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**SPECIAL POPULATIONS**

An Investigation of European American Therapists’ Approach to Counseling African American Clients

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Interviews were conducted with 9 European American psychologists, asking them to recall their first 12 counseling sessions with a current or recent successful case with an African American client. Using consensual qualitative research (CQR) methodology, the psychologists revealed that they generally attended to differences in race between themselves and clients directly and openly within the first two sessions. This was done to acknowledge this difference and convey to the client comfort and trust; psychologists also intended to engender client trust and participation in therapy. The psychologists saw race as a central component to be discussed and continually attended to in establishing and maintaining a trusting and solid working relationship. They typically saw race-related issues as relevant to clients’ concerns. Despite wide variability in theoretical orientations and variety of client presenting problems, they typically reported using Rogerian core skills to engage the client and establish the relationship. However, they also reported using more culture-specific and sensitive interventions to deepen and strengthen the therapy relationship. These interventions included relying on their level of racial identity development to understand the client, being attuned to the client’s racial identity development and worldview, and attending to client reports of racism.

In the last two decades, there has been an appreciable increase in the amount of theory development and empirical research directed at helping counselors develop more sensitive and appropriate interventions in their work with racial and cultural minorities in the United States (Constantine & Ladany, 2001; Ponterotto, Fuertes, & Chen, 2000; Sue et al., 1998). For example, as part of a recent review of the multicultural counseling literature, Ponterotto et al. (2000) and Fuertes and Gretchen (2001) reviewed 16...
different theories and models of multicultural counseling, albeit at various stages of development and with varying degrees of empirical inspection. The two longest standing approaches, the counselor multicultural competency model (Sue, Arredondo, & McDavid, 1992; Sue et al., 1998) and the racial identity interaction model (Helms, 1984, 1990), have generated considerable theoretical scrutiny, modifications, and empirical support (Ponterotto et al., 2000).

However, despite these developments, a review of the literature has yielded a dearth of empirical evidence about what actually happens and works in cross-cultural counseling, particularly when differences exist in race or ethnicity between the therapist and the client. Although there has been considerable empirical activity on factors associated with counselor multicultural training (Ponterotto, 1998) and numerous counseling analogue and survey studies of minority students’ attitudes, preferences, perceptions, and reactions to counselors (Beutler, Machado, & Neufeldt, 1994; Coleman, Wampold, & Casali, 1995), very little work has examined clients’ or therapists’ experiences in cross-cultural counseling. As Sue, Zane, and Young (1994) noted, there has been a lack of applied, empirical research in the field of multicultural counseling, both in terms of process (e.g., therapist interventions and client reactions to these interventions) and outcome (i.e., whether racial, ethnic, and other cultural minority groups actually benefit from therapy).

Our review of articles and textbooks in multicultural counseling (e.g., Constantine & Ladany, 2001; Helms & Cook, 1999; Sue et al., 1998) revealed a need and an opportunity for research that involves counselors and clients, and for in-session, exploratory research that might describe several important processes and events in multicultural counseling. These processes include the techniques used by therapists to engage and establish rapport with ethnic minority clients (Helms & Cook, 1999); the process by which therapists attend to and discuss with their clients sensitive, race-related topics (Berg & Wright-Buckley, 1988; Pomales, Claiborn, & LaFromboise, 1986; Thompson & Jenal, 1994); and the skills and timing therapists use to cope with client apprehension that might be related to racial differences in the dyad (Terrel & Terrel, 1984; Thompson, Worthington, & Atkinson, 1994). In the present study, these topics are examined.

The authors were also inspired and guided by the multicultural competence model (Sue et al., 1998) and Helms’s (1984, 1990) racial identity and interaction model to examine the process by which participants examined and discussed race with their clients, the extent to which they discussed race in light of relationship and treatment issues, and the difficulties they encountered and the skills they used in discussing race-related material. Data or
observations on these processes in multicultural counseling may increase the quantity and quality of services provided to the increasing numbers of racial, ethnic, and cultural minorities in the United States and may galvanize researchers in the field to conduct more empirical work in this area.

As suggested to investigators conducting qualitative research (McCracken, 1988) and consensual qualitative research (CQR) studies (Hill, Thompson, & Williams, 1997), we created manageable parameters in the current study by limiting the focus on successful cases where the dyads consisted of European American therapists and African American clients. There is little empirical evidence about this dyad combination in counseling (Sue et al., 1994), despite this being a racially disparate and sensitive dyad in counseling (Atkinson, Morten, & Sue, 1998; Sue & Sue, 1999). We also delineated parameters of observation by selecting the first 12 sessions for a look at early events in counseling. Many therapy experiences, particularly those associated with the establishment of trust and a working relationship, usually occur in the first 12 sessions (Gelso & Fretz, 1992). Also, the nature of long-term treatment is often determined by the quality of events in this initial set of sessions (Gelso & Hayes, 1998). To add depth and accuracy to the interview (McCracken, 1988), the participants were asked to select a current or past case they recalled vividly and/or for which they had progress notes.

We selected qualitative methodology, given the complexity of the phenomena of interest. Qualitative research methods have not been often applied to the study of multicultural counseling, despite the potential that these methods provide for discovery, in-depth analysis, and clinical description (Ponterotto, 2002). Hence, in this study, we applied the CQR (Hill et al., 1997) method to examine some general questions about multicultural counseling. We were compelled to use the CQR method because it has now been used successfully to examine therapy, supervision, and training topics in counseling and psychotherapy research (e.g., Gelso, Hill, Mohr, Rochlen, & Zack, 1999; Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000; Williams, Judge, Hill, & Hoffman, 1997). CQR offers rigor to qualitative analyses by emphasizing the use of multiple researchers, consensus on themes and ideas, and representativeness of data across cases (Hill et al., 1997). Consistent with suggested parameters of qualitative inquiry (Glaser & Strauss, 1967; Taylor & Bogdan, 1984) and as guided by our review of the relevant literature, our research questions were discovery oriented and centered around three broad areas: (a) How did these European American therapists engage African American clients in counseling? (b) What problems or difficulties did they encounter in helping the client? and (c) What skills or special interventions did they use?
METHOD

