapter 3, quality research involves validation strategies. According to Creswell (2007), issues such as credibility, transferability, dependability, confirmability, reflexivity, and intra- and intercoder reliability are important, helping to solidify accuracy in documentation of the study. The purpose of phenomenological qualitative research is to gain a greater understanding of

the phenomenon. In this present study, understanding emerged through learning about participants' personal experiences of the phenomenon of having therapy with a European American counselor. The participant is the only legitimate one who can judge the results. Thus, one of the best ways to establish credibility is to have participants check the data for accuracy. I held a second interview with each participant to allow interviewees to review the summation of the transcripts for correctness, also referenced as member checking, which is the most significant method to verify credibility, according to Creswell (2007). This study also addressed credibility through saturation of data. Member checking resulted in confirming the capture of the essence of each participant's voice.

Transferability

Transferability refers to the degree to which results can transfer to other populations or settings (Tromisch, 2000). I addressed transferability through purposeful sampling and through descriptive documentation of the population and setting. Though this study used a specific sample, the results may be applicable to other African American populations in the southeastern and other parts of the United States.

Dependability

Reliability in quantitative research can be seen as dependability in qualitative research. This research established dependability through the use of auditory taped interviews. I reviewed these professionally transcribed audiotapes numerous times to maintain accuracy in conjunction with detailed field notes of each interview.

Confirmability

Confirmability is the degree to which the results can be confirmed by others (Morse, Barrett, Mayan, Olson, & Spiers, 2002). This was easily established by documenting the procedures for checking and rechecking the data. The second interview with participants allowed me to recheck accounts of their experiences through review of my summation of their initial interview responses.

Reflexivity, according to Creswell (2007), addresses the awarenesses of the researcher of their biases. It is important for researchers to be conscious of the experiences they bring to a study; in this case, I share a similar background and culture with the participants. Bracketing allows one to “table” personal views and experiences, and see the information gained through the study as new material to be studied. Originally, I thought I would find many negative experiences with European American counselors, due to documentation from several previous researchers (Westra, Constantino, & Aviram, 2011; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). However, because I was able to table my expectations and earnestly listen to what participants wanted to express, I was able to see a different perspective from what I learned from previously published authors.

Researchers accomplish intercoder reliability when two or more coders code the themes. Intracoder reliability means only one person was coding. I intracoded in a systematic manner to ensure all coding was consistent (Creswell, 2007; Van den Hoonaard, 2008.).

Study Results

Of the 10 interviews, three participants had negative experiences and the remaining seven of the 10 interviewees described positive experiences. The APA indicated that empathy and therapeutic alliance are cornerstones to positive therapeutic outcomes (Moyers & Miller, 2013; Norcross & Wampold, 2011). Consistent with this, the seven interviewees who described positive therapeutic outcomes as well as the three interviewees who described negative outcomes captured the importance of empathy and therapeutic alliance as necessary factors to achieve positive therapeutic outcomes, as well as the lack of these factors, resulting in negative resolutions and experiences.

Overall, 13 themes (see Tables 1 and 2) emerged to answer the research questions. These themes were: (a) empathy/lack of empathy, (b) cultural competency/lack of cultural competency, (c) cultural mistrust/lack of cultural mistrust, (d) trust/lack of trust, (e) positive/negative contributing factors, (f) positive/negative resolutions, (g) desire for an African American doctor, (h) difficult, (i) initial/changes in feelings overtime, (j) moving forward/stuck, (k) anxiety/frustration, (l) doctor ability to help/lack of ability to help, and (m) therapeutic alliance/lack of therapeutic alliance. However, seven themes seemed to dominate in the results for negative outcome and six for positive outcomes. I discuss each theme aligned with research questions below, seeking to offer answers to the original four research questions.

Research Question 1

What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician?

African American patients in this original study described their encounters as having experienced both positive and negative outcomes. Seven (70%) of 10 were positive resolutions and three (30%) of 10 were negative resolutions. Although three (30%) participants did report overall negative resolutions with their European American counselors, mainly due to lack of empathy, therapeutic alliance, cultural competency, anxiety, and frustration, feeling stuck, and the counselors' inability to help, very surprising and encouraging results that were positive emerged from 70% of participants. Negative and positive themes described in answer to Research Questions 2, 3, and 4 adequately approach this overall research objective (Research Question 1).

Participants indicating they had a positive resolution and experience made statements like: "I had my breakthrough, when I felt like I was able to talk about certain things, and I felt very vulnerable, she was there for me." Similarly Participant 5 said,

She broke it down to me from some of the things that I went through. She'd help me understand what it was I was dealing with. You could go in and get a diagnosis and that's it. But, she helped me see, you're feeling this way because X, Y, Z. She helped me put some pieces of the puzzle together about my life, about some of the trauma that I had experienced and that it was very realistic for me to be feeling like I was feeling. Through therapy and other resources, I could overcome those things. That's meeting me where I was and guiding me through this process.

Likewise Participant 7 stated, "Her being able to able to identify with what I was going through or maybe empathize. ... Our faiths definitely helped." Participant 7 claimed it

was “Her genuineness and resourcefulness ... her education, and her knowledge. She said she was able and she proved it. She did it, which put me in a different direction ... and change different areas of my life.” This quotation also illustrated the dominant theme of positive resolution.

Some participants indicated they had a negative resolution and experience with their European American counselors. Participant 2 said,

There was one situation where I felt bad because he (the counselor) thought he was helping me, but, I’m like “dude, you’re not going to convince me with probability.” I felt like he wasn’t listening to me. Because I’m like “dude, your telling me to control my breathing.” I think that’s rookie. Everybody tries to sit back and try to take a deep breath when they’re kind of stressed out. He’s giving me these rookie tactics and things that I’ve already thought about, and that’s his treatment. I feel like some of the things he’s giving me is common sense that I think most people would do under those circumstances. Those were the situations where I felt he wasn’t helping me at all.

Similarly, Participant 3 made the statement,

We just never got to that place where she understood. I feel, what I was really trying to resolve. I think she came from a perspective of, I think her own particular background made it difficult for her to connect to me and she was trying to fit my experience into her understanding, which was limiting.

Likewise Participant 6 said regarding her third visit with the counselor,

The explosion of okay this is what I feel you all should do. You all should just separate immediately. Your wife's animosity level is so high, I don't see where she can get beyond this. It would take God to basically turn this around. I didn't expect him to be God but, I thought that he could give us some guidance. ... At that time when he said that we needed to separate, my husband didn't want to do that. I came back by myself. [The counselor] said you can't have a marriage counselor unless both of you are coming. There's really no reason to work on it if you can't get him to come back in. These were his words.

