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Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy

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Abstract

A phenomenological/consensual qualitative study of clients' lived experiences of cross-racial therapy was conducted to enhance our understanding of whether, how, and under what conditions race matters in the therapy relationship. The sample consisted of 16 racial/ethnic minority clients who received treatment from 16 White, European American therapists across a range of treatment settings. Participants who reported a satisfying experience of cross-racial therapy (*n*=8) were examined in relation to gender- and in most cases, race/ethnicity-matched controls (*n*=8) who reported an overall unsatisfying experience. Therapy satisfaction was assessed during the screening process and confirmed during the research interview. Therapy narratives were analyzed using consensual qualitative research to identify the client, therapist, and relational factors that distinguished satisfied from unsatisfied cases. Findings reveal substantial differences at the level of individual characteristics and relational processes, providing evidence of both universal (etic) as well as culture/context-specific (emic) aspects of healing relationships. Recommendations for facilitating positive alliance formation in cross-racial therapy are provided based on clients' descriptions of facilitative conditions in the therapy relationship.

Keywords

Racial/ethnic matching; psychotherapy; therapeutic alliance; phenomenology

With the quickening pace of population growth among racial and ethnic minorities in North America, interracial encounters in the therapy context are becoming increasingly common. A 2007 survey of 20,046 American Psychological Association (APA) members indicated that 86% of respondents already provide services to racial and ethnic minority clients (APA Research Office, 2003). However, the bulk of these services continue to be provided by White, European American therapists despite efforts to diversify the mental health workforce. While there are a number of visible markers of difference (e.g., gender, social class, age), race and ethnicity have been identified as particularly salient for both therapists and clients (Comas-Diaz & Jacobsen, 1991). As a result, multicultural counseling competence guidelines have highlighted the importance of attending to racial and ethnic issues in particular as they impact the therapy relationship (Sue, Arredondo, & McDavis, 1992).

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Although there are numerous positive aspects of increasing interracial contact, such interactions are frequently experienced as stressful by both majority and minority individuals, and have been empirically linked to a number of negative cognitive, psychological, physiological and interpersonal outcomes (Clark, Anderson, Clark, & Williams, 1999; Dovidio, Gaertner, Kawakami, & Hodson, 2002). As noted by Richeson and Shelton (2007), the specific stressors associated with interracial contact vary across groups such that "White participants … are often concerned about appearing prejudiced, whereas racial minorities are often concerned about being the target of prejudice and/or about confirming negative group stereotypes" (p. 317).

In the counseling context, researchers have described the particular discomfort that many White, European American counselors experience when dealing with racial differences compared to other sociodemographic differences with their clients (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Utsey, Gernat, & Hammar, 2005). The present study, a qualitative exploration of clients' experiences of cross-racial therapy, focuses attention on the psychological and social significance of race while acknowledging the lack of consensus surrounding the construct in psychological research (Cokley, 2007; Helms, Jernigan, & Mascher, 2005). We share the view that racial categories are sociopolitical constructions rather than biological fact (Smedley & Smedley, 2005), and therefore cannot be studied as psychological constructs in themselves (Helms et al., 2005). Nevertheless, one's ascribed race does influence one's socialization as a member of a dominant or oppressed group as well as the types of life experiences to which one is exposed (Helms, 2007). As such, the psychological significance of race is linked to its interpersonal significance, e.g., how it shapes *others'* perceptions, affective reactions, and behaviors towards the racialized self and vice versa within a given social context. Along these lines, we choose to emphasize the term *race* rather than ethnicity to reflect our interest in the former as a highly charged and frequently *visible* aspect of therapist-client differences that requires psychological processing and interpersonal negotiation. At the same time, we recognize that individuals' internal representations and experiences of race may overlap with constructions of ethnicity and culture, blurring the already fuzzy boundaries between terms. In an effort to distinguish between ascribed racial differences and their subjective psychological and interpersonal meanings, we apply the terms "*race"* to denote the former, and "race/ethnicity" or "race/ethnicity/culture" (REC) to denote the latter. Cross and Cross (2008) likewise adopted the abbreviation REC to indicate that "the discourses on racial, ethnic, and cultural identity overlap at the level of the *lived experience* to the point that there is little reason to associate each construct with a distinct identity constellation" (p. 156). Terminology aside, as the literature on mismatches between therapist and client has expanded, it is clear that we must move beyond treating race as a grouping variable and unpack the various subjective meanings that subtend racial and interracial experience.

Despite studies implying the significance of therapist and client race in the therapeutic relationship (Coleman, Wampold, & Casali, 1995; Wintersteen, Mensinger, & Diamond, 2005), the literature on racial/ethnic matching does not suggest a strong relationship to clinical outcomes. On the one hand, several studies suggest that clients seeing a therapist of dissimilar race or ethnicity are more likely to drop out of treatment and to attend a fewer number of sessions compared to clients whose therapists share their racial/ethnic background (e.g., Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Wintersteen et al., 2005). However, meta-analytic studies indicate that the effect sizes associated with matching are small (Maramba & Hall, 2002; Shin et al., 2005), and matching is not associated with symptom improvements (Erdur, Rude, & Baron, 2003; Sue et al., 1991). These findings confirm that matching by itself is neither a necessary nor sufficient condition for therapeutic effectiveness, nor is mismatching inherently problematic. In fact, studies suggest that other individual and process factors such as racial or ethnic identity, cultural values, cultural

mistrust, therapist cultural competence, and worldview match are more proximally related to treatment outcomes and may moderate the impact of racial differences (Helms & Cook, 1999; Zane et al, 2005).

Although this literature has been helpful in suggesting that there are numerous intersubjective meanings and processes attached to race in the context of counseling, the bulk of this work has grown out of investigators' a priori assumptions about the significance and meaning of race in individuals' lives. Few studies have examined clients' subjective experiences and perceptions regarding the impact of racial difference on the therapy relationship. This is particularly problematic given that research indicates that it is the client's evaluation of the therapy relationship, not the counselor's view, that is most strongly associated with therapy outcome (Horvath & Bedi, 2002). That research has shown that therapists are not fully aware of client reactions, particularly negative reactions (Hill, Thompson, Cogar, & Denman, 1993) is further indication that much may be unknown about how clients experience and negotiate interracial interactions in therapy. Indeed, clients and therapists frequently differ in their views of how the therapy is progressing (Hannan et al., 2005). Although such misattunements may become less frequent over time (Horvath & Bedi, 2002), differences in therapist and client understandings of therapy events may lead to ruptures in the relationship, particularly in the beginning stage of treatment (Keenan, Tsang, Bogo, & George, 2005).

The present study draws on recent trends in process and outcome research that emphasize the role of client perceptions and contributions to positive outcomes (Tallman & Bohart, 1999). To identify the conditions under which racial differences may affect counseling satisfaction, we conducted a phenomenological/consensual qualitative research study of racial/ethnic minority clients' experiences of cross-racial therapy. Below, we provide a brief review of the literature on the impact of racial differences on the therapy relationship as it informed the design of our study.

The Therapeutic Relationship in Cross-Racial Therapy Dyads

Psychotherapy research involving racial and ethnic minority clients has tended to focus on therapist characteristics such as racial attitudes (Ridley, 2005), multicultural counseling competence (Fuertes et al., 2006), and behaviors such as counseling style (Li & Kim, 2004) that are thought to influence the therapeutic relationship. Although the field continues to struggle towards operationalizing multicultural counseling competence and its component parts (Sue, Zane, Hall, & Berger, 2009), some research suggests that counselors' multicultural counseling competence is critical for effectively working with clients of color, accounting for a significant proportion of the variance in clients' satisfaction beyond ratings of general therapist competence, attractiveness, expertness, and trustworthiness (Constantine, 2002; Fuertes & Brobst, 2002). Conversely, perceptions of therapist cultural insensitivity and racial prejudice have been found to adversely affect minority clients' experiences of therapy. For instance, recent work applying the concept of racial microaggressions to the therapy context has demonstrated the ways in which counselors may unconsciously or unintentionally communicate denigrating messages to minority clients. Examples include minimizing the importance of racial-cultural issues to a client of color, pathologizing cultural values or communication style, or conversely, normalizing potentially dysfunctional behaviors on the basis of an individual's racial or cultural group (Sue, Bucceri, Lin, Nadal, & Torino, 2007). In a study of African American clients' perceptions of their White counselors, Constantine (2007) found that these expressions of more covert and frequently subconscious racist attitudes were predictive of a weaker therapeutic alliance, lower ratings of general and multicultural counseling competence, and lower levels of counseling satisfaction.