Participants

Nine European American psychologists volunteered as participants; 6 were women and 3 were men. All had a doctorate (8 in counseling psychology and 1 in clinical psychology) and some experience in working with African American clients (number of African American clients seen postdoctorate: $M = 32, SD = 25$, range = 8-75). They reported an average age of 40 ($SD = 9$) and an average of 9 ($SD = 8$, range = 2-28) years of postdoctorate experience. The sample represented three geographical regions of the United States: the Northeast, Midwest, and Mid-Atlantic areas. The psychologists were employed in university counseling centers ($n = 4$), private practice ($n = 3$), and mental health agencies ($n = 2$). Seven interviews were conducted by telephone and 2 in person. Participants reported having an average of 2 ($SD = 2$, range = 0-5) courses in multicultural counseling and having attended an average of 9 ($SD = 10$, range = 0-31) workshops in multicultural counseling as part of their training. Two of the psychologists reported feminist theory as their primary approach to counseling, 2 reported being psychodynamic, and 5 reported being eclectic-integrative.

Researchers

The primary team of researchers included one counseling psychology faculty member and two doctoral counseling psychology students, one Hispanic American man, one Indian American man, and one European American woman. The auditors for the team were a European American faculty member in counseling psychology and a European American female doctoral counseling psychology student at a different university than that of the primary team. All three members of the team participated in the interviewing, and all members (including auditors) participated in the qualitative analysis process.

Bracketing biases. As recommended for consensual qualitative research, the researchers identified and recorded their biases regarding expectations about the results of the analysis. Collectively, the researchers believed that the therapists would demonstrate a high level of racial identity and sensitivity to issues of racism, bias, and oppression. We also believed that these therapists would be mindful of how they were being perceived by their clients, particularly with respect to race sensitivity and possibly racist or ignorant views or attitudes. We also expected these therapists to be American in the sense
that they would express in various ways their fundamental belief in individual freedom, self-reliance, competition, and leadership. The primary research team members discussed these biases and expectations to increase awareness and minimize the effect of these biases and misconceptions on the data analysis.

**Measures**

A semistructured questionnaire was created following the guidelines set by McCracken (1988). Questions were generated by each researcher and then discussed by the team. The questions generated for the interview were guided by the following three general questions: (a) How did these European American therapists engage African American clients in counseling? (b) What problems or difficulties did they encounter in helping the client? and (c) What skills or special interventions did they use? Inquiries and follow-up probes were added to the final questionnaire through a process of mutual negotiation in the research team. The interview protocol was then organized into five categories, which are presented in the appendix along with sample interview questions for each category.

**Procedure**

*Recruiting.* Approximately 30 psychologists were identified through professional contacts made during the past few years by members of the research team. These psychologists were contacted by letter or phone call with descriptions of the purpose of the study and the criteria for participation. Ten participants met the criteria for our study (i.e., they were European American, had earned a doctorate in clinical or counseling psychology, and had some experience in counseling African American clients) and were willing to participate. Although the current sample is one of convenience, we purposely made contacts with professionals known to reside in three distinct regional areas of the United States and who worked in three different settings in an attempt to sample a broad group of psychologists.

To maintain homogeneity in our sample, 1 of the interviews was subsequently removed from analysis because the participant’s client was a native of Africa and had recently migrated, unlike the other clients (who were U.S.-born African American). Participants were assured of full anonymity and confidentiality and encouraged to be as candid as possible. All the participants received the questionnaire ahead of time to familiarize them with the focus of the interview and to recall the specifics of the case.
Clients. Participants reported their clients to be 8 African American women and 1 man, with an average age of 34 (SD = 12, range = 23-53). The average number of sessions completed with the clients overall was 38 (SD = 29, range = 9-100), although 3 of the cases were ongoing at the point of data collection. The treatment issues and focus of therapy for the clients were (a) close-head injury, memory loss, and sexual dysfunction; (b) major depression and chemical dependence; (c) career transition and spousal relationship; (d) incest and rape; (e) academic performance and relationship with college roommate; (f) panic disorder and phobic responses; (g) diagnosis of AIDS and mild depression; (h) major depression and chemical dependency; and (i) anxiety and panic disorder.

Interviews. One pilot interview was conducted. The participant was a 42-year-old male European American counseling psychologist with extensive experience working with African American clients. The client discussed was an African American man treated for mild depression. The pilot interview was conducted as a conference call by one of the team members as another team member listened and took notes. Feedback was elicited from the participant about the questionnaire and changes were made in its structure and organization to facilitate a more even transition between topics. This pilot interview also served as a model for the interviews, which were audiotaped.

About 3 months after the interviews were conducted, packets were prepared and sent out to each participant. These packets included a demographic data questionnaire, a copy of the interview transcript for the participants to review for accuracy, and a separate questionnaire with open-ended questions for the participants to answer as follow-ups to the interview (these questions asked about the accuracy of the transcript, allowed participants to make changes or expand/clarify comments made in the interview, asked about progress with current clients, and invited additional comments).

Data preparation. Each interview was transcribed by a graduate assistant not involved in the research team, at which time any personal identifying information (e.g., references by the participants to the city or area where they lived) was removed. The interviews were then given numbers to assure the participants confidentiality and anonymity. The interviewer listened to the tape with the accompanying transcript to record words or phrases the transcriber had difficulty understanding and made corrections to assure accuracy.

Coding into domains. The research team randomly selected 2 of the interviews to be removed from further analysis until the other 7 had been coded into domains, core ideas had been abstracted, and cross-analysis had been
completed. This was done to provide a separate data analysis to compare to the initial set of 7 for saturation. With these interviews placed aside, each team member independently categorized 2 of the remaining 7 interviews using the general categories from the interview protocol. The team members then rotated responsibility for the other 5 interviews, and as each interview was categorized, progressive changes were made to domains to encompass the changing conceptualizations of the labels.