Participant 6 went on to describe feeling dissatisfied that the counselor, having only three sessions, told her to separate from her marriage and never encouraged her or her husband to seek counseling separately. He just told them to separate and left it right there. These statements give further evidence of the dissatisfaction that led to the negative resolution that these African American patients experienced with their European American clinicians.

Research Question 2

From the perspective of African American clients, what was the most satisfying aspect of treatment with a European American clinician?

Six themes emerged from the interviews to answer this research question examining the most satisfying aspect of treatment with a European American clinician. The following dominant themes seemed to describe the most satisfying aspects of treatment with a European American clinician and yielded positive therapeutic

resolutions: (a) empathy, (b) therapeutic alliance, (c) trust, (d) clinician's ability to help, (e) moving forward; eventually leading the participant to a (f) positive resolution.

The first dominant theme that seemed to describe the most satisfying aspect of therapy and also lead to positive resolutions was empathy from the clinician. The theme empathy emerged when participants described a sense of genuineness or realness, unconditional positive regard, or a sense of feeling what the participant was feeling and relating it back to them. Seven of the 10 participants in this study described continuous incidents when the clinician would talk to them on a human-to-human level, thereby showing empathy, which was the most dominant theme. No hierarchies or doctor versus patient levels emerged. Therapy consisted of merely two equal human beings present in the room, which allowed for progress toward healing and positive therapeutic outcomes.

Participant 10 illustrated this theme in the statement "A genuine caring about the way I was feeling and what she was gonna do to help me." Similarly Participant 4 said, "She treated me like a human being. I was a single mother and she still treated me with dignity. She didn't make me feel ashamed, especially with the stigmas that are attached to single Black mothers" This result illustrates the dominant theme of empathy. Similarly, Participant 4 also illustrated the dominant theme of empathy when saying, "Yeah, she treated me like a human being." Likewise, Participant 5 stated, "She was really compassionate and really met me where I was." Participant 7 stated, "I felt like maybe she felt my pain."

When it came to describing the most satisfying aspect of therapy with a European American clinician, the second dominant theme to emerge in the lived experiences of this

African American participant pool was therapeutic alliance. Seven of the 10 participants discussed the theme therapeutic alliance. This theme emerged when participants described cognitive and emotional levels of connection: feeling mutual respect and agreement on goals to work on. Participant 5 exemplified this code in the statement:

I think it goes back to what I said before, the validation, her being relatable. I remember a particular time when we were talking about the pressure in the society and stuff like that and her being transparent about her own walk and just making me feel like I'm not the only one that struggled in this area.

Similarly Participant 10 said, "She was open, willing to listen to what I had to say." This statement also illustrated the dominant theme of therapeutic alliance. Likewise,

Participant 7 stated,

She created that atmosphere for you to just speak. "tell me what's going on."

Again she would pull the things out of me in order for her to be effective. That's what she said in the beginning. She said "I want to help you. This is what I do for a living. These are my credentials. I believe I can help you, if you allow me."

Very inviting!

The third dominant theme that seemed to describe the most satisfying aspect of therapy with a European American clinician and positive resolutions were trust of the clinician. The theme trust emerged in seven of the 10 interviews, seen when participants described a sense of trust in general, on a human-to-human level, not necessarily based on culture. Participant 4 exemplified this code in the statement, "I was very confident that she gave me the care that I needed. I trusted her. I think she genuinely cared that I got

better.” Similarly Participant 7 said, “I felt safe with her,” illustrating the dominant theme of trust. Likewise, Participant 5 stated, “I think the validation, her being experienced in what she did and it was just a very reassuring experience.”

The fourth dominant theme that seemed to describe the most satisfying aspect of therapy with a European American clinician and positive resolutions was the clinician’s ability to help. The theme clinician’s ability to help emerged in seven of the 10 interviews. The theme emerged when participants described their perception that the clinician had the ability to help them. Participant 7 illustrated this theme in the statement,

Because she was honest with me. When I would tell her my behavior of what I was doing, she was very honest. She was very open. She wasn’t clinically correct as far as maybe her verbiage. She was straightforward. Her questions she posed to me made me think, and made me stop my behavior. She was real.

Similarly, Participant 10 said,

She would open with, “How are you feeling today? and Has anything happened since the last time we were here? Those questions like that, of extending the wanting to know how I felt and listening to that before making statements or we moving forward, I think that contributed to a lot of the success as well and her ability to communicate, be it verbally or non-verbally. Shaking of the head, maybe not saying anything, but just nodding or whatever non-verbal communication. Both ways.

Participant 9 also illustrated the dominant theme of clinician’s ability to help stating,

“She allowed me to look within and get the strength that I knew was there and balance it.”

The fifth dominant theme that seemed to describe the most satisfying aspect of therapy with a European American clinician and positive resolution was moving forward. The theme moving forward emerged in seven of the 10 interviews when participants described feeling their clinician's ability to help them move forward or ability to help. Participant 5, illustrated this theme in the statement,

Just for a while I was sad because I couldn't finish the journey with her because of financial situation. I know that experience allowed me to be open and reach out for help and to be less guarded, even though it was years later where I reached out for help again. I know without that experience, I might not have reached out for help again.

Similarly Participant 1 said,

I think the success again goes back to her basically pushing me forward and not allowing me to kind of wallow in the moment and stay in that little sad place for too long. Pushing me into action or at least identifying what I needed to do to go into action so I could move forward. We even devised a step by step plan.

Participant 7 stated,

I trusted her. I felt that I could take her help. I could use what she was giving me. Her suggestions, or her advice, I could take that. I did, and it was really helpful. It gave me the courage to do what I needed to do, and stop some of the madness.

This quotation illustrated the dominant theme of moving forward.

The sixth dominant theme that seemed to describe the most satisfying aspect of therapy with a European American clinician was positive resolutions. The theme positive

resolution emerged in seven of the 10 interviews. The theme emerged when participants described feeling they were able to move forward to the resolution for which they had originally sought therapy. Participant 9 illustrated this theme in the statement,

She helped me peel back the layers as to where all of these thoughts were coming from and get to the core, not causing me to lose who I am at my core, but, helping me to relearn the things that were healthy for me to make better decisions and choices to get me to where I am now.