Compared to therapist factors, studies of client factors and their relationship to multicultural counseling process and outcome are relatively rare. Although analogue studies of cross-cultural counseling scenarios suggest the importance of client factors such as racial identity and cultural values in predicting help-seeking preferences and counseling process (e.g., Atkinson & Lowe, 1995; Kim, Ng, & Ahn, 2005), few studies have examined how clients' attitudes, perceptions, and experiences relate to therapy process and outcome in actual multicultural counseling relationships. The result is a knowledge base that is somewhat constrained by investigators' understandings of the factors that may affect minorities' experiences of therapy.

A recent study by Sanders Thompson and Alexander (2006) illustrates the limitations of relying upon investigator-developed measures of therapy process, even in the context of investigating actual therapy encounters. The authors examined 44 African American clients' perceptions and experiences following random assignment to either interpersonal or problem-solving therapy provided by either a European American or African American therapist. Clients assigned to European American therapists were also randomly assigned to one of two conditions regarding how racial differences would be handled during the first session. Results indicated that clients' understanding and acceptance of the treatment approach and perceptions of therapeutic benefit was higher when assigned to an African American therapist. Contrary to expectation, European American therapists' discussions of race in the initial session had no effect on therapy ratings. The authors concluded that, "It is conceivable that race, because of its influence as a social category, affected how clients and therapists interacted in therapy and the subsequent ratings of understanding and acceptance of therapeutic goals and interventions" (p. 107). However, in the absence of qualitative information about participants' experiences of therapy, the authors were unable to ascertain the ways in which race may or may not have played a role in clients' final assessments. Moreover, they were unable to explain why European American therapists' discussions of race had no effect on participants' therapy ratings.

In recent years, qualitative approaches have gained popularity as a method for capturing the subjectivity inherent in assessing therapy according to individuals' working models of successful counseling relationships (Levitt, Butler, & Hill, 2006). For example, Bedi (2006) interviewed 40 clients about the specific behaviors considered helpful in the development of the therapeutic alliance. In general however, the use of racially homogeneous client samples and the absence of data regarding therapist race within this literature make it difficult to evaluate the extent to which findings may generalize to cross-racial or cross-cultural counseling situations.

In our review of the literature, we identified only one study of minority clients' subjective experiences of cross-racial or cross-cultural counseling. Pope-Davis and colleagues (2002) investigated clients' conceptualizations of multicultural competency using grounded theory. Ten students who had been in counseling with a counselor who was "culturally different than themselves" were interviewed about their counseling experience, focusing on cultural issues as they affected the working relationship and how cultural concerns were addressed. The resulting theoretical framework provides a rich description of how clients actively conceptualized cultural competence and managed cultural differences in the counseling relationship.

One important consideration however is the transferability of their model, given the unique characteristics of the sample: predominantly young women engaged in university studies and all but one reporting that cultural issues were moderately to very important in their sessions (Pope-Davis et al., 2002). The investigators also directed individuals early on in the interview to explicitly consider such issues as "cultural differences and similarities" with

their therapist and "cultural concerns brought up in counseling". These instructions provided a conceptually focused but restrictive lens through which clients were asked to evaluate their experience of counseling. Although clients' view of cultural competency was the focus of the study, the interview format may have biased clients towards emphasizing cultural issues in the therapy rather than allowing them to describe whatever elements were salient in their own experience.

The Present Study

This study highlights the client's perspective to enhance our understanding of whether, how, and under what conditions race matters in the therapy relationship. Our goal was to identify the therapeutic and extra-therapeutic elements that distinguished client accounts of satisfying and unsatisfying experiences of cross-racial therapy. Findings are used to clarify how REC differences influence the therapeutic relationship and the etic and emic conditions deemed necessary for positive alliance formation.

Methods

The qualitative approach to the study was informed by phenomenology and consensual qualitative research (CQR; Hill, Thompson, & Williams, 1997). Phenomenology was selected as an orienting framework in an effort to obtain a window into clients' experiences of cross-racial therapy relationships, distinct from preconceived notions regarding the social significance of race and assumptions regarding how racial differences would be constructed and enacted in the therapeutic relationship. Consistent with traditional phenomenological approaches (Giorgi, 1997), we consciously sought to "bracket" previous disciplinary theories and assumptions regarding the importance and impact of racial difference in cross-racial therapy dyads (Wertz, 2005), though we acknowledge that they may have inadvertently influenced the research process (see *Author Biases* below). Whereas phenomenology informed our approach to data collection, CQR was adopted as our data analytic strategy. CQR provides a systematic method for assessing the representativeness of key themes across cases, which was useful for comparing results across clients who had a satisfying versus unsatisfying experience of cross-racial therapy.

Sample and Recruitment Procedures

A stratified matched pairs design was used to isolate the factors that predicted racial/ethnic minorities' satisfaction with cross-racial therapy. Satisfied participants were examined in relation to gender- matched (and in most cases, race/ethnicity-matched) controls who reported an overall unsatisfying experience. A diverse sample of sixteen participants (8 women, 8 men) was selected from a larger pool of 33 to create the matched pairs (see Table 1). Satisfaction ratings were dichotomously coded as either generally satisfied or generally unsatisfied based on participants' self-designation during the screening and research interviews.

Participants were recruited across New York City via multilingual advertisements (in English, Chinese, Japanese, Korean, and Spanish) posted on electronic and community bulletin boards and local newspapers. Initial screenings were conducted by phone or email. Eligibility criteria included a self-reported racial mismatch and treatment termination within the prior 12 months. Exclusion criteria included a positive screen for psychotic symptoms or other acute symptoms that would compromise their ability to provide informed consent. Individuals who reported current involvement in psychotherapy were also excluded from participation.

The broad recruitment effort yielded a demographically diverse sample of participants, which is reflected in the demographic diversity of the 16 participants analyzed for this study. For this sample, ages ranged from 19 to 50, with a mean of 33.5 (*SD*=8.8). Highest educational level was mixed, with 5 participants possessing advanced degrees and 2 an undergraduate degree, 6 who completed some college and 3 who completed high school only. Five (32%) participants were born outside of the United States. Sexual orientation was not systematically assessed across the entire sample, although six (38%) participants self-identified as lesbian, gay, transgender, bisexual, or queer in the interview. All participants saw non-Hispanic White therapists, and 12 of the 16 therapists seen were female. Length of treatment ranged from 6 weeks to 6 years. Seven participants remained in therapy for one year or more, 7 for 6 months to a year, and 2 were treated for less than 6 months.

The most common presenting problems (not mutually exclusive) were “Loneliness/Isolating myself from other people” (9), “Mood swings or depression” (9), “Career/work-related stress” (9), “Family conflicts” (8), and “Feeling anxious for either known or unknown reasons” (5). Seven participants (44%) discussed their presenting problems in the context of racial or cultural issues. For example, two of the Asian clients described feeling resentment towards their families because they believed that childhood traumas they had suffered were exacerbated by cultural norms around gender and family roles. Several participants perceived discrimination from superiors and peers in school and in the workplace, which precipitated their distress and anxiety. Two immigrant clients also reported varying degrees of acculturative stress and experiences of prejudice and discrimination.

The majority of participants (9) saw therapists in a private practice setting, while (7) were treated in a clinic or hospital. There were no marked differences between clients who were satisfied versus dissatisfied with treatment with regard to age, treatment setting, duration of treatment, or presenting problem. The only characteristic that varied between groups was educational level: everyone in the unsatisfied group had attended at least some college, whereas three of the participants in the satisfied group had graduated from high school only.