Abstracting core ideas within domains. Once each transcript had been domained, transcripts were abstracted for core ideas. This involved examining the interviews and reducing them into meaning units, representing the focus of each statement. For example, the transcribed statement, “Well, I think one of the things that I used was to bring my awareness of my own racial identity and, you know, my own development in terms of racial identity, and be aware of that part of me, and try to understand where the client was in terms of her own identity development,” became the core idea, “The therapist used his awareness of his own racial identity development to try to understand where the client was in terms of her identity development.”

Auditing of core domains and core ideas. The domains and core ideas were then presented to the auditors. Suggestions from the auditors included retaining more detail from the transcribed statements in some areas as well as general observations about emerging domains or possible subcategories within the domains. After considering and incorporating the auditors’ feedback, the team argued to consensus for the 7 interviews and came up with nine general domains.

Cross-analysis. Each domain was examined for common themes across participants. These themes were organized into subcategories. For example, the domain, “The relevance of race and race-related issues” was divided into two subcategories: “relevance of race to establishing the relationship” and “relevance of race to the treatment issue(s).”

Auditing of cross-analysis. The cross-analysis of the domains was submitted to the auditors who provided written feedback to the team regarding the inclusion of certain core ideas within subcategories. The suggestions were discussed among the research team members and consensus was attained on changes to be made.

Stability check. The team then revisited the two interviews that had been initially removed from the analysis and proceeded to organize the data into domains and abstract the core ideas within each domain. The researchers
TABLE 1: Summary of Categories From the Cross-Analysis of the Cases (N = 9)

<table>
<thead>
<tr>
<th>Domain and Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists’ background, level of racial identity</td>
<td></td>
</tr>
<tr>
<td>Descriptions of racial and cultural background</td>
<td>General</td>
</tr>
<tr>
<td>Therapists acknowledge power and privilege</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapists acknowledge racism and oppression</td>
<td>Variant</td>
</tr>
<tr>
<td>Therapists’ multicultural competence</td>
<td></td>
</tr>
<tr>
<td>Self-assessment of multicultural competence</td>
<td>General</td>
</tr>
<tr>
<td>Skills necessary to work with African American clients</td>
<td></td>
</tr>
<tr>
<td>Awareness of race and history of racism/oppression</td>
<td>Typical</td>
</tr>
<tr>
<td>Attending to and understanding the client in the context of race</td>
<td>Variant</td>
</tr>
<tr>
<td>Knowledge necessary to work with African American clients</td>
<td></td>
</tr>
<tr>
<td>Knowledge and awareness of African American culture</td>
<td>Typical</td>
</tr>
<tr>
<td>Multicultural education and training</td>
<td>Variant</td>
</tr>
<tr>
<td>Exposure to and experience with African American culture</td>
<td>Variant</td>
</tr>
<tr>
<td>Client racial identity</td>
<td></td>
</tr>
<tr>
<td>Therapists were attuned to the client’s racial identity</td>
<td>Typical</td>
</tr>
<tr>
<td>Skills used to establish a working relationship/alliance</td>
<td></td>
</tr>
<tr>
<td>Core skills</td>
<td></td>
</tr>
<tr>
<td>Focus on setting up goals and working alliance</td>
<td>General</td>
</tr>
<tr>
<td>Attending and listening</td>
<td>Typical</td>
</tr>
<tr>
<td>Empathy</td>
<td>Typical</td>
</tr>
<tr>
<td>Other skills</td>
<td></td>
</tr>
<tr>
<td>Nondirective approach</td>
<td>Typical</td>
</tr>
<tr>
<td>Educating the client about therapy</td>
<td>Typical</td>
</tr>
<tr>
<td>Communicating a collaborative theoretical stance</td>
<td>Typical</td>
</tr>
<tr>
<td>Use of nontraditional interventions</td>
<td>Typical</td>
</tr>
<tr>
<td>Use of referrals and other resources</td>
<td>Variant</td>
</tr>
<tr>
<td>Relevance of race differences and race-related issues</td>
<td></td>
</tr>
<tr>
<td>Race as relevant to establishing the relationship</td>
<td>General</td>
</tr>
<tr>
<td>Race as relevant to the treatment issue(s)</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapists attended to race differences by</td>
<td></td>
</tr>
<tr>
<td>Inquiring with the client</td>
<td>General</td>
</tr>
<tr>
<td>Relying on multicultural awareness</td>
<td>Typical</td>
</tr>
<tr>
<td>Being open and supportive to reports of racism</td>
<td>Typical</td>
</tr>
<tr>
<td>Race-related difficulties and barriers encountered</td>
<td></td>
</tr>
<tr>
<td>Therapist ambivalence due to race differences</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapists attended to their ambivalence by</td>
<td></td>
</tr>
<tr>
<td>Seeking consultation and supervision</td>
<td>Variant</td>
</tr>
<tr>
<td>Client ambivalence due to race differences</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapists attended to the client’s ambivalence by</td>
<td></td>
</tr>
<tr>
<td>Understanding and supporting the client</td>
<td>General</td>
</tr>
<tr>
<td>Confronting the client</td>
<td>Variant</td>
</tr>
<tr>
<td>Going beyond the prescribed role of therapist</td>
<td>Variant</td>
</tr>
<tr>
<td>Seeking client collaboration in setting the pace and agenda of therapy</td>
<td>Variant</td>
</tr>
<tr>
<td>Relevance of other differences</td>
<td></td>
</tr>
<tr>
<td>Therapists attended to other differences</td>
<td>Typical</td>
</tr>
<tr>
<td>Other variables were salient to client identity</td>
<td>Variant</td>
</tr>
</tbody>
</table>
found that little modification of the original domains was necessary, and the inclusion of the core ideas into the existing subcategories supported the findings yielded from the first analysis. The results were again sent to the auditors, whose feedback was discussed and incorporated in a consensual manner by the researchers.