Similarly Participant 10 said,

I brought that list back, we went through that list extensively and it made me feel—even on the con-side—she was able to help me see it in a positive way. Even though I may have had it on the bad side, she helped me to see it in a good way.

This also illustrates the dominant theme of positive resolution.

Research Question 3

From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider?

Six dominant themes seemed to describe the most difficult aspect of therapy with a European American clinician, leading to negative therapeutic relationships and resolutions: (a) lack of empathy, (b) lack of therapeutic alliance, (c) lack of cultural competency, (d) lack of the clinician's ability to help, (e) feeling frustrated and anxious, (f) feeling stuck, which eventually lead the participant to a (g) negative resolution.

From the perspective of African American clients in this study, the first dominant theme that seemed to describe the most difficult part of the treatment process with a

European American provider was a lack of empathy. The theme lack of empathy emerged in three of 10 interviews. This thematic finding seemed to lend some understanding to what led to negative therapeutic relationships and resolutions overall. The theme lack of empathy emerged when participants described lack of genuineness or realness, lack of unconditional positive regard, or lack of a sense of feeling what the other person was feeling and relating it back to them. Participant 2 illustrated this theme in the statement,

Sometimes I feel like the goal is just to get me better and not focus on the day to day problems. There's obviously some benefit for him getting me better for the government. Its almost like they're forgetting about me.

Similarly Participant 6 said, "I felt like he should have been more compassionate."

Likewise, Participant 2 said, "The sessions are almost programmed. I don't think you should be able to tell that they're programmed and you can." This outcome also illustrates the dominant theme of lack of empathy.

The second dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician and negative resolutions was lack of therapeutic alliance. The theme became apparent in three of 10 interviews. Participants described a lack of cognitive and emotional levels of connection, lack of mutual respect felt, and lack of agreement on goals to work on. Participant 3 exemplified this code in the statement, "I don't feel like he connected with us as an educated African American family. I believe he was not use to our level of class that we were coming from. He could not relate to us." Participant 3 also stated "I went in to the session optimistic, enthusiastic, and it waned over time to the point where the connection wasn't made and it was easy

actually for me to leave.” Similarly, Participant 6 said “It was very difficult to talk to him about personal issues; I didn’t think he could relate.”

The third dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician and negative resolutions was lack of cultural competency. The theme became apparent in three of 10 interviews. The theme lack of cultural competency emerged when participants described their therapist as having or displaying little knowledge and awareness about cultures other than their own. Participant 3 illustrated this theme in the statement, “She didn’t have the framework, I don’t believe, for what I was actually going through and the interactions I was having within my community.” Similarly, Participant 6 said, “If we’d have had probably African American male or female would’ve been more compassionate and understood where I’m coming from as a Black woman.” This outcome also illustrates the dominant theme, lack of cultural competency from the clinician. Likewise, Participant 3 stated,

This is what I thought, if she thinks that all African Americans were raised in the ghetto and their whole story’s been a climb out of the ghetto or whatever other stereotypical, or maybe even common things that are maybe a part of the public perception of African Americans, I felt that it was really difficult for her to look at me through my experience and through their experience of what they thought the African American experience was.

The fourth dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician and negative resolutions was the clinician’s ability to help. This theme became apparent in three of 10 interviews. The theme lack of

clinician's ability to help emerged when participants described their perception that the clinician lacked the ability to help them. Participant 2 illustrated this theme in the statement,

There was a situation where he was giving me a remedy because I have a fear of crossing bridges. He was telling me, "Hey nothings going to happen. You need to control your breathing." ... I tell him these things don't work, and he starts getting into discussions of probability and I told him, "I'm not stupid. I know the probability but that doesn't hearse the potential for me. Don't try to force this theory on me that I'm not going to buy off on." Then he thinks that's good enough.

Similarly Participant 5 said,

I went in with confidence that this is hopefully going to open some doors and we can finally get to the root of our problems. Instead, we separated and divorced. Oh confidence was definitely lowered. If you can't keep us in counseling. ... He couldn't keep us in session nor did he do anything to try and regain control. Maybe he kind of lost control of the sessions.

What Participant 3 said also illustrates the dominant theme of lack of the clinician's ability to help: "I felt that she didn't have the ability to help me. I felt that she did not connect to the fact that I was African American; that I was a women of faith."

The fifth dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician and negative resolutions was feeling frustrated and anxious. The theme became apparent in three of 10 interviews. The theme

frustrated and anxious emerged when participants described feeling their clinician's inability to create therapeutic alliance or help them move forward or the ability to help.

Participant 3 illustrated this theme in the statement,

You know, I think I grew more frustrated because I did not feel like we were getting to what I needed to get to. I got a level of frustration and I experiences, on top of the reason I was going, I experience frustration of not even getting to what I wanted to get to.

Similarly, Participant 6 said, "He never brought [race] up. I think that's what my husband felt. He was not being heard as a Black man. He was not being heard." Likewise,

Participant 2 stated,

I feel like the sessions are really about him listening. I think maybe he expects me to talk more and I expect the total opposite. I'm kind of waiting on him to ask me direct questions. ... I intentionally make it awkward because I want him to realize I want him to kind of pick up the pace a little bit, to reach me.

This quotation illustrates the dominant theme of feeling frustrated and anxious.

The sixth dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician and negative resolutions was feeling stuck. The theme became apparent in three of 10 interviews. The theme feeling stuck emerged when participants described feeling they were unable to move forward to resolution.

Participant 3 illustrated this theme with the statement,

I genuinely think when you seek out, at least from my experience, when you seek out therapy, you're looking for something that can move you forward, can help

resolve issues or help you think through some things. To spend time and not have that resolved, or even addressed or even tools or some connection, it's very frustrating.

Similarly, Participant 2 said, "I can tell you the things I'm experiencing but I'm expecting you to give me very candid feedback on things I can do to improve myself." Participant 2 also stated,

The government pays a lot of money to help PTSD. You can limit that by showing guys are getting better because that can limit the amount of money they have to pay out. If a doctor can generate paperwork to show pathology that you're getting better, it can reduce how much they have to give to you. I just felt like that's his goal, to show a pathology of incremental improvement vice really trying to hit on my day to day issues like I feel like he should be.

Likewise, Participant 6 said,

I think you have to build rapport. There was not enough time to build rapport as well as if he was concerned for me, he would really want my marriage to work. I feel like not only did he not reach out to my husband and talk to my husband to try to bring us back, he also pushed me out of counseling.