Procedures

Interviewers were matched to subjects on race/ethnicity, gender, and language preference, although all 16 of the interviews presented here were conducted in English. There were 11 interviewers in our diverse pool of interview staff, all of whom conducted at least one interview. Multiracial subjects were invited to specify the interviewer race/ethnicity with which they felt most comfortable, as the possibility of assigning and interviewer based on an exact racial/ethnic match was not possible. The interviewers consisted primarily of M.A. and Ph.D.-level students in counseling or clinical psychology. All interviewers received 6 hours of training that included discussion of articles on phenomenology and interviewing and role plays of the interview protocol. Regular supervision and feedback based on reviews of audiotapes of the interviews was provided by the first author.

The semi-structured face-to-face interview lasted between 1 to 3 hours. All interviews were conducted in lab offices on campus. Before the interview began, informed consent was obtained and participants were asked to provide basic demographic information and to complete a checklist of problems that prompted them to seek therapy when they did. Consistent with phenomenological approaches (Giorgi, 1997), the interview began with a “grand-tour” question in which participants were invited to tell the story of their therapy without explicitly directing them to discuss the implications of racial difference: “Please describe for me your experience of therapy, starting from the very beginning and taking me through that experience until the very end.” This open-ended question elicited a naturally unfolding description of participants’ experience and allowed us to observe the salience of racial difference in their initial constructions of the therapy story. To control for individual

differences in story-telling style and depth and breadth of their subjective accounts, we followed the initial "grand tour" question with a semi-structured interview that explored key time points in the chronology of the relationship (e.g., initial session, early phase, termination phase), perceptions of therapist characteristics, the therapeutic relationship, and specific behaviors and interventions considered to be helpful or unhelpful. The list of standard questions asked of each participant is presented in Table 2.

Only at this point in the interview did we explicitly introduce race into the discussion through a series of questions regarding participants' racial, ethnic, and cultural identity attitudes and perceptions regarding the significance and effect that racial differences had on their therapy experience. Questions assessing the effects of race on the therapy relationship explored both the perceived advantages and disadvantages of mismatching. Lastly, clients were asked to draw upon their own experiences to provide recommendations for therapists working with racially different clients. At the end of the interview, subjects were paid $30 for their participation and asked whether they would be willing to be contacted one week later for a brief follow-up conversation "to see if you have any additional thoughts you'd like to share." Interest in participating in a member-checking meeting at the conclusion of the study was also assessed at this time. Thirteen of the 16 participants consented to be contacted one week later to process their reactions to the interview and to clarify any responses that were unclear. However, eight of the 13 were unable to be reached despite repeated attempts. Following each contact, interviewers completed field notes which included behavioral observations, salient themes, and process notes. Each interview was digitally audiotaped and transcribed. Identifying information was removed and identification numbers were substituted for participant names. For confidentiality purposes, all participant names referenced below are pseudonyms.

Analysis

Interview data were analyzed using CQR (Hill et al., 1997). CQR emphasizes consensus-building across multiple researchers as a crucial component of the research process. To enhance the validity of our interpretations and minimize group-think, we convened a diverse coding team of 5 judges plus an additional 1–2 rotating judges who participated in coding groups composed of 2 to 3 judges each. All judges were graduate students in psychology and four also served as interviewers. The self-described identities of the judges were as follows: "White Latina," "gay White male," "Hispanic female," "mixed Vietnamese-Caucasian queer female,", "Japanese female," "Korean-American female," "adopted Korean female," "mixed-race woman of Asian, White, and Jewish descent," "Hispanic female," "African," and "Jewish American woman." The principal investigator, a Chinese-American female, served as the primary auditor. As recommended by Hill et al. (1997), before initiating the coding process, each judge recorded their expectations about the study based upon their experiences and beliefs regarding the subject matter. The essays were discussed as a group to facilitate communication and reduce hidden biases pertaining to race, ethnicity, and culture and the therapy relationship.

Author biases—Doris F. Chang is a licensed clinical psychologist and an assistant professor of clinical psychology. A second generation Chinese-American, she grew up in a predominantly White neighborhood in Texas that encouraged assimilation. Since leaving Texas in 1994, she has lived and worked in a number of multicultural environments including cities in China and Taiwan, and now considers herself to be bicultural. Given her own comfort navigating culturally and racially diverse social environments as well as her therapeutic work with clients of diverse backgrounds, she expected that the effects of race on the therapeutic relationship would vary according to clients' own racial/cultural attitudes and communication skills as well as the therapist's own comfort addressing racial

differences. Alexandra Berk is a doctoral candidate in cognitive, social, and developmental psychology. In this study, she served as judge and project manager. Descended from Eastern European Jews, she always maintained an interest in the psychology of oppression and prejudice. While she grew up in a predominantly White suburb of Boston, her experiences and academic interests in race, culture, and mental health have raised her awareness of the unintentional racism that even well-meaning White service providers can exhibit towards minorities. She expected that White therapists would not display overtly racist behavior towards their minority clients; however, they may inadvertently marginalize them by endorsing stereotypes or trying too hard to minimize the differences between them.

While we worked to bracket and examine our biases during all phases the study, we acknowledge that our expectations may have unconsciously influenced our understanding and interpretation of the data presented here. Coding of the data proceeded in four stages:

Domain coding—The domain coding process originated with a set of domains designated as a "start list" (Miles & Huberman, 1994) to aid in the efficient development of a codebook. The initial set of domains, compiled based on a review of the literature and the interview protocol, was later refined through an iterative process consisting of open coding one transcript at a time and expanding, eliminating, or combining domains as required to fit the data (Hill et al., 1997). The codebook was finalized after coding five cases, as subsequent cases fit the emergent structure well. Teams of at least two members independently coded each transcript, discussed their results until consensus was obtained, and then submitted their consensus version of the results to the auditor. After final consensus was achieved, the qualitative analysis software Atlas.ti (Muhr, 2004) was used to organize the interview text into these central domains.

Writing core ideas—In the second stage of analysis, "core ideas" or a descriptive summary of key themes were written for all of the text captured within each domain for each individual case and argued to consensus. The auditor reviewed the core ideas for each domain, provided feedback, and the original coding teams developed a final consensus version for each case.

Cross-Analysis—In the final stage, core ideas for each domain were analyzed across cases. Coding teams brainstormed how these core ideas converged into categories, adding an explicit interpretive layer to the thematic description that had preceded this stage (Hill et al., 1997). The cross analysis was reviewed by the auditor with comments discussed by the team to arrive at a final consensus version of the results. The number of cases that fit within each emerging category was tabulated as a means of describing the representativeness of these categories across our two comparison groups (satisfied versus unsatisfied). Following Hill et al. (1997), categories were labeled *general* if they applied to all eight cases within a group, *typical* if they applied to at least half but not all of the cases (4–7), and *variant* if they applied to less than half but at least two cases. Narratives of the satisfied and unsatisfied groups were systematically compared; only those categories that differed in frequency class (e.g., typical versus variant) are reported below.

Validity Checks—The cross-analysis was initially conducted with 12 cases to arrive at the final categories and their frequencies across groups. To assess whether theoretical saturation had been achieved (Strauss, 1987), we then incorporated an additional four cases into the cross-analysis and confirmed that our final list of categories could account for all of the data collected. The re-analysis also confirmed the original pattern of results, providing evidence of redundancy of data, e.g., that the results were stable and unlikely to change even with the inclusion of additional cases (Lincoln & Guba, 1985). Finally, the trustworthiness or credibility of the results was assessed via member checking (Lincoln & Guba, 1985).

Consenting subjects were invited to a presentation and discussion of the study findings. Five participants attended the meeting and provided feedback that supported our emerging model. Individuals who were unable to attend were sent a copy of the results and were invited to provide feedback by email, although none did.