RESULTS

Table 1 shows the frequency of cases for each of the categories and subcategories within the domains. Hill et al. (1997) considered a category that applies to all cases as “general,” “typical” if it applies to half or more of the cases, and “variant” if it applies to 2, 3, or less than half of the cases. In this study, we followed these criteria and described the frequency for each of our categories on a scale ranging from general if it applied to all 9 cases, typical if it applied to 5 to 8 cases, and variant if it applied to 3 to 4 cases. We found no appreciable differences in the participants’ responses as a function of the therapists’ gender or whether the case had ended or was ongoing.

Therapist Background and Level of Racial Identity

Therapists described their background in terms of race (i.e., White, European American, or Caucasian) and cultural background (e.g., Italian American, Anglo-Celtic, Jewish, Irish American, and English descent). All men-

<table>
<thead>
<tr>
<th>Domain and Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of supervision and consultation</td>
<td></td>
</tr>
<tr>
<td>As an informational source</td>
<td>Typical</td>
</tr>
<tr>
<td>Helpful and supportive</td>
<td>Typical</td>
</tr>
<tr>
<td>Factors associated with client persistence in therapy</td>
<td></td>
</tr>
<tr>
<td>Therapist affirmation and caring</td>
<td>General</td>
</tr>
<tr>
<td>Therapist understanding</td>
<td>Typical</td>
</tr>
<tr>
<td>Client progress</td>
<td>Typical</td>
</tr>
<tr>
<td>Relationship factors</td>
<td>Typical</td>
</tr>
<tr>
<td>Outcomes after 12 sessions</td>
<td></td>
</tr>
<tr>
<td>Symptom reduction, goals met, improved functioning</td>
<td>General</td>
</tr>
<tr>
<td>Stronger working alliance and relationship</td>
<td>General</td>
</tr>
</tbody>
</table>

NOTE: General = evident in all 9 of the cases, Typical = evident in 5 to 8 of the cases, and Variant = evident in 3 to 4 of the cases. Categories that included less than 3 cases are not shown.
tioned additional aspects of their background including gender, socioeconomic status, physical disability, and sexual orientation. Respondents were asked, “How do you understand your race in relation to others?” Typically, responses included an awareness of the privilege associated with being White in the United States, including being part of the norm and standard socially, not having to face discrimination, not having to think of being “different,” and having access to power. As a variant category, respondents acknowledged Whites’ historical legacy of oppression of others and the historical and contemporary existence of racism. A sample core idea from this domain is, “[Therapist] understands her race in relation to others’ as mostly in terms of White people having had access to power and privilege and in getting and keeping it; they have oppressed other races.”

**Therapists’ Multicultural Competence**

Participants typically described themselves as competent in working with African American clients. One therapist described her level of multicultural competence as low to adequate, 6 described themselves as fairly or moderately multiculturally competent, and 2 described themselves as above average in multicultural competence. A sample core idea from this domain is, “[Therapist] would say that she is above average in her skill and competence in working with African American clients, but [therapist] would not say excellent or superior.”

**Skills Necessary to Work With African American Clients**

Therapists mentioned an awareness of having been oppressed in some way themselves, an awareness of having been oppressors, of having a one-up position with their clients, and recognizing that the reality of racism and tension between European Americans and African Americans is reflected in the counseling hour. Some of the skills mentioned included being direct but sensitive to issues pertaining to race, conveying a sense of openness and acceptance of the historic effects of racism, having patience and sense of timing, and an ability to vicariously identify with the client. For example, one psychologist noted, “I think what’s really important is to convey a sense of openness and acceptance of the historic effects of racism and the healthy mistrust that an African American client would bring to a counseling relationship with a White counselor... because at some point, I really believe it’s going to be in the process.” Another psychologist stated, “I think what I have in my head as sort of a guiding principle is if I’m working with an African American person, don’t shy away from it; bring it up when it seems appropriate.”
Knowledge Necessary to Work With African American Clients

Participants typically noted knowledge of what it was like to be different and to have an awareness that racial, cultural, and socioeconomic influences create a multicultural experience for clients in counseling. They also cited specific and general knowledge of African Americans, including the history of slavery, Jim Crow laws, the Civil Rights movement, and a sincere appreciation of the stark sociopolitical reality their clients often face as African Americans. Also noted were an understanding of the universal human condition, an understanding of racism, an awareness of the effect of living in a racist society, valuing diverse people and knowledge, managing counter-transference to differences to race and ethnicity, and a knowledge of racial identity and its central role in their clients’ lives. Therapists noted two major sources for this knowledge: educational experiences within training curricula (e.g., courses in graduate training and workshops) and experiences sought outside of academia (e.g., friends and significant others). A sample core idea for this domain is, “[Therapist] says that the knowledge of what it means to be human and an understanding of racism are indispensable skills to have.”

Client Racial Identity

Generally, therapists were aware and able to make statements about their clients’ racial identity, except 1 psychologist who said he was not sure and “did not detect any level of discomfort or pride either way” in the client. Statements about clients’ level of racial identity typically described a level of racial identity development characterized by comfort and pride in being Black and clients reporting to therapists that they were connected to their respective African American communities. A sample core idea from this category is, “[Therapist] reports the client is well educated about ‘Black issues’ and is taking classes in that area.”

Skills Used to Establish a Working Relationship/Alliance

Core skills. Therapists typically described using core skills, such as listening, attending, paraphrasing, asking open-ended questions, and conveying open and accepting nonverbal cues to engage the client in therapy. They mentioned using these skills with all clients and not just the African American client being discussed. As a typical category, therapists also described using empathic understanding of the client, conveying this understanding to show clients they were being understood and that the therapist knew their
frustration and where they “were coming from.” Communication of this empathy seemed to strengthen rapport and deepen the level of experiencing and work for the client. All the therapists mentioned the importance of setting up goals and doing so collaboratively to engage and empower the client. Setting up and developing a purposeful alliance, categorized by agreed-on goals and a sense of trust, seemed to give purpose and direction to counseling. A sample core idea from this domain is, “[Therapist] used the skills of real listening, accurate reflection, empathy, caring, and genuineness.”