This quotation also illustrated the dominant theme of feeling stuck.

The seventh dominant theme that seemed to describe the most difficult aspect of therapy with a European American clinician was negative resolutions. The theme became apparent in three of 10 interviews. The theme negative resolution emerged when participants described feeling they were unable to move forward to resolution for the

issue about which they originally sought therapy. Participant 3 illustrated this theme with the statement, when asked what factors contributed to success in your therapy with your European American clinician, “I don’t think it was successful. I actually think it was a failure. In my situation, I think it was an utter failure.” Similarly, Participant 6 said,

We’ve addressed (with the counselor) that we are Christians and our goal is to try to address and work on our marriage. You (the counselor) tell us to separate. The separation causes us to become further apart and eventually divorce. ... We didn’t continue counseling. ... It should’ve been the counselor’s job to reach out to him and try to bring him back in and counsel him separately, and even counsel me separately. That’s how he could’ve brought us back together.

Likewise Participant 2 stated,

I feel like there’s a benefit in him making me appear better on paper, but I don’t necessarily feel like he’s addressing my direct problems. I feel like he can write me up to appear that certain things are getting better but, when I walk away, maybe he’s ... he hasn’t even asked me direct question about, “Hey, how are you dealing with crowds? How are you dealing with driving over bridges?” Things I’ve talked to him about.

This also illustrates the dominant theme of negative resolution.

Research Question 4

Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

One main theme that emerged from the interviews to answer this research question, examining what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad. The theme empathy was the most compelling factor that seems to have led to a successful therapeutic alliance between this racial dyad of African American patients and their European American clinicians during counseling! This one factor was present as each and every one of the seven (70%) participants described having a satisfying therapeutic process and a positive therapeutic outcome. Therapeutic alliance was best established when empathy was present. Empathy seemed to be the gatekeeper that allowed for the other positive attributes of their experiences to come forth, such as therapeutic alliance, trust, feeling as though the doctor had the ability to help, feelings of moving forward, and positive therapeutic resolution.

Results from the analysis revealed one main theme to answer this question. Participants revealed that meeting patients where they were and talking with them on a human-to-human level—empathy according to Rogers (1959)—helped create an atmosphere that developed therapeutic alliance. Participant 9 illustrated this theme by stating, “She was very transparent and did share some stuff and that was more of what I would say sprit to sprit kind of issue. In that moment ... it let me realize even therapist go through stuff.” Similarly, Participant 5 stated, “She was very empathetic. I think she showed real concern for my well-being.” Participant 10 said, “She appeared to be very concerned about me and what I was going through.” Participant 10 also said, “I just think that she expressed her remorse for all that I was going through. Like I said, she was a

good listener.” These quotations further illustrate the importance of relating to them in a human-to-human way.

No comments or themes emerged that were considered discrepant to the conceptual framework of empathy in this data. However, in comparing data from this original study to previous studies, a discrepancy does emerge. Earlier research inquiries indicated that African Americans in counseling with European American clinicians often ended in early termination due to dissatisfaction (Williams, 2014; Westra, Constantino, & Aviram, 2011; Chang & Berg, 2009). Therefore, the seven study participants in this original study can be considered discrepant cases because they all resulted in a positive therapeutic outcome. They did not abort sessions prematurely and tended to stay until their needs were successfully met. Study findings indicated that empathy and therapeutic alliance were displayed in their lived experiences with their European American clinicians.

Table 1

Positive Thematic Findings

1, 4, 5, 7, 8, 9, 10	Empathy
1, 4, 5, 7, 8, 9, 10	Therapeutic alliance
1, 4, 5, 7, 8, 9, 10	Trust
1, 4, 5, 7, 8, 9, 10	Clinician’s ability to help
1, 4, 5, 7, 8, 9, 10	Moving Forward
1, 4, 5, 7, 8, 9, 10	Positive resolution

Table 2

Negative Thematic Findings

2, 3, and 6	Lack of Empathy
2, 3, and 6	Lack of therapeutic alliance
2, 3, and 6	Lack of cultural competence
2, 3, and 6	Lack of clinician's ability to help
2, 3, and 6	Anxiety/frustration
2, 3, and 6	Feeling stuck
2, 3, and 6	Negative resolution

Summary

This chapter provided results of this original study that examined the phenomenon of African American patients having counseling with a European American clinician. The four research questions sought to discover the lived experiences of African Americans in counseling with a European American clinician: their most satisfying, most difficult experiences, as well as their thoughts on what factors contributed to successful therapeutic alliance with their European American clinicians. Results led to 23 codes and 13 thematic findings. The overall results indicated that participants' experiences varied. Of participants, 70% reported having a positive experience, whereas only 30% reported having a negative experience. The most satisfying aspects of therapy with a European American clinician, experienced by seven of 10 participants, were: empathy, therapeutic alliance, trust, the clinician's ability to help, the ability to move forward and positive resolution (see Table 1). The majority of patients found that when the clinicians spoke to them on a human-to-human level, when the therapist was able to meet them where they

were and employ therapeutic alliance and empathy this was the most satisfying aspect of having therapy with a European American counselor.

The most difficult aspects of having counseling with a European American clinician, experienced by three of 10 participants, were lack of empathy, lack of therapeutic alliance, lack of cultural competency, the clinicians' lack of ability to help, feeling frustrated and or anxious, and feeling stuck, which all led to a negative resolution (see Table 2). Participants described a lack of satisfaction when the clinician failed to connect with them personally, their needs were not met, and they terminated sessions prematurely or continued therapy only because they "had to" as a job-related requirement.

The most significant factor, empathy, a feeling of connection with the counselor, along with trust, are the factors demonstrated to these African American patients that contributed to successful therapeutic alliance in their therapeutic relationship with their European American clinician. The majority of participants, seven of 10 in this study, had a positive experience. This suggests that it is possible for an African American patient to have a positive counseling experience with a European American clinician, if the clinician comes to the treatment process and relationship with empathy and therapeutic alliance.

In this chapter, I outlined the results of the present study and presented an introduction and a recapitulation of the original research questions. I also included the research setting, demographics, data collection, and data analysis, along with issues of trustworthiness in this chapter. Chapter 5 follows, including an introduction,

interpretation of thematic findings, limitations of the study, recommendations, implications, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician in the Southeastern region of the United States to learn what African American clients thought about their lived experiences and to identify elements of a good alliance. Traditionally, in therapy, according to Constantine (2007), African Americans seeking mental health treatment with a European American clinician have not experienced positive therapeutic outcomes. The factors necessary for positive outcome are empathy and therapeutic alliance. The results of this study add to the body of knowledge relating to the lived experiences of African Americans receiving mental health counseling with the assistance of a European American clinician.