Results

Description of Comparison Groups

To clarify the meaning of clients' global satisfaction ratings, summative statements regarding their therapy experiences were analyzed. Participants who described themselves as predominantly satisfied with therapy frequently reported that a) their expectations and goals for the therapy were met (General), b) they felt emotionally attached or connected to their therapist (Typical), c) they felt satisfied with their termination experience (Typical), and d) they were interested in maintaining contact with their therapist and/or resuming treatment at a later date (Typical). For example, Ane, a Latina participant who developed a close attachment to her Anglo male therapist, summed up her final session as follows, "It was important to me to see especially by the end of the therapy that he was very moved…I did feel that there was all this respect and connection between us and that is very meaningful to me because coming from a Latin culture, the emotional connection is the greatest, most important thing."

In contrast, clients who described themselves as predominantly unsatisfied tended to report that a) they felt misunderstood or disconnected from the therapist (General), b) the therapy was not beneficial or "a waste of time" (Typical), c) the therapist was unable to fulfill their needs or expectations (Typical), d) the therapist did not seem engaged or invested in the relationship (Typical), and e) the relationship degenerated over time (Typical). For example, Wei, an Asian client who saw a White Russian therapist described feeling as though she was "pushing" him towards pharmacologic treatments for his depression rather than engaging him in a therapeutic interaction. He summed up his disappointment as follows, "It really didn't feel like she was trying to serve me or help me. It was that I was there to serve her so that she can write out something to the insurance company and get money from it. If you're a patient and you come in wanting to engage and it doesn't happen…you are just left kind of high and dry."

Clients' polarized descriptions of their experiences of therapy support their self-classification into the two groups (satisfied and unsatisfied). Emergent categories suggest convergence with theoretical descriptions of the working alliance, with clients basing their overall evaluations of the therapy on the quality of the bond between parties and their ability to work collaboratively to address the client's treatment goals and expectations (Gelso & Mohr, 2001). Thematic categories that differed in frequency between the satisfied and unsatisfied groups were organized into therapist factors, client factors, and relationship factors (see Table 3).

Therapist Factors

Differences in how satisfied and unsatisfied participants described their therapists were organized into two major areas, therapist techniques and therapist personality characteristics. Note that these categories emerged spontaneously in participants' narrative descriptions or in response to general probes about helpful and unhelpful aspects of the therapy.

Therapy Techniques

Active vs. passive style: Compared to satisfied clients, more than twice as many unsatisfied clients described their therapists as passive or not "proactive" enough (5 vs. 2). Specific

complaints included the lack of feedback, progress reports, or deep questioning regarding the client's experience. Conversely, indications that the therapist had an active or directive style were more frequent in satisfied clients. Active style was conceptualized as composed of three subcategories, all of which were more common in satisfied participants: a) offering concrete advice, suggestions, and skill development, b) asking thought-provoking questions and challenging the client's thinking, and c) providing psycho-education. Overall, strategies such as providing direct answers and offering concrete tips, advice, and mentoring were valued by two-thirds of the clients.

Cultural competence: Although participants did not explicitly use the term "cultural competence," a number specifically addressed their therapists' capacity to work with racially or culturally different clients. Half of the total sample (8 of 16) criticized their therapists for a) providing interventions that were too "textbook" and not tailored to the client's specific life contexts and history, and b) their lack of sufficient group-specific knowledge and experience. The majority of individuals from the unsatisfied group lamented their therapists' lack of group-specific skills and knowledge compared to a minority of the satisfied cases. Culture-specific knowledge mentioned by participants as conspicuously absent from their therapists' knowledge base included issues related to being a sexual minority, racism and discrimination, oppression related to multiple minority statuses, stigma related to psychological problems and help-seeking, racial/cultural and multiracial/multicultural identity development, communication style differences, and family cultural dynamics. For example, Regina, a mixed-race (Asian/White) participant felt that her therapist had "this kind of book-learned…image of some kind of immigrant family, instead of…an emotional understanding of what it's like to be, like Asian in [specific small city, in the intermountain West]". Joel, a Black gay man, initially had high expectations for his Jewish therapist, but observed that "barriers started to come into place" after a few months of working together:

> I guess her being a Jewish woman and my being a Black man made it a little difficult because sometimes growing up in an African-American community where my grandfather was a minister, you're expected to act a certain way…and she didn't have first-hand knowledge of that community. She only had secondhand knowledge which she read, or what I told her or what she heard. It was difficult for her to truly understand what I was talking about and the true level of value that I thought that it deserved. A lot of times I thought that she would minimize some of the things that I was saying, but to me they were tantamount, they were just large (laughs). And (hesitates) the last thing I wanted to hear was that "I know a friend," or "I have a friend who is Black". That I didn't want to hear in therapy and that is what I heard.

Three quarters of the unsatisfied clients (6/8) described instances in which the therapist displayed a lack of awareness of the dynamics of power and privilege in clients' lives and in the therapeutic context. In contrast, none of the satisfied cases described this lack of awareness on the part of their therapists. Several of the unsatisfied clients relayed instances in which their therapists minimized their experiences of discrimination or oppression. For example, an Asian immigrant participant told her therapist about participating in a heated debate on white privilege in a college class, which created tension between her and her classmates. Her White therapist responded by suggesting that her "preoccupation" with race was a just a "phase" she was going through. Other participants described feeling as though their therapists held racial/ethnic stereotypes or biases, which led to feelings of mistrust and undermined the therapist's credibility.

Self-disclosure: Therapist self-disclosure was another discriminating feature associated with treatment satisfaction. Even though we adopted an inclusive definition of therapist self-

disclosure for coding purposes, the majority of self-disclosures described involved the sharing of personal factual information versus self-involving or process-related disclosures (McCarthy & Betz, 1978). Approximately half of the self-disclosure examples concerned REC issues (e.g., therapist REC identity, experiences of discrimination or oppression) while the other half involved disclosures of personal history (e.g., marital/parental status, places lived or visited, personal experiences of similar problems). Seven out of 8 satisfied cases reported the use of therapist self-disclosure compared to only two out of the 8 unsatisfied cases. The only satisfied case that did not experience therapist self-disclosure indicated that he would have liked his therapist to share more. Further, out of the 7 satisfied cases that reported therapist self disclosure, all but one reported that the therapist's self-disclosure enhanced the relationship. Kareem, a Black male described the profound influence that his White therapist's self-disclosures about her family life had in making him feel respected and equal in the relationship:

> We were going back and forth. We were having a conversation like people do. … You had to have been there that moment 'cause you're looking at this lady, she's comfortable talking to you, she doesn't feel threatened, she doesn't feel intimidated or scared or anything, and (bangs hand on chair) as I would share my experiences with her, and she's talking to me like it's no big deal.

Both of the unsatisfied participants who reported therapist self-disclosure found the self-disclosure to have a negative effect on their therapy experience. One gay, politically liberal, Black Latino male participant reported that his White therapist's disclosures revealed that he was married, relatively wealthy, and politically conservative, which only emphasized the cultural and social distance between them. The other unsatisfied participant reported that his therapist's self-disclosures were not helpful because they did not have the sort of close relationship required. He notes, "Maybe she thought we were at a different level in the therapy where she thought she could do that. I just didn't like that." Of the 6 participants with negative experiences whose therapists did not engage in self-disclosure, two stated that they wished that their therapists had disclosed more. One of these participants was a Chinese-American immigrant who was hoping to share an "immigrant connection" with her German-American immigrant therapist; however the therapist resisted her attempts to draw upon this commonality.

Professionalism/ethics: Half of the sample discussed instances in which their therapists engaged in what participants' described as "unprofessional" or unethical behavior. These instances were more often described by unsatisfied participants than satisfied participants (5/8 versus 3/8, respectively). Examples included coming to sessions late or canceling sessions altogether, answering the phone or doing paperwork during the session, or violating confidentiality. Such behaviors made the client feel disrespected and led to perceptions of the therapist as poorly trained and uncaring. At the other extreme, a few participants criticized therapists who were "too professional," meaning that they focused on maintaining a professional distance at the expense of relating in a personable way.

Personal Characteristics

Attentive vs. disengaged: Attentiveness, or lack thereof, was mentioned by the majority of participants, suggesting that this is an essential trait for the therapeutic relationship. Overall, half of the participants (8/16) participants described their therapists as attentive, caring, and sensitive. Seventy-five percent of the participants who expressed this view were from the satisfied group, whereas only 25% were from the unsatisfied group. Therapists with these traits facilitated clients' feelings of comfort, trust, and emotional connection. In contrast, half of the participants in the study complained about a lack of attentiveness or engagement from their therapist.