Other skills. Typically, the therapists were sensitive to the client’s needing time to “warm up” and commit to counseling. Thus, they made comments about not pushing the client, taking a nondirective stance to engage the client, and seeing the client as an expert in his or her life. Most therapists mentioned educating and informing the client about what therapy involves, each participant’s role, and rules regarding time limits, session limits, missed appointments, and insurance/out-of-pocket payments. The therapists also emphasized the importance of taking a collaborative stance with the client, again beyond seeing the client as an expert in his or her own life, recognizing client strengths and ideas, demystifying counseling, and staying close to the clients’ experience (i.e., as opposed to “being too ahead of the client, with clinical assumptions and interpretations”). The therapists also mentioned being as flexible as possible with their schedule and frequently used the telephone to follow up with clients who had missed appointments or who needed to reschedule. The therapists also reported using resources and referrals to help the client, such as directing clients to medical consults, obtaining campus resource information, and suggesting reading materials. A sample core idea from this domain is, “[Therapist] wanted to let the client be in her own space for a while before [therapist] pushed too hard, because [therapist] had a feeling that the client could disappear fairly quickly because the client had been in therapy before and had left.”

Relevance of Race Differences
and Race-Related Issues

Race as relevant to establishing the relationship. Generally, the therapists discussed race as a factor in the formation of the therapy relationship. Although the importance of discussing race varied from dyad to dyad, all the participants acknowledged having discussed race differences or race issues in some way during the first two sessions with their clients. An example of a core idea in this category is, “[Therapist] thinks his bringing up the issue of
race helped establish a relationship . . . it helped the client understand that [therapist] was not afraid of talking about it.”

*Race as relevant to the treatment issue(s)*. Therapists typically mentioned that race was related to clients' concerns, although its importance for the client increased, emerging as a topic for exploration later in the sessions. One psychologist said of her client,

Should you ask this person about race, she would say it doesn’t matter very much, although as we explored specific issues in her life, it did matter. So as we explored some of the specific difficulties she may had with certain agencies or individuals, certainly race came up.

However, its relevance remained more ancillary than central to other, more pressing concerns. Another participant noted, “[Racial, ethnic concerns] was not a common theme that’s went throughout, where some other things did, but, you know, it always came back. It was never totally absent from the room.” Therapists who did not see race as related to clients' treatment issues had clients with clear clinical symptoms and mentioned that the saliency of these problems probably deflected any conversation about race or racism. For example, one psychologist said, “So much of my focus was on helping him deal with living with AIDS and his depression . . . and maybe the saliency of those issues distracted me from doing more exploration of race-related issues.”

**Therapists Attended to Race Differences**

*By inquiring with the client*. Generally, therapists discussed race early in therapy because it was “an elephant in the room” or they mentioned that “race was in the room.” It had to be acknowledged in some way and the purpose of doing so seemed to be to acknowledge the client and communicate to him or her comfort and trust with race differences. Acknowledgement of race in the room was also intended to get the client to talk about it and for the therapist to assess how race and race differences with the therapist were important to the client. The therapists initiated the discussion by pointing to race differences at some appropriate point in the therapy, usually in the first or second session. For example, when asked how she handled racial differences, one therapist responded, “directly, is it okay with you that I’m your counselor and a person of noncolor?” Another asked her client, “‘Are there any other issues or sensitivities that you have not mentioned, for example, Whom you would like to work with or who you would find it difficult to work with?’ ”
By relying on multicultural awareness. In discussing race-related issues in counseling, therapists were typically guided by their own awareness and comfort with their own racial identity. They were also comfortable with potentially not knowing or fully understanding their clients’ perspectives or experiences. They typically communicated to their clients a certain amount of humility and openness to possibly not knowing, misunderstanding, and wanting the client to clarify anything not fully appreciated. For example, one therapist told her client, “Any time that you feel I’ve missed the boat, I want you to tell me that I didn’t understand, and that your experience or reality is very different.” Therapists reported using knowledge of their clients’ community and its resources and vernacular to meet and help the client. As one psychologist noted, “I really tried to speak in lay people’s language, because [the client] wasn’t therapy wise, and her religious background was so negative about therapy, so I tried to make it sound like something she could relate to.” Another participant remarked that he engaged the client by “understanding [the client’s] community, understanding of the language of the community, and there was a willingness to talk about God, which I think was pretty profound in this particular relationship.”

By being open and supportive to reports of racism. Therapists reported communicating an open and sensitive stance to client reports of racism and bias and typically were active and directive in helping clients identify and name experiences as encounters with racism. When asked how she dealt with the issue of racism, one psychologist responded, “We talked about it. We examined different ways for her to deal with it, in terms of asserting herself, because that happened, people wrote her off.” Another participant reported, “Enjoining with her in that anger, and the feeling of being misunderstood, misjudged, and the racial component in there.” They were affirming of clients’ experiences with racism and supportive in helping them cope with it. A sample core idea from this category is, “[Therapist] supported [the client] in terms of naming racism when [therapist] thought it was at work, [therapist] would say, ‘It sounds like racism is at work.’” As a variant category, therapists reported that their discussion of race differences with their clients became a building block and interest point to spark client participation and greater involvement in therapy.

Race-Related Difficulties and Barriers Encountered

Therapist ambivalence due to race differences. Therapists typically reported mild ambivalence due to race differences with the client. Therapists’
ambivalence can be characterized as concern with being perceived by their clients as helpful, understanding, and able to empathize. Sample core ideas from this category are: “[Therapist] was apprehensive working with this client and thinks it was racial apprehension” and “[Therapist] questioned if there would be a barrier that would prevent the work and the relationship from taking hold that was tied to race.” As a variant category, therapists dealt with their own ambivalence in supervision and consultation with colleagues and supervisors that were for some African American and others European American.