The nature of this qualitative study included 10 African American participants, interviewed for approximately 35 minutes each. In the answers to four research questions, I found that the majority of African American participants enjoyed a positive relationship with a European American clinician. Seven of 10 participants, or the majority, had positive experiences that led to positive resolutions when having counseling with a European American clinician. Eight out of the 10 European American clinicians were women and two were men. Six dominant thematic findings emerged that provided evidence for this claim. Of these six themes, empathy was the most dominant. The elements that made a successful relationship were (a) empathy, (b) therapeutic alliance,

(c) trust, (d) clinician's ability to help, (e) moving forward, and (f) eventually leading the participants to a positive resolution.

Three of 10 participants (30%) had negative experiences when having counseling with a European American clinician. The elements that did not lead to successful therapeutic relationships or positive therapeutic outcomes were (a) a lack of empathy, (b) a lack of therapeutic alliance, (c) a lack of cultural competency, (d) a lack of the clinician's ability to help, (e) feeling frustrated and anxious, (f) feeling stuck, and (g) leading the participant to a negative resolution.

Interpretation of Findings

This chapter provides the results of the study on the phenomenon of African American patients having counseling with a European American clinician. I created four research questions to discover the lived experiences of African Americans in counseling with a European American clinician: their most satisfying and most difficult experiences as well as their thoughts on what factors contributed to a successful therapeutic alliance with their European American clinicians. From the interview data, 23 codes and 13 thematic findings emerged. The participants' experiences varied. Of the participants, 70% reported having a positive experience, whereas only 30% reported having a negative experience. The most satisfying aspects of therapy with a European American clinician, experienced by seven of 10 participants, were empathy, therapeutic alliance, trust, the clinician's ability to help, the ability to move forward, and positive resolution (see Table 1). The majority of patients found that when clinicians spoke to them on a human-to-human level, when the therapist was able to meet them where they were, and was able

employ therapeutic alliance and empathy were the most satisfying aspects of having therapy with a European American counselor. This finding confirms what Rogers (1980) described.

The most difficult aspects of having counseling with a European American clinician, experienced by three of 10 participants, were a lack of empathy; a lack of therapeutic alliance; a lack of cultural competency; the clinicians' lack of ability to help; feeling frustrated and or anxious; and feeling stuck, which led to a negative resolution (see Table 2). Participants described a lack of satisfaction when the clinician failed to connect with them personally, their needs were not met, and they terminated sessions prematurely or continued therapy only because they had to due to job-related requirements.

The most significant factor, empathy, a feeling of connection with the counselor, along with trust were the factors demonstrated to these African American patients that contributed to successful therapeutic alliance in their therapeutic relationship with their European American clinician. The majority of participants, seven of 10 in this study, had a positive experience. It is possible for an African American patient to have a positive counseling experience with a European American clinician if the clinician comes to the treatment process and relationship with empathy and therapeutic alliance.

This study included 10 African American participants. All 10 interviewees met with me separately to be interviewed about their experience of having therapy with a European American clinician. African Americans tend to terminate sessions prematurely due to dissatisfaction (Owen et al., 2012; Rosen et al., 2012). In this study, seven (70%)

of the 10 interviewees described positive experiences and did not leave therapy prior to getting issues resolved. Only three (30%) of interviewees described negative experiences in therapy with their European American clinicians. Every time positive experiences occurred, empathy and therapeutic alliance were also present. These findings confirm what the APA indicated: Empathy and therapeutic alliance are cornerstones of positive therapeutic outcomes (Moyers & Miller, 2013; Norcross & Wampold, 2011). Yet, in this study, 70% of those interviewed described positive therapeutic outcomes and did not leave sessions prematurely. Likewise, the three (30%) participants who described their experiences as negative did not experience empathy or therapeutic alliance with their European American clinicians. Along with therapeutic alliance and empathy, trust was also present in the positive therapeutic relationships. Trust arises when empathy and therapeutic alliance are established between this racial dyad in a therapeutic relationship.

In this study, I confirmed the APA (2003) finding that empathy and therapeutic alliance are cornerstones to positive therapeutic outcomes. Simultaneously, I disconfirmed previous studies that indicated that African Americans typically prematurely abort sessions when in therapy with a European American clinician, due to dissatisfaction (Owen et al., 2012; Rosen et al., 2012). Historically this racial dyad has not resulted in positive therapeutic alliances or outcomes. I found that the factors necessary for positive outcome are empathy and therapeutic alliance. When these two factors are present, the racial dyad experiences trust in the therapeutic relationship. This study extended the body of knowledge concerning the lived experiences of African

Americans receiving mental health counseling with the assistance of a European American clinician.

Empathy

Empathy was the conceptual framework for this qualitative, exploratory, phenomenological study. Rogers (1957, 1959, 1980) reasoned that the proper environment is necessary for healing to occur. Open and honest communication is key, and empathy promotes effective communication between two people. In this study on the therapeutic alliance between African American clients and European American providers, seven of 10 participants described empathy in ways that construed (a) genuineness or realness; (b) unconditional positive regard, which creates a climate for change and acceptance; and (c) empathetic understanding, sensing the personal feelings and meanings the client is experiencing and communicating these back to the client. This process allowed for better communication and relationship between the client and the clinician. Similar to Crenshaw and Kenney-Noziska's (2014) study, I found that this factor did promote positive therapeutic alliance and therapeutic outcome.

When empathy was present in the therapeutic relationship between themselves and their European American clinicians, the participants in this study felt heard, cared for, and tended to. These characteristics allowed them to open up and share their innermost feelings and thoughts without fear of reprisal or judgment. In an environment that is free from harsh opinion, they were able to find the healing and resolve they initially sought when they were seeking counseling.

Rogers (1980) asserted that once a patient feels heard, he or she would feel satisfied, supported, and able to grow in his or her intention to heal, to move forward, and to move past his or her present obstacles. I confirmed this notion. The seven participants who attested to experiencing empathy from their clinician also indicated that they were able to have positive resolution.