Accepting vs. critical: Twice as many unsatisfied clients (4/8) described their therapist as critical, invalidating, or dismissive of their concerns as compared with their satisfied counterparts (2/8). These experiences ranged from subtle expressions of disapproval involving nonverbal gestures ("I felt that she was just telling me with her eyes to get over it") to simply the absence of validation, to explicit criticism on the part of the therapist ("I felt like she was always challenging me, but in an argumentative fashion"). Conversely, twice as many satisfied participants (4/8) described their therapist as nonjudgmental and validating compared to unsatisfied participants (2/8). These clients noted that their therapists were "accepting" and "affirming" and normalized their concerns. One participant described this experience in the following way: "[the therapist] gave me… a ticket, like a pass, like a right to feel a certain way."

Client Factors

Perceptions of the Salience and Meaning of Racial Difference—Perceptions of the salience and meaning of racial differences differed across the satisfied and unsatisfied groups. Salience was assessed using two sources of data, namely a) the point at which the issue of race emerged in participants' narratives, and b) explicit statements regarding the impact of racial differences on their relationship. In the first instance, we assigned each participant a level of race salience based on a 4-category scale, with "high race salience" defined as early and spontaneous emergence of racial themes in the therapy story. Participants who discussed race only in response to explicit interviewer-posed questions regarding the impact of race on the counseling relationship were viewed as "low in race salience." Notably, the majority of participants (13 out of 16) were classified as high in race salience as evidenced by unprompted discussion of racial themes in the therapy relationship. Of the 13 participants, 8 were in the unsatisfied group while 5 were in the satisfied group, suggesting that racial differences were salient for the majority of the sample, regardless of overall treatment satisfaction.

However, there was a qualitative difference in the meaning attached to racial dissimilarity across groups. All of the satisfied clients praised their therapists for their professionalism and expertness, emphasizing general therapeutic competence and skills rather than cultural competence per se. For example, clients described their therapists as compassionate, nonjudgmental, empathic, attentive, and skilled in communication and rapport-building. These therapist traits were seen as transcending any barriers that may have arisen as a result of racial differences, as evidenced by statements emphasizing the universal aspects of human experience (e.g., "we all have the same needs") and healing (e.g., "the same good advice should work for anybody"). As Ane said of her White therapist, "Whatever was inside him, it was good and that transcends a lot of things." These sentiments were not expressed by any of the unsatisfied cases.

The majority of satisfied clients also perceived that racial, ethnic, or cultural (REC) factors were unrelated to their presenting problem and goals for treatment, which contributed to their diminished importance in therapy. For example, one multiracial participant acknowledged that while his racial and cultural identity was a salient issue, the fact that his therapist could not fully understand his struggle was not problematic in that he did not see it as factoring into his depression. Not only did satisfied participants view racial differences as exerting a minimal impact on the counseling relationship, they also perceived significant advantages of working with a racially dissimilar therapist. These advantages included a) that it was easier to discuss some issues that would have been awkward discussing with a therapist of the same background (e.g., sexuality) (3 cases), b) that racially different therapists offered a broader perspective that clients could learn from (4 cases), and c) White therapists offered the opportunity to explore race-specific facets of their presenting problem

(2 cases). In contrast, only one participant in the unsatisfied group acknowledged any benefits of working cross-racially.

History of Intraracial/Intraethnic Oppression—A second client factor that distinguished satisfied from unsatisfied participants was a personal history of oppression or alienation from members of one's own group. Although this emerged only as a minor category, the issue was spontaneously discussed by nearly half of the participants who reported satisfaction working cross-racially, and was frequently associated with negative or ambivalent expectancies of what it would be like to work with a racially or ethnically similar therapist. Descriptions of both colorism and homonegativity within the Black community were particularly salient and may have contributed to the development of a positive ethnocultural transference towards White therapists in particular. As Joel imagined it, "I think if my therapist was Black, I would be…damned! I would be berated; I would be chastised [for being gay]."

Relationship Factors

Although therapist and client factors clearly contribute to the development of a particular relational dynamic, we identified a separate set of relationship factors that we considered to reflect explicit styles of interaction arising from efforts on the part of either the client or therapist to cultivate the therapeutic alliance. Three groups of categories emerged: client's efforts to bridge perceived differences, therapist's efforts to bridge perceived differences, and therapist's responsiveness to clients' expressions of dissatisfaction with aspects of the therapy.

Client's Efforts to Bridge Differences—The majority of the sample (11 of 16) reported that REC differences presented a barrier to the development of a strong working relationship. Yet half of the sample went on to establish a satisfying and productive relationship with their therapist. Satisfied and unsatisfied clients differed in their employment of two key strategies to minimize the impact of perceived difference: compartmentalization of race and identification with the therapist.

Compartmentalization of race: In 80% of the satisfied cases, we observed contradictions in clients' descriptions about the significance of REC in the therapy relationship. In these cases, clients explicitly stated that such issues were secondary, or irrelevant to their presenting problem or the therapeutic work, so that it mattered little that their therapists were racially dissimilar. However, elsewhere in their narratives, they expressed a clear awareness of the extent to which their presenting concerns were shaped by their experiences of being a visible minority. Several revealed psychological conflicts related to their racial or ethnic identity, although most did not draw a link between their own ambivalence about racial/ethnic issues and their minimization of difference in the therapeutic relationship. Rather, it appeared that they attempted to resolve any potential sources of internal and external conflict by de-emphasizing the importance of race in their description of the therapy work and the therapy relationship. We labeled this strategy of conceptualizing one's problems as untouched by race or minimizing the racialized aspect of one's being within the context of the therapy relationship as the *compartmentalization of race*.

For some, compartmentalization seemed to be a strategy that was employed defensively, for example to help them to avoid dealing with the psychological, social, and economic reality of race in their everyday lives or to preserve an idealized relationship with their therapist. Michiko, a Japanese international student avoided discussing with her therapist issues related to Japanese culture specifically, even though she was experiencing culture shock, discrimination, and communication difficulties as a result of cultural and linguistic issues. In

the interview, she spoke at length about her struggles to feel positively about her Japanese heritage and her idealization of White Americans: "I just always generally have this [sic] thoughts, ideas, like maybe stereotype, that maybe Americans are better than I am. They are valued more or—I just had a hard time, I am having hard time, like gaining self-esteem and … yes, I recently realized that, I was discriminating against myself, because I actually had hard time respecting Japanese people here." This admiration of all things American led her to choose a White "American" therapist rather than a Japanese therapist with whom she may have shared a common culture and language. Notably for the present study, she also requested to be interviewed in English by a non-Japanese interviewer rather than meet with the female Japanese interviewer who was also available.

For others, compartmentalization appeared to be an approach that was employed strategically, in a conscious attempt to obtain a high quality of care by engaging the therapist and catering to his or her area of expertise. Joanne, a Black participant, sought help for political problems at work which she saw as related to power hierarchies that privileged gay and Jewish employees. Yet in therapy, she studiously avoided discussing her problems in these terms because she did not want to offend her therapist, whom she assumed was also gay and Jewish:

> It really wasn't a major concern. I can discuss my problems without talking about the ethnicity… So I just don't go in that direction. I just talk about the problem generically versus getting into my specific feelings that there is some level of discrimination I feel that goes on in my job.

This pattern of compartmentalization was not observed among unsatisfied cases, suggesting that such individuals were not motivated or were unwilling to disregard the significance of race in their lives or in the therapy relationship. For example Imani, a Black lesbian from Africa, was initially pleased with the advice she received from her White lesbian therapist about how to navigate the sexual and gender politics of her conservative workplace. However as time passed, she became increasingly frustrated that her therapist repeatedly ignored her efforts to insert race into the discussion: "She was able to address my sexuality and me being a gay woman in general but she wasn't able to address the race part, really at all…or how that all factors in."