Client ambivalence due to race differences. Therapists typically reported client ambivalence that was due to race differences in the dyad. This ambivalence was characterized by client behaviors such as missing sessions and being noncommittal (e.g., not talking or holding back). Therapists dealt with client ambivalence by understanding and supporting the client and by accepting some of this ambivalence as normal or expected, given the therapists’ race. Therapists also went beyond the prescribed role of therapist. They called clients after missed sessions and were very flexible with their weekly schedule to meet clients. Finally, they also allowed the client to collaborate on setting the pace and agenda of therapy. A sample core idea for this domain is, “[Therapist] thinks that racial differences may have played a part early on, because the client was very distrustful, kept everything inside, and verbalized little.”

Relevance of Other Differences

Psychologists mentioned other variables that were salient to clients’ identity and relevant to the treatment of the client, at times more so than race or race differences. These variables were typically attended to in a sensitive way by the therapists because recognition of these affected client trust and involvement in therapy. The therapists typically saw inclusion of issues associated with these variables (e.g., sexism, homophobia) as integral to the treatment and to establishing a working relationship. A sample core idea from this domain is,

[Therapist] thinks that the client’s racial identity is part of who she is on a day-to-day basis, which is also influenced by class (raised by a single parent and fairly poor growing up) and sexual orientation. Also, the client is a recovering addict.

As a variant category, the other variables salient to clients’ identity were the following: gender, socioeconomic status, physical disability, and sexual orientation.
Use of Supervision and Consultation

As a typical category, therapists sought supervision and consultation from supervisors and colleagues for information and help with the case. They sought medical consults and concrete community resources for their clients’ concerns. They also sought help to discuss interpersonal/racial issues they were experiencing in counseling that they thought were affecting the therapy relationship. Therapists typically found supervision helpful, calming, reassuring, and supportive. There was wide variability in the frequency of the supervision, ranging from none to “once or twice informally” to regular weekly supervision.

Factors Associated With Client Persistence in Therapy

As a general category, therapists reported that clients experienced understanding, caring, and encouragement in counseling. All therapists expressed considerable liking and admiration for their clients. As a typical category, therapists speculated that client pain and clinical symptoms maintained their clients in counseling as well as the fact that clients were beginning to experience relief and better functioning. Therapists also pointed to the therapy relationship as an important factor that maintained the clients in treatment. The relationship was trusting, safe, and comfortable, and once trust and rapport was established, clients experienced motivation to continue working.

Outcomes After 12 Sessions

All 9 therapists reported appreciable gains for their clients after 12 sessions in counseling. These improvements included symptom reduction (lifts in depression, reduced anxiety, decrease in panic attacks, and decreased drug use) and better interpersonal relations. Therapists reported an increase in insight and racial identity awareness, and a better sense of direction for their clients. As a separate general category, all therapists mentioned development and progress in their therapy relationship with these clients at this point in therapy. Therapists mentioned better rapport, increased intimacy and disclosure on the part of their clients, some risk taking with respect to clients’ disclosing aspects of their lives never before discussed (such as childhood sexual abuse), and overall improved client participation and involvement in therapy.
DISCUSSION

The following discussion is organized around the three broad questions that stimulated the study. With respect to the first general research question, the results indicate that therapists recalled using mostly core skills to establish the relationship, despite variability in their professed theoretical orientation and variability in clients’ presenting issues. The participants emphasized basic attending and listening skills in establishing rapport and engaging the client. They recalled that they used these skills effectively at the beginning to establish trust with their client. They also noted that they used these skills as they did with any other client. Reflection of feeling, restatements, open-ended questions, empathy, and other person-centered skills were used as a foundation on which to build other, theory-specific, and multicultural interventions.

All the therapists recalled setting up goals for counseling and made client comfort and trust a central goal early in therapy. To give clients a sense of control and engender trust and motivation, some participants deliberately used a nondirective approach to counseling and communicated a collaborative stance. A major component of engaging the clients in counseling involved discussing race and race differences very early in therapy. Participants recalled that addressing the issue of race differences directly, typically in the first two sessions, was an important step in creating a trusting, therapeutic relationship. However, we note that the intensity and length of these discussions varied considerably among the dyads. These discussions seemed to have the general effect of benefiting the relationship by increasing client trust and involvement in therapy, particularly with respect to discussing race-related concerns. For example, one participant noted that having conveyed openness to discussing race issues early on communicated to the client the therapist’s comfort with the topic of race and the race of the client. The client, in turn, conveyed her wish that the therapist was Black so that she could understand exactly what the client had been through. The therapist empathized with the client’s sentiment and conveyed her desire to understand the client’s experience, which led to other client disclosures and a deepening of the bond in the relationship. It is important to emphasize that the emotional bond with the therapist seemed particularly important for these clients (albeit as reported by the therapists) and that it facilitated client involvement in working through the goals and tasks of therapy.

There was also no singular pattern used by these therapists to discuss race-related issues or race differences with their clients. However, three interventions or themes are worth noting. First, therapists inquired directly with
the clients about race differences and the client’s comfort in therapy. Second, they relied on multicultural competence skills (although most participants did not use this term to classify their interventions), and third, they were open and supportive to reports of racism. As mentioned in the results section, all 9 discussed race differences with their clients early in therapy because it was “an elephant in the room” or because they were acutely aware that “race was in the room.” Therapists seemed to have simply “opened the door” to the topic, allowing and empowering the client to bring up race differences, race-related content, or racism if and when it became necessary or important. This inquiry into the issue of race and race differences with clients has been described in the literature as an essential component of establishing and maintaining rapport with clients of a different race (e.g., Helms & Cook, 1999). Beyond discussing race and race differences, however, the most emotionally charged and important issue for these therapists seemed to be their ability and willingness to attend to and respond to clients’ experiences with racism. Although reports of racism did not surface in every case, when they did an appropriate therapist stance and response seemed to generate client trust and belief in the therapist.