Empathy was the one main that allowed the participants to continue seeking therapy with their European American clinician, even when they originally desired an African American clinician, because they thought they would be better able to relate to an African American. For example, Participant 1 stressed at the beginning of the interview that she really wanted an African American doctor. She felt that several cultural aspects were lacking, initially, in the form of ethnicity and spirituality. Yet, she was able to move forward due to the presence of empathy and therapeutic alliance. When these two factors were present, resolution of her issues manifested. The doctor took time to build rapport so trust could be established and was able to lead the patient to clarity and becoming unstuck.

To understand the client's symptoms, the therapist must fit current issues into the client's perspective and experiences. Walling et al. (2011) found it important not only to have an understanding of symptoms with regard to race, but also to have awareness of the changing levels and position of the working alliance that can develop between ethnic and racial clients and their European American clinician. Though working alliance may be dismal at the start of therapy, due to experiences of microaggression and cultural mistrust

of the ethnic patient, it is possible that an alliance can develop as time and therapy sessions continue. This was confirmed with Participant 1.

Therapeutic Alliance

Therapeutic alliance, also referenced as a working alliance, is a determining factor between therapist and patient for positive therapeutic outcomes to be a reality (Beutler et al., 2012; Duff & Bedi, 2010; Horvath et al., 2011; Johansen et al., 2013; Kazdin & Durnin, 2012; Porter & Ketring, 2011; Ryan et al., 2012; Smith et al., 2012; Wagner et al., 2012). In this study, seven of 10 participants described the theme therapeutic alliance as emerging when collaborative efforts between their therapist and themselves were present, so they could work on mutually agreed goals. The alliance is a partnership that expands cognitive and emotional levels. It includes both parties purposefully considering and negotiating how they will approach the tasks at hand. It also includes each offering honesty and mutual respect, as each puts forth good effort to be human in each other's presence, allowing for empathy and bonds to form as they engage in the process of healing (Horvath, 2001). This process allowed for better communication and relationship between the client and the clinician.

Horvath (2011) not only defined alliance as a partnership, but also highlighted the importance of therapeutic alliance in setting the environment that inspires and builds trust. This setting allows transparency on both participants' parts and establishes upfront that both are human beings worthy of respect, honor, and dignity. The two parties are equals, and the relationship is not predicated on the usual doctor-patient or adult-child relationship. Study participants in this study confirmed this aspect when they made

statements like, “I think I felt really connected because she validated (me), which I later would learn validation is really important in that type of relationship.”

Trust

Constantine (2007) warned that cultural mistrust may be at the forefront of factors that can lead to a lack of positive therapeutic outcome and relationship. However, in conducting this study, I found that a majority of the participants described feeling a sense of trust between themselves and their European American clinician. Therefore, this study’s findings are incongruent with previous results. In fact, seven of 10 participants described the theme trust having emerged when participants described a sense of trust in general, on a human-to-human level: not necessarily based on culture. This process allowed for better communication and relationship between the client and the clinician. Trust was always present every time empathy and therapeutic alliance were evident. APA (2003) stated that therapeutic alliance and empathy are cornerstones to positive therapeutic outcomes. Trust will also co-inhabit the positive therapeutic atmosphere and relationship when these two cornerstones are present, thereby potentially adding a third cornerstone to the positive therapeutic-outcome equation.

Moving Forward

In this original study, seven of 10 participants described the theme moving forward as emerging when participants described the ability to resolve issues for which they originally sought counseling. These results are congruent with findings from the APA (2003), stating that empathy and therapeutic alliance are cornerstones to positive therapeutic outcomes. The process of the clinician employing empathy and creating an

atmosphere that inspired and maintained therapeutic alliance in the therapeutic relationship allowed for better communication and the ability for the patient to feel safe enough to reveal their innermost thoughts and receive the help the clinician was equipped to offer, ultimately moving the patient forward. Participant 7 exemplified this code in the statement,

I felt I could trust her. I felt that I could take her help. I could use what she was giving me. Her suggestions, or her advice, I could take that. I did, and it was really helpful. It gave me the courage to do what I needed to do, and stop some of my madness.

Positive Resolution

In this original study, seven of 10 participants described the theme positive resolution as emerging when the ability to come to a resolution or resolve the issues at hand were present. This process occurred because of positive communication, positive therapeutic alliance, positive atmosphere, and a clinician who was empathetic to the African American patient. This study's results are also congruent with earlier findings from the APA (2003). These positive outcomes might not have been possible had the patient never sought counseling, or if, when they did seek help, the European American clinician was not empathetic and did not provide an environment that was conducive to transparency, mutual respect, and nonjudgmental interactions between this racial dyad.

The truth still remains that sometimes it is hard for people in U.S. society to seek mental health help. This is, in large part, due to the negative perception that surrounds seeking mental health help in the general U.S. population, and in particular, the African

American community (Rosen et al., 2012). This sensitivity has formed, in large part, through a historical lens of slavery and racism. Historical experiences have influenced and inspired a culture of mistrust (Benkert et al., 2006) and created a need, when providing mental health to people of color, to regard how a person perceives themselves in relation to racial identity, as this may prove important to acknowledge when attempting to provide care (Benkert, 2006; Cardemil & Battle, 2003; Terrell & Terrell, 1981; Townes, Chavez-Korell, & Cunningham, 2009).

Racial matching has strong ties to therapeutic alliance and positive outcomes, largely due to similar understandings of culture and lived experiences (Atkins, Bui, & Mori, 2001; Owen, Adelson, Imel, & Rodolfa, 2012). These similarities help therapists and clients establish connectedness and foster positive therapeutic outcomes, such as completing the number of recommended sessions and patients indicating treatment was a success. Because relatively few people of color enter the mental health field, particularly at the doctorate level, patients of African American descent will likely receive treatment from European American providers. Demographic characteristics of APA members by membership status indicate that African Americans at the doctoral level account for only 1.5% of the total body of providers. European Americans, in contrast, at the doctoral level, account for over 59% of clinical providers (APA, 2013). Yet, if clinicians lack proper multicultural education and field training, African American clients may not receive appropriate care (Owen, Adelson, Imel, & Rodolfa, 2012).

In contrast to the aforementioned, my research showed that it is possible to have positive therapeutic outcomes even in lieu of lacking racial matching between client and

clinician. Seven of 10 participants in my study indicated they were able to have a positive therapeutic outcome with their European American clinician. However, it became very evident in my study that although racial matching was not of most importance to the therapeutic outcome, empathy and therapeutic alliance were imperative and allowed this racial dyad to have a positive therapeutic relationship and outcome for the patient.