Identification with the therapist: A second way in which satisfied participants' differed from unsatisfied participants was their emphasis on shared aspects of identity with the therapist. Whereas unsatisfied clients tended to emphasize their perception of cultural distance, two-thirds of satisfied clients identified with their therapist in some important way. In particular, several participants felt a kinship with White therapists whom they knew or perceived to be a minority of some kind (e.g., related to religion, sexual orientation, immigration status, physical appearance), because of assumptions of a shared experience of discrimination, oppression, or marginalization. Yet it is unclear to what extent satisfied participants' emphasis on therapist similarities rather than differences reflects a particular motivation to bridge REC differences, or the presence of particular therapist characteristics that facilitated their ability to find common ground.

Perceptions of Therapist's Efforts to Bridge Differences—The majority of satisfied cases also indicated that whatever REC differences did exist did not adversely affect the therapy because the therapist was culturally responsive and able to work through any conflicts or misunderstandings that arose. This sentiment was not expressed by any of the unsatisfied cases. Satisfied participants described a natural back-and-forth quality to these negotiations, suggesting the therapist's comfort level working across differences and revising interpretations in response to client feedback. This ability on the part of the therapist to bridge differences and its enhancement of the participants' attachment was

perhaps most clearly illustrated in a series of exchanges described by Lisa, a Latina who worked with a White Ukrainian American therapist after being victimized by violence. During her initial visit, the participant felt a positive connection with the therapist because she started making tea at the start of the session and offered hand lotion to the participant. Even though Lisa did not really need lotion, she took it because it was "like a peace offering." Later in the therapy, she challenged her therapist's ability to understand what it was like to be a "disadvantaged woman," struggling with issues related to minority status, immigrant status, sexism, as well as experiences of ethnic discrimination and prejudice. Her therapist responded by confronting the clients' efforts to push her away and selectively disclosing shared aspects of experience: "[She showed] me that because of our differences, we're very alike also. …that's where I understood that, okay, well, this woman, I'm thinking she's so different from me, but she's gone through a lot, too, you know she's really suffered also… I never saw her as a human being before."

Therapist's Responsiveness to Client Expressions of Dissatisfaction—The final category that differentiated our two comparison groups was not specific to negotiation of REC differences per se, but rather refers to perceptions of the therapist's general responsiveness to the clients' efforts to express their needs and frustrations with the therapy over time. This category also encompasses the therapist's ability to repair "ruptures" in the relationship stemming from therapist misunderstandings or misattunements. In 14 of 16 cases, participants described expressing disagreement or dissatisfaction with their therapist in either indirect or direct ways. Indirect expressions of dissatisfaction, reported in 7 cases, included withdrawal behaviors such as avoiding certain issues or topics, missing sessions, or not returning the therapist's calls. Direct expressions of dissatisfaction, reported in 14 cases, were more confrontational and included explicit expressions of dissatisfaction, requests for specific interventions, and raising REC-related issues that the therapist was not addressing. Clients reporting a satisfying experience typically indicated their therapists were responsive to their concerns and worked to remedy the problem. In contrast, the majority of unsatisfied participants reported that their concerns were not satisfactorily addressed despite their efforts to communicate their needs. For these cases, failed attempts at self-advocacy gave way to more and more acts of passive resistance, until many just "gave up" or "stopped trying" to salvage the relationship.

Discussion

This study highlights the client's perspective in addressing the question, "What makes some cross-racial therapy relationships succeed while others fail?" While we acknowledge individual differences in clients' experiences of cross-racial therapy, our focus was on identifying the common elements associated with client satisfaction across racial and ethnic groups and specific therapist-client racial pairings. Clients' narratives reveal substantial differences at the level of individual and relational processes and provide evidence of both universal (etic) as well as culture/context-specific (emic) aspects of healing relationships.

Etic Elements of Successful Cross-Racial Therapy Relationships

Consistent with ideas expressed by other scholars (Fischer, Jome, & Atkinson, 1998), our findings suggest that there are critical ingredients of care that appear to be equally important for racially or culturally mismatched dyads as for matched dyads. For instance, clients' summative evaluations may be read as a distillation of what matters most, namely affective involvement in the relationship and the belief that the counselor is addressing core needs and aiding in the achievement of treatment goals. These ideas echo theoretical descriptions of the therapeutic alliance (Bordin, 1979; Gelso & Mohr, 2001) and affirm the centrality of the therapeutic relationship in clients' overall appraisals of treatment. Second, satisfied clients in

cross-racial therapy were more likely to describe their therapists' attitudes and behaviors in terms analogous to what has been previously identified as core facilitative conditions such as therapist caring, respect, and acceptance (e.g., unconditional positive regard), congruence (genuineness), and validation and responsiveness to expressed needs (Rogers, 1951).

Third, there was a strong relationship between therapist self-disclosure of personal history and treatment satisfaction. This finding is consistent with conceptual and empirical work describing the generally beneficial effect of therapist self-disclosure on the therapeutic relationship (Hill & Knox, 2002). Results confirm that therapist self-disclosure is an effective strategy for bridging perceived social and power distance in cross-racial dyads (Berg & Wright-Buckley, 1988), despite the fact that only half of the self-disclosures addressed REC issues in particular. While the limited research on therapist self-disclosure in cross-racial therapy suggests that intimate disclosures in response to client experiences of racism and discrimination are particularly valuable (Burkard, Knox, Groen, Perez, & Hess, 2006), our findings suggest that even general self-disclosures of therapist personal history may have positive consequences for the therapy relationship. Given that our sample may be described as a fairly acculturated group of immigrant participants however, we acknowledge that this may not be true for more traditional Asian and Latino immigrant clients, who may expect that professional hierarchies and appropriate social distance be maintained within the clinical relationship (Sue & Sue, 2008).

The fourth culture-general process that emerged in this study concerns the ability of the client and therapist to productively communicate and negotiate ruptures in the relationship. This theme was most frequently discussed in terms of therapists' responsiveness to clients' expressions of dissatisfaction, communications of needs, and attempts to cultivate the therapy relationship. This finding is consistent with Safran and Muran's (2000) view that the therapeutic alliance reflects a process of productive negotiation, rather than collaboration, between the client and therapist. Safran (1993) defines a rupture as "a negative shift in the quality of the therapeutic relationship or an ongoing problem in establishing one" (p. 34). Ruptures may occur as a result of misunderstandings or misattunements on the part of the therapist (Keenan et al., 2005), clients' dysfunctional interpersonal schemas (Safran, 1993), and/or difficulties arising out of the "real" aspects of the relationship (Gelso & Carter, 1985). Studies suggest that ruptures, if successfully repaired, may positively affect both the quality of the alliance (Stiles et al., 2004) as well as clinical outcomes (Strauss et al., 2006). Our findings provide additional evidence in support of the rupture-repair hypothesis and suggest that cross-racial relationships may be particularly vulnerable to ruptures (Keenan et al., 2005). For example, several participants described instances of trying to correct their therapist's avoidance or minimization of topics related to the client's experiences as a racial, ethnic, or cultural minority in an effort to provide a broader framework for understanding their problems against a larger sociopolitical context.

This last example illustrates that despite the seeming universality of these core therapeutic processes, the dynamics of racial/ethnic mismatches introduce unique challenges to the therapy relationship that may require attention and flexible adaptation of basic therapy skills. In addition, differences in cultural worldview and communication styles may require context-specific (etic) approaches. For example, while most clients appear to value therapists' expressions of attention and concern, the ways in which those processes are conveyed and understood have been found to vary across cultural groups (Sue & Sue, 2008).

Emic Elements of Successful Cross-Racial Therapy Relationships

Our analysis of therapist factors suggests that minority clients working with racially or culturally dissimilar therapists may have different expectations and standards for evaluating therapeutic expertise, credibility, and competence. Although insight and personal growth

were also valued, the majority of participants turned to their therapists for expert guidance, advice, and explicit instruction in achieving specific treatment goals. Consistent with previous studies demonstrating minority clients' preferences for structured, problem-focused interventions (Zane, Hall, Sue, Young, & Nunez, 2004), therapists who adopted an active and directive role were rated more favorably and were seen as more engaged and helpful than less directive therapists.