Therapists’ multicultural competence (Sue et al., 1992, 1998) could be summarized in part as racial-cultural self-awareness and an awareness of the clients’ disposition or ability to talk about the sensitive topic of race, particularly with a European American therapist. The participants seemed to have been sensibly guided as to the importance of race by being in tune to the clients’ level of racial identity. Therapists’ appreciation of their clients’ racial identity development has been described as important in making race and race-related issues an appropriate overt topic in counseling (e.g., Helms, 1984; Helms & Cook, 1999). It is also consistent with a self-report given by D’Andrea (1998) about his approach to discussing race with African American clients. He reported that with those clients who seemed uninterested in discussing race he did not push the topic, but with those who seemed concerned with race and race differences he supported and even encouraged this discussion. It is noted, however, that some participants mentioned race as not being their issue in counseling. The goal of discussing race differences was to establish and deepen client comfort and trust. Therapists not only attended to and supported clients with their reports of racism, but also in a few instances named certain experiences as racism for their clients and advocated for them with issues of institutional racism.

The second and third general research questions were about the difficulties that the psychologists encountered while helping the client and the special skills or interventions that they used in coping with these difficulties. As evident from the results, some therapists recalled client ambivalence that was
related to race differences. Beyond dealing with this ambivalence by discussing race and race differences with their clients as noted previously, these therapists also reported being patient and understanding of this ambivalence and seeing it as natural or expected.

Patience and understanding were important skills for these therapists. They did not label or diagnose their clients’ ambivalence as pathological resistance, as has been cautioned in the multicultural counseling literature (e.g., Ridley, Li, & Hill, 1998). The therapists were content with letting their clients work at their own pace and with clients having the need to “size up” or “test” their commitment as therapists. This seems important, given that client testing of therapist loyalty has been documented in the cross-cultural counseling research (Thompson & Jenal, 1994) even when the therapist is of the same race as the client. That said, therapists knew when to challenge the client and how to confront ambivalence or apprehension in a sensitive and empathic fashion. Beyond patience and understanding, these therapists were also quick to engage in advocacy for their clients by making calls, finding referrals and medical consults, and helping clients identify and cope with interpersonal and institutional racism. This apparent flexibility in role cannot be overemphasized and is consistent with the broader counselor role recently discussed by Atkinson, Thompson, and Grant (1993) as part of their three-dimensional model of multicultural counseling. For example, Atkinson et al. (1993) suggested that therapists can be advocates, advisers, and change agents for their clients, given clients’ problems and level of acculturation. These participants seemed to be acutely aware of “where their clients were at” and what they needed most at a particular time, and consistent with this assessment, therapists went beyond the traditional role of the therapist to help their clients.

It is also worth noting that the therapists took time early in therapy to educate or inform their clients about counseling. For example, they explained agency policies about appointments and cancellations, described their role as therapists and their approach to helping clients, and outlined other factors regarding general parameters for counseling. The process of clarifying expectations and roles and educating clients about the parameters of counseling has been discussed in the literature as important in establishing a therapy relationship with ethnic and racial minority clients (e.g., Helms & Cook, 1999).

The therapists were forthright in admitting a certain level of apprehension to seeing the client and that this apprehension was due to race differences with their clients. As noted in the results, the overriding concern for the therapists was with being able to empathize and being perceived as helpful by their clients. Therapists reported that their training in academia, professional
training workshops, and personal experiences, along with supervision and support from colleagues, helped them in handling their apprehension and being competent with their clients. Beyond technical and strategic assistance with the case, therapists sought personal and emotional support, primarily in the form of reassurance that what they were doing with their client was sensitive, appropriate, and helpful. Some therapists sought support from African American colleagues in the field to ensure that their interventions would be helpful.

It is important to note that the therapists did not develop tunnel vision by focusing exclusively on the race of the client or by overestimating its relevance to the exclusion of other factors. In fact, therapists described their clients’ interpersonal concerns as deeply intertwined with factors such as sexism, homophobia, and poverty.

At the same time, a collective reading of the transcripts and all of the counselors’ interventions indicates that race and race differences were deeply embedded in all the work and that separation between core skills and multicultural skills should probably not be made. Race, racial differences, and race-related issues such as racism, difference, and other forms of oppression permeated the work and thus the therapists had to be sensitive and “on” all the time. The reader should note that the therapists did not indicate that certain interventions were traditional and others multicultural; that distinction was made by the researchers to organize and present the data. The apparent overlap between core and theory-specific skills and multicultural interventions is such that it lends support to recent quantitative findings by Coleman (1998) and Fuertes and Brobst (in press). These researchers have found considerable overlap between clients’ and research participants’ perceptions of counselor general competence and multicultural competence. Fuertes, Bartolomeo, and Nichols (2001) recently suggested that multicultural competencies may be considered higher order skills that involve personal growth and specialized training and experience and that may only be attained after a thorough training in basic traditional counseling skills (such as listening skills, the use of empathy, open-ended questions, summary statements, etc.).

A few other general (and tentative) observations about these results are also worth noting. We cannot conclude, based on what has been observed in this study, that one theoretical approach as practiced by the participants was better or more effective than another. Whereas all the therapists emphasized basic Rogerian skills in establishing and sustaining the relationship, they reported differences in their theoretical training and approach to therapy. Nevertheless, no one approach or therapist did better than another.

This observation is consistent with the dodo bird hypothesis that has been discussed in the outcome literature (Wampold et al., 1997). An implication is
that therapists from different theoretical orientations have the potential to be effective in working with African American clients as long as they can create and nurture basic core conditions in counseling and deliver their services in a culturally competent/sensitive manner.