Limitations of the Study

As stated in Chapter 1, no perfect studies exist; all research designs have flaws (Marshall & Rossman, 2006). Though a qualitative study design does provide many advantages when seeking to explore lived experiences, it still presents with some limitations. This original study included only 10 self-identified African American participants recruited from the southeastern region of the United States. Therefore, due to the small unique population, the data may not be generalizable to other minority populations in other regions, possibly limiting transferability.

Dependability concerns the ability to replicate the observed twice. This may be a challenging task due to the presence and relationship one researcher may build with each participant versus another researcher's ability to do the same in the exact same ways. Thus, room must exist to allow for the human factor. Additionally, it is plausible that each participant may recall different things at particular times. Thus, what one participant recalls today may influence any secondary questions the researcher might ask subsequently. Therefore, dependability may be an issue. It is conceivable that, given that the semistructured questions were written down, a different researcher could achieve similar results, given that both researchers are asking the exact same initial interview

questions. Yet, semistructured questions may invoke a particular response from one interviewee that it may not from a different interviewee, causing the interviewer to ask follow-up questions that are different each time.

I came to the research with the intent that any possible bias was set aside. I had no agenda for the outcome and was only interested in learning and highlighting the true lived experiences of African Americans in therapy with European American counselors. Additionally, all researchers experience the potential to influence interviewees with voice pitch, giving direction to desired responses. The potential for bias lies in the fact that the participants and I are all African American, and that I may have preconceived concepts about what is being said or what would be said. These factors were considered beforehand and thus, I did seek only to receive data in its purest form without influencing participants by what was asked or how it was asked. I prepared a list of interview questions that were followed in the exact sequence, verbatim, for each participant interviewed, to address these limitations. One could also consider, if the researcher was European American, there may have been different dynamics at work.

Recommendations

One of the first recommendations for further study would be for researchers to design a study with participants having various educational levels. Although, one of the strengths of this original study was that the researcher was able to incorporate different educational levels (high school through doctoral level) in the participant interviewee pool, it soon became obvious that there was an overrepresentation of participants with higher education, in particular having earned master's and doctoral degrees. A future research

project could include perhaps a two-part study: one study with participants having obtained higher level degrees verses high school or less education to compare and contrast those two subset results to see if there was a marked difference in how participants' viewed the clinicians' ability to display empathy and therapeutic alliance.

A second recommendation for future studies could include conducting a study in which the researcher was European American to determine if the racial identity of the researcher makes a difference in the results of the study. Because I am of the same ethnic and cultural background as the participants may be considered a distinct advantage in that participants appeared to be at ease with me and, thus, may have been more open and transparent about their true perspective of working with a European American clinician. In a future study, it might be interesting to see if a European American researcher would have the same outcome. This could potentially answer questions about research and African American participants and European American researchers' abilities to obtain pure, unfiltered results from this population. It is possible that a European American researcher may observe aspects in African American participants that African American researchers may not have observed, because they are coming to the study as an outsider. Researchers of another ethnicity may counter any natural biases that were not overcome from sharing the same ethnic and culture background as participants in this original study. The European American researcher may come in as an outsider with the potential ability to be more objective in their approach to the study in asking questions of participants, the relationship built between the researcher and the participant, to see if there is a difference. If a European American researcher conducts the same study, would the findings be

different? The point here is to discover what impact racial difference makes in achieving therapeutic alliance. I make these recommendations to further explore multiple factors in a racially and culturally diverse therapeutic relationship.

A third recommendation for future research is to seek participants from different geographical areas. This original study focused on recruiting participants from the southeast region of the United States. A potential question for future studies might include Does culture vary from one part of the United States to another and if so, would this affect the perceptions of African Americans and their view of obtaining counseling from a European American clinician? A future study could actively recruit participants from the northern states and the southern states to compare and contrast perceptions of empathy and therapeutic alliance between African American patients and their European American clinician. Another possibility is to compare and contrast African American participants living in inner cities and those living in rural and suburban areas of the United States.

A fourth recommendation is to see if difficulties or challenges arose in this racial dyad if the doctor was African American and the patients were European American. Given the history of racial conflict between these two races and cultures in the United States, does the same cultural mistrust present a challenge to the therapeutic alliance and empathy displayed if the positions are reversed? Is clinician bias an issue in either direction? Likewise, as specified earlier in Recommendation 2, if the researcher was European American and study participants were African American, would the study findings be the same? Researcher bias, as well as clinician bias, can equally impact the

outcome. According to Elo et al. (2014), researcher bias can be a threat to trustworthiness and can distort outcomes. Likewise, clinician biases can threaten the therapeutic alliance. If a clinician does not seek to eschew their biases and is not cognizant of the stereotypes they hold about African Americans, these biases may negatively impact the therapeutic alliance in the therapeutic relationship. The outcome may not be a positive one, according to the APA (2003). Therefore, it is imperative to reduce bias whenever possible, this is true in research as well as in counseling. All these aspects can have implications on future research participants and future patients alike.

A fifth recommendation would be to conduct the same exact study however, look to see if gender were an issue with the same racial dyad. A factor that could be of interest here is the fact that eight of the ten European American clinicians, that the 10 African American participants interacted with, were female. Thus, gender could be of importance to the therapeutic alliance building process. Although, this was not the focus of this current study, it may be of interest to future research.

Implications

Previous studies highlighted that African Americans do not seek or stay in mental health treatment at the same rates as their European American cohorts (Conner et al., 2010; Villatoro & Aneshensel, 2014). When African Americans do seek help, researchers indicated they tend to terminate sessions prematurely, due to dissatisfaction in experiences with their European American clinicians (Westra, Constantino, & Aviram, 2011). This study explored the lived experiences of African American clients who sought therapy with a European American clinician. It highlighted what factors were present that

allowed this group of racially and culturally different people to function in a way that led to positive therapeutic outcomes for the African American client.

A potential implication for social change on the individual, family, and community level is that African Americans could have greater access and opportunity for counseling if they were more likely to have a positive experience or hear from others in their communities that they trust who have had positive experiences. They would not be limited, due to cultural mistrust, in whom they could go for help. They would have greater opportunity to receive help if all European American clinicians would present with empathy and therapeutic alliance and without bias. As a result of African Americans having greater access, they may feel stronger as individuals, leading to stronger families and communities.