Clients also praised therapists who demonstrated culture-specific knowledge, skills in navigating racial/cultural dynamics inside and outside of therapy, and awareness of the importance of race and culture in shaping individual experience and identity and criticized those who displayed cultural ignorance or insensitivity. Interestingly, participants' spontaneous discussions of various aspects of therapists cultural awareness, knowledge, and skills converged with theoretical formulations of multicultural counseling competence as consisting of this core triad of competencies (Sue et al., 1992), confirming that these elements are also subjectively important to minority clients (Pope-Davis et al., 2002). Notably, clients' descriptions of therapists who dismissed their race-related concerns or experiences of marginalization or oppression echo Sue et al.'s (2007) conception of *microinsults*, a category of racial microaggressions involving "communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (p. 274).

Along these lines, we were surprised to find that therapist cultural competence was not associated with treatment satisfaction whereas cultural *in*competence—e.g., behavior suggesting lack of cultural awareness, knowledge, or therapeutic skill—was associated with treatment *dis*satisfaction only. The unidirectionality of this finding is somewhat in contrast to Constantine (2002) who found that students' perceptions of therapists' multicultural competence was significantly associated with treatment satisfaction. However, it is consistent with other research suggesting that therapist demonstrations of racial microaggressions or other acts of cultural insensitivity are experienced negatively by minority clients (Constantine, 2007; Thompson & Jenal, 1994). These findings raise the possibility that the construct of counseling competence should be conceptualized as a multidimensional construct involving separate assessments of competence and incompetence across different skill arenas, including but not limited to general counseling skills and multicultural counseling skills. Notably, in our study, many of the satisfied clients appeared to base their satisfaction ratings more on appraisals of general counseling competence without weighting multicultural competence as heavily. It may be that for satisfied individuals, cultural competence serves as the icing on the therapeutic cake; it enhances positive working relationships but does not separately predict counseling satisfaction once general counseling effectiveness is taken into account.

On the other hand, descriptions of therapist cultural *incompetence* figured prominently in unsatisfied clients' narratives, suggesting that it was a key source of dissatisfaction and/or offered a convenient explanation for the failure of the relationship. For these individuals, there appeared to be a stronger connection between appraisals of general counseling incompetence and multicultural incompetence as other studies would suggest (Coleman, 1998; Constantine, 2002). There was another subgroup of clients however, who were sensitive to being treated differently because of their race and desired only to be treated the same as anyone else. That therapists' handling of REC issues could be seen as both an important and unimportant aspect of the relationship by different subgroups of clients underscores that there are important individual differences that require careful assessment prior to determining the optimal strategy for negotiating racial differences in therapy.

With regard to client factors, a central finding was that clients differed in the meaning and salience attached to race, ethnicity, culture and difference, with important implications for how such differences would be interpreted and negotiated within the therapeutic relationship. Individuals who viewed these factors as important were more likely to value therapist demonstrations of cultural competence and base their treatment satisfaction on how successfully key REC differences were bridged. Those who viewed these factors as less important than more general therapeutic skills or saw them as irrelevant to their presenting problem tended to describe their relationship as uncomplicated by cultural barriers. Instead, they were more likely to identify positive aspects of working cross-racially and emphasized intergroup similarities that served to strengthen their relational bond. Notably, many of these participants also had positive expectancies regarding working with out-group therapists, which may be partially attributed to their negative experiences with in-group members particularly around sexual orientation issues.

However, we also identified a subgroup of clients that revealed inconsistencies in their conceptualization and approach to REC differences with their therapist. As discussed in the category *compartmentalization of race*, these clients explicitly minimized the salience of REC differences while revealing contradictory attitudes suggesting the importance of REC in their life world and/or presenting concerns. This approach facilitated their ability to overlook REC differences and adapt to their therapists' knowledge base and skill set. Clients in Pope et al.'s (2002) study demonstrated a similar flexibility in their ability to adapt to the treatment context, limiting the type and amount of information they were willing to discuss based on their appraisal of their therapists' abilities. In some instances, this approach to handling cross-racial dynamics appeared to serve a defensive function (e.g., an effort to avoid rejection from their therapist). As one Black participant noted during member checks, "You don't want to be stereotyped as that 'angry Black man'. People would rather pretend that we all get along." On the other hand, this approach may also be viewed as an expression of *clients'* cultural competence, that is clients' ability to bridge cultural distance to achieve their desired end goal (e.g., therapeutic change).

Limitations

Although we consider the diversity of our sample an asset given our goal of identifying common processes, we acknowledge that there are likely to be group-specific or dyad-specific issues which we were unable to examine (e.g., Black-White dyads vs. Asian-White dyads, immigrant-U.S.-born dyads, gender-matched vs. mismatched dyads, etc.). Further, the sample was restricted to minority clients, all of whom saw a majority (White) therapist. Therefore findings should not be generalized to situations where the therapist is a minority-group member working with a majority (White) client or one from a different minority group. Both scenarios are likely to produce unique interracial dynamics not explicitly addressed in this study. In addition, although our sample included a substantial number of immigrant participants, the majority were acculturated enough that they could be interviewed in English; results may not apply to less acculturated clients working with mainstream therapists.

In addition, because we relied entirely upon client self-reports, our findings likely underestimate clients' contributions to the outcomes they describe while emphasizing therapist factors as contributing to negative outcomes in particular. Furthermore, as with all human perception, the clients we interviewed were susceptible to biases in recall and limitations in their ability to describe complex experience. However, consistent with the phenomenological approach (Giorgi, 1997), we regard the clients' subjective reports as valid data for capturing their lived experiences and include any filters on memory or expression as part of their internal representation of that experience. Finally, we were unable to assess the

relative importance of the various factors described by clients as salient in their evaluation of the therapy experience.

Recommendations for Clinical Practice

Acknowledging that clients themselves bring particular expectations and biases, personality traits, cultural histories, etc. to the therapy situation, this study suggests that there are a number of general strategies that may facilitate positive alliance formation. Findings indicate, for example, that adopting a more directive therapeutic style may be an important technique for improving outcomes with racial/ethnic minority clients. Specific interventions mentioned as helpful include asking probing questions about the client's verbalized thoughts and actions, offering concrete advice, and providing skills training and psychoeducation.

An open conversation early in the therapy relationship about the client's expectations of therapy, as well as occasional process evaluations and discussions, can help inform the therapist as to what techniques clients' find most beneficial. Addressing resistance and providing an open opportunity for the client to provide feedback and express concerns about the therapeutic process is especially important with minority clients who may not feel empowered to do so otherwise. A large number of participants in this study did not feel able to openly express their concerns with the therapist regarding the direction of the therapy, often contributing to negative feelings, withdrawal, and early termination. Such conversations may also help to minimize the power differential that is particularly pronounced in dyads involving a majority group therapist and a minority group client. Self-disclosure on the part of the therapist appears to also be a highly effective strategy for bridging cultural and power distance. Simply sharing a bit of personal information may also facilitate clients' efforts to identify with the therapist and find common ground. Basic displays of professional courtesy, such as beginning sessions on time, returning phone calls promptly, and being fully and visibly attentive during sessions, also take on a heightened importance with racial/ethnic minority clients who may be sensitive to signs of disrespect or unequal treatment from a majority therapist. However, attention to professionalism should be balanced by culturally appropriate expressions of warmth and caring.

Results suggest that while cultural awareness, knowledge, and skills are clearly valued in cross-racial contexts, clients are particularly sensitive to acts of cultural *incompetence*. Such acts to be avoided include applying either "generic" or "textbook" interventions that do not take clients' lived experiences into account, addressing only particular facets of clients' complex cultural selves, and invalidating the social realities of being a racial or cultural minority. These findings affirm the importance of adopting an idiographic perspective, conceptualizing the client as a whole person with multiple and intersecting cultural identities (including gender, family role, immigration history, religion, age, SES, race, and sexual orientation) and choosing interventions that are tailored yet do not stereotype the client based on normative assumptions about their cultural group (Ridley, 2005). As the experiences of Imani and Joel illustrate, many clients suffer multiple oppressions based on REC, sexual minority status or other characteristics (Szymanski & Gupta, 2009) and thus multiple sets of therapist competencies are required to adequately meet their needs. Therapists should aim for an understanding of clients' internal and external struggles as informed by all of their cultural identities.