What also seems to come through from our analysis is that these therapists were good and skillful clinicians. By *good* we mean that they were humble and careful in handling the client; they did not push the client and often checked in with them to stay on track, clear up assumptions, or avoid misunderstandings. By *skillful* we mean that these therapists seemed to be comfortable with their approach and technique to counseling. So although theoretical orientation did not, in and of itself, seem crucial to the effective treatment of these clients, therapist caution and proficiency in his or her approach to counseling were important.

We did not find any evidence for the role of similarity factors between therapists and clients (Beutler et al., 1994; Coleman et al., 1995), albeit as reported by the therapists, on the process or outcome of counseling. In fact, therapists’ responses seemed to indicate that there were appreciable differences between their worlds and those of their clients. Although we hesitate to make much of this observation, we will note that what therapists tended to do was to be open, willing, and able to meet their clients where they were, in terms of their phenomenology and experiences. Therapists’ adaptability, or interpersonal adjustment to the experience of the client, that is, their ability to be on a par with their clients, may have served a matching function of sorts that may have been experienced as helpful or positive by their clients.

A final observation is support for the importance that has been given in outcome (Lambert & Bergin, 1994; Wampold, 2000) and process (Hill & Williams, 2000) research to the therapy relationship. These counselors worked diligently from the beginning at engaging their clients in therapy, by working on improving client comfort and trust, and by making therapy a collaborative process that was galvanized by trust and mutually agreed-upon goals.

**Limitations**

There are several limitations to the study. Its design limits the generalizability of the findings, but they may be nonetheless relevant to European American therapists who have had some training and experience in multicultural counseling and are committed to serving African American clients. The selection of therapists was not random but purposeful and convenient. We did not sample expert therapists to provide a more representative view of how therapists in the field conduct counseling with African Ameri-
can clients; thus, we caution the reader against interpreting the current results as ideal or as somehow endorsed by the researchers of the study. The results presented here may serve best in terms of their heuristic, not their clinical or training, value in that they may stimulate further conceptual and empirical research on this topic. We also acknowledge that we limited the scope of inquiry and discovery by the very questions that we asked and the parameters we set for the study (e.g., the focus on the first 12 sessions). Thus, we likely missed important data about the experiences of these therapists and their clients. It is also important to note that the results presented here were the recollections of the therapists and their recall may have been affected by factors such as the passage of time. However, to counteract this effect we asked them specifically to choose a case that they recalled vividly and for which they had progress notes.

Social desirability responding is also a potential limitation, but to counteract this effect we assured the respondents of complete confidentiality and asked them to be as candid as possible in their responses. Last, although we attempted to be aware and account for our personal biases, it is possible that our worldviews and biases crept into the analyses and interpretation of the data generated.

Future Research

Future research may focus on clients’ reports of their experience in counseling. The clients’ voice and experience seems very important to the counseling enterprise and should be included in the empirical research. Interviews with African American clients, as well as clients from various ethnic and racial backgrounds, may yield important observations that would inform multicultural counseling. Future research may examine the factors that lead to unsuccessful multicultural cases, for example, those characterized by client premature termination or a failure to meet treatment goals. Insights as to why minority clients terminate prematurely from counseling are sorely needed in the multicultural counseling literature. Future researchers might also conduct more intense, in-depth analyses of a single cross-cultural dyad. An examination of the progression of counseling by one dyad over 12 to 15 sessions may yield useful and informative data that addresses temporal, sequential, and interaction factors in the process and outcome of counseling. These data may yield a deeper appreciation of how counselor interventions are perceived and experienced by clients and provide insight into how the therapy relationship develops or unfolds in cross-cultural counseling.

It may also be interesting to examine the role of the real relationship (Gelso & Hayes, 1998) in multicultural counseling. The real relationship has been hypothesized to include positive and negative feelings and thoughts that
are genuine and based on realistic perceptions between counselor and client, beyond the purposive and contractual nature of the working alliance. The type of I-thou interaction that characterizes the real relationship (Gelso & Hayes, 1988), where the person in the client and the therapist are acknowledged and the roles of client and therapist seep momentarily to the background, appears important and may even be necessary for cross-cultural counseling to be effective.

It may also be important to examine the process by which therapists integrate culturally sensitive interventions with their more traditional training and technique. Research may examine how therapists who have been trained, for example, in psychodynamic psychotherapy are able to integrate into their practice elements of diversity and culturalism. Finally, it may also be fruitful to examine therapist interpersonal adjustment to the client. This research could examine, for example, how therapists adapt to the unique interpersonal styles of some of their clients, including belief systems and worldviews that are different from or foreign to the therapist.

**APPENDIX**

Sample Interview Questions

**Category 1: Counselor’s Theory, Level of Racial Awareness, Self-Appraisal of Knowledge and Skills**

How would you describe your own racial background?
How do you understand your race in relation to others’? (Define your race; what is its relation to others’.)
How skilled or competent do you consider yourself to work with African American clients?
What specific skills and knowledge do you find indispensable to work with African American clients?

**Category 2: Client’s Racial Id Development and Its Influence on Therapy**

How would you describe this client’s own understanding of his or her race?
How do you think he or she feels about being Black?

**Category 3: Interventions Used at the Beginning of Therapy**

How did you engage the client?
What helped you to engage the client in therapy?
Given racial differences, how did you establish a relationship with the client? What were some ways you established the relationship? How did you handle the differences in race between the two of you? Did racial differences become a part of therapy? Did the clients’ level of racial identity become an important issue in therapy?

**Category 4: Interventions Used Past the Beginning of Therapy Through 12 Sessions**

What would you say kept the client in therapy for that time period? Given racial differences, what helped maintain your relationship with the client during this time period? Given racial differences, why do you think the client found therapy worthwhile? Helpful? Describe difficulties that you had in maintaining the client in therapy during this time period. Were these related to racial differences between the two of you? What were some of the threats to the continuation or smooth flow of therapy? Were these based on racial differences? How did you deal with this?

**Category 5: Use of Supervision and Consultation**

Did you seek supervision or consultation during this time period? If yes, with whom? What was helpful and unhelpful?

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**REFERENCES**