European American clinicians must check any biases and stereotypical views they may have about African American when they are engaging in therapy with an African American patient. The opposite would be counteractive in that, without checking their biases and seeing the African American patient, no therapeutic alliance would emerge.

A better understanding of the process could lead to meaningful patterns and themes that address the gap of not knowing which factors would lead to successful therapeutic alliance between this racial dyad and the lack of practical application in the therapeutic room. Thematic findings revealed that positive therapeutic outcomes could occur between African American clients and their European American clinicians. These findings underscore the importance of clinicians employing empathy and therapeutic alliance every time they hold therapeutic sessions with an African American client.

Another implication for this study is the huge potential impact for positive social change at the individual level, family, and community level! If European American clinicians, when seeking to serve African American clients, employ therapeutic alliance and empathy in their therapeutic sessions, these study findings indicate that a positive therapeutic outcome will result. This result will allow African American clients to heal and find the positive resolutions they originally sought. This outcome will have a positive impact on the individual as well as potentially on their family, place of employment, and the society in which they live and interact.

A final potential implication for social change could be in the form of alterations in how scholars write textbooks and teach graduate psychology courses, which has the power to translate into how educators supervise clinical internships. If professors, writers, and supervisors emphasize that therapeutic alliance and empathy are key factors to producing quality therapeutic experiences and positive outcomes for interactions with all patients, and in particular with African American clients, the therapeutic atmosphere will have been enriched and the lives of many students, professors, patients, and supervisors may change for the better. These findings hold the potential for societal change in the form of didactic and supervision instruction, as well as overall policy levels in work environments when instructing current and future clinicians who seek to serve this population.

Findings from this study and the choice to use the qualitative phenomenological approach yielded great promise that African American patients can find empathy and therapeutic alliance when in a therapeutic relationship with a European American

clinician. Thus, the methodological implication for this study further supports phenomenological qualitative studies on this topic to further understanding of how this racial dyad can best work together in therapy and yield positive therapeutic outcomes for the African American patient.

A theoretical implication exists to strengthen the concept of empathy and the use and monitoring of therapeutic alliance. Educators must help therapists in training be very aware that it is their job as the therapist to employ empathy and therapeutic alliance. Likewise, simultaneously it is their job to have an ongoing assessment of the level of therapeutic alliance occurring between themselves and the African American client. Clinicians must continue to assess for possible ruptures in the therapeutic alliance (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011; Westra, Constatino, & Aviram, 2011). If a clinician creates a therapeutic alliance at the onset of therapy but is not careful to assess for ruptures and repairing these ruptures, alliance can quickly fade and the possibility of positive therapeutic outcome be lost. This study points to the possibility for this racial dyad of an African American patient in therapeutic session with a European American clinician to have positive therapeutic relationship and move toward positive therapeutic outcomes. Thus, the importance training clinicians in the art and practice of displaying empathy and creating true therapeutic alliance includes assessment and repair of ruptures.

Conclusions

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African American clients in a therapeutic relationship with a European American clinician, to learn what African American clients think about their lived

experiences and to identify elements of a good alliance. Historically this racial dyad has not resulted in positive therapeutic alliances or outcomes. This study suggests that the factors necessary for positive outcome are empathy and therapeutic alliance. It also points to the fact that when these two factors are present, it establishes trust within the therapeutic relationship between this racial dyad. The value of this study is that the findings extend the body of knowledge concerning the lived experiences of African Americans receiving mental health counseling with the assistance of a European American clinician.

In summary, this original study suggests that African Americans can have positive resolution with European American clinicians if empathy and therapeutic alliance are present in the therapeutic relationship. The APA (2003), states that empathy and therapeutic alliance are cornerstones to positive therapeutic outcomes, in general. However, most studies indicate that in this racial dyad, outcomes are predominately negative. This is due, in large part, to dissatisfaction felt by the African American patient with their therapeutic relationship with a European American clinician (Owen, Imel, Tao, Wampold, Smith & Rodolfa, 2011; Rosen, Nakash, Miller, Halperin & Alegria, 2012; Westra et al, 2011). Usually, a lack of cultural competency, as well as cultural mistrust disallows a positive therapeutic outcome. However, this original study found that despite a lack of specific cultural understanding, it is possible to have a positive therapeutic outcome when European American clinicians promote and emphasize empathy and therapeutic alliance with this population in particular.

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Appendix A: Recruitment Flyer

Attention: African American community members



Q: Have you ever received mental health counseling from a European American therapist?

If so, you are invited to participate in an academic research study designed to shed light on and give voice to your lived experience.

If you are an African American adult (age 18 years +) and are interested in being a part of this research, please contact Mrs. Johnson-Hood today at (contact number deleted) to obtain more information about this no-cost, confidential study.

Appendix B: Demographic checklist

Race/Ethnicity:

African American/Black

Black (Hispanic Origin)

Black (Caribbean)

Black (Other: _____)

Annual Household Income:

\$0–30,999

\$40,000–\$ 70,000

71,000–\$100,000 +

Age Category:

18–25 _____ 26–35 _____

36–45 _____ 46–55 _____

56–65 _____ 66 & older _____

Education Level:

High School graduate: _____ College Graduate: _____

Graduate School: _____

Marital Status:

Single _____ Divorced _____

Appendix C: Interview Protocol

From the perspective of the African American client:

Research Question 1: What are the lived experiences of African American clients about receiving mental health treatment from a European American clinician?

Interview protocol:

- I. Can you describe your experience in therapy with your counselor?
- II. Can talk about how you felt about your therapist's ability to help you?
- III. Can you describe your relationship with your therapist?

Research Question 2: From the perspective of African American clients, what was the most satisfying aspect of treatment with a European American clinician?

Interview protocol:

Please tell me about when you felt most satisfied in therapy.

- I. Can you tell me about when you felt your therapist was most connected to you?
- II. Do you believe that your therapist was genuinely concerned for your welfare?
- III. As you continued meeting with your therapist, how did your feelings change over time?

Research Question 3: From the perspective of African American clients, what was the most difficult part of the treatment process with a European American provider?

Interview protocol:

- I. Please tell me about when you felt least satisfied in therapy.

- II. Please describe the most difficult part of the treatment process with your European American clinician

Research Question 4: Based on the lived experiences of African American clients, what contributes to a successful therapeutic alliance in the African American and European American therapeutic racial dyad?

Interview protocol:

- I. Please tell me about what factors contributed to the success of your therapy with your European American clinician.
- II. Can you tell me about when you felt your therapist was most connected to you?