After inviting the client to discuss important cultural reference groups, the therapist should follow the client's lead in determining how REC differences are likely to be experienced by the client and adjust their focus accordingly. Therapists working with clients high on race salience should actively demonstrate their comfort and willingness to broach topics involving race, ethnicity, and culture, whether by self-disclosing personal history or by inquiring into how the clients' presenting concerns are affected by REC issues. On the other

hand, the same approach may alienate clients who view REC issues as irrelevant to their presenting problem. In these cases, therapists should focus on addressing clients' core concerns and clarifying possible sources of cultural misunderstanding as needed. While therapists may consider broaching the significance of REC differences with all clients, they should be responsive to clients' feedback rather than assume that such differences should necessarily be a focus of discussion (Cardemil & Battle (2003). Careful assessments and adjustments in intervention style, technique, and focus are essential for cultivating one's relationship with a racially different client and repairing ruptures resulting from misalignments in the relationship (Keenan et al., 2005).

Finally, findings suggest that many clients are mistrustful of therapists who do not acknowledge that racial/cultural differences may influence the therapy relationship. For the therapist, being honest with oneself about potential sources of bias and limitations can help inform treatment decisions. Therapists who have never before treated a client of a particular cultural group may increase their credibility by acquiring cultural knowledge, especially in the form of real-life, immersion experiences as opposed to "textbook" knowledge alone (Sue et al., 1991). Consulting a cultural expert or a colleague who has experience working with this type of client, is an important way to gain an insider's perspective on the client's lived experiences and confirm that one's interventions are culturally appropriate (Sue & Sue, 2008).

Future Research Directions

Longitudinal, mixed-methods research is needed to confirm the hypothesized associations between the therapist, client, and relationship variables identified in the present study, the therapeutic alliance, and key clinical outcomes in cross-racial therapy relationships. Self-report assessments as well as behavioral process measures would offer different perspectives on how situational, client, and therapist characteristics interact to produce particular relational outcomes. In addition, investigators should examine whether the study's findings extend to specific client subgroups and specific client-therapist racial pairings. That so many of our participants endorsed multiple social identities also highlights the importance of exploring how intersecting identities and power differentials between client and therapist (i.e., straight Black client-gay White therapist) may affect perceptions of similarity and difference. Given the differential associations between cultural competence, cultural incompetence, and therapeutic alliance found in this study, researchers should also consider studying the specific effects of cultural incompetence (including but not limited to racial microaggressions) on the therapy relationship and individual well-being. In addition, whereas affective disconnection and premature termination are obvious adverse consequences of failed efforts to negotiate cross-racial therapy interactions, the costs and benefits of clients' bridging strategies such as compartmentalizing race remain unclear.

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Table 1

Participant characteristics stratified by race/ethnicity, gender, and treatment satisfaction

Race/Ethnicity*	Gender	Satisfaction	Therapist Race/Ethnicity*
Asian (Japanese)	Female	Satisfied	White
Asian (Chinese)	Female	Unsatisfied	White (German)
Asian (Chinese American)	Male	Unsatisfied	White (Russian)
Black (Black, born in Africa)	Female	Unsatisfied	White
Black (Nubian)	Female	Unsatisfied	White (Greek)
Black (African-American)	Female	Satisfied	White
Black (African-American)	Male	Unsatisfied	White (Jewish)
Black (African-American)	Male	Satisfied	White (Greek)
Black (African-American)	Male	Satisfied	White
Latino (Puerto Rican)	Female	Satisfied	White (Ukrainian)
Latino (Basque/Spanish/American)	Female	Satisfied	White (American, British)
Latino (Puerto Rican and Black Portuguese)	Male	Unsatisfied	White (Yugoslavian)
Latino (Mixed Black and Hispanic)	Male	Unsatisfied	White
Latino (Puerto Rican)	Male	Satisfied	White (Jewish)
Multiracial (Chinese and White)	Female	Unsatisfied	White
Multiracial (White-Latino and Jewish)	Male	Satisfied	White (Jewish)

* Client and therapist ethnicity, where indicated in parenthesis, is provided in clients' own words.

Table 2

List of standard interview questions

1	"Grand tour" question: Please describe for me your experience of therapy, starting from the very beginning and taking me through that experience until the very end.
2	Sometimes prior to seeing a therapist, people identify qualities that they want the therapist to have. What qualities did you identify as being important, before you went to your first appointment**?**
3	Where did you go for treatment? What was it like?
4	How did you get hooked up with your particular therapist?
5	Now, I'd like you to think back to your very first session with your therapist. What do you remember about that first meeting?
6	What was your first impression of your therapist? Did you feel a connection with him/her?
7	At the end of that session, did you want to come back? Why or why not?
8	Tell me a little about your therapist.
9	How much did you feel like you had in common? In what ways did you feel like you were different?
10	How was it working with him/her? What kind of relationship did you have?
11	How satisfied were you with how the therapy went? How helpful was it?
12	What were specific things that the therapist did that were HELPFUL?
13	What are specific things that the therapist did that were NOT HELPFUL?
14	How did your therapy end?
15	Some people consider themselves to be Black or African American, Asian, Chinese American, Latino, Mexican American, White, American, Italian American, etc…How do you identify yourself?
16	How much do you identify with (use client's own words) culture versus (mainstream) "White"/European American culture? For some people it is more important for them to hold on to cultural traditions and values, for others it is more important to be a part of mainstream American culture, for some both are important, and for others, neither is as important as some other aspect of their identity (i.e., religious, gender, etc.). What about for you? In your daily life, how does that play out?
17	Some people think that things such as race, ethnicity, and culture—these things we've been talking about—exert a significant impact on the therapy relationship, while other people think that these factors are not very important. What do you think?
18	Reflecting on your experience in therapy, how important were racial differences?
19	Thinking back on your experience in therapy, did the fact that you were from different backgrounds affect what you felt comfortable sharing with him/her?
20	Was there ever a time when you felt like your therapist just couldn't understand you because of your racial or cultural differences? Can you tell me what happened? How satisfied were you with how the misunderstanding was resolved?
21	Thinking back to that first therapy session, did your therapist bring up the fact that you were from different racial, ethnic, or cultural backgrounds? What was that like?" IF YES, Was this an issue that came up again? IF NO, Did either of you at any time talk about it directly?
22	In general, how sensitive would you say your therapist was to issues related to race, ethnicity, and culture? What did he/she do or say to make you feel that way?
23	Looking back on your whole experience of therapy, how do you think it would have been different to be in therapy with an (insert client's racial/ethnic/or cultural identity *in their own words*) therapist? How important is it to you that your therapist shares your background?
24	As someone who has experienced this situation first hand, what kinds of suggestions do you have for therapists who are working with people of different racial/cultural backgrounds?
25	Do you think in general, that it would be helpful for therapists to talk about racial/cultural differences with their clients?

Table 3

Therapist, client, and relationship factors that distinguished satisfied from unsatisfied cases of cross-racial therapy.

Category	Description	Satisfied (*n*=8)	Unsatisfied (*n*=8)
	THERAPIST FACTORS		
1. Techniques			
A. Active vs. Passive*	Therapist adopted an active role in the therapy	Typical	Variant
	Therapist adopted a passive role in the therapy	Variant	Typical
B. Cultural Competence*	Therapist's interventions seen as too "textbook" and not tailored to client's specific life contexts/ personal history	--	Typical
	Therapist's knowledge about their community was perceived as superficial or stereotypical	--	Variant
	Therapist was viewed as dismissing or minimizing of patient's experiences of oppression or exclusion due to minority status	--	Variant
	Therapist revealed a lack of awareness of the impact of their stereotypes or biases about the patient's racial/ethnic/cultural group on the client	--	Typical
C. Self-Disclosure	Therapist disclosed personal information to the client	Typical	Variant
D. Professionalism/Ethics	Therapist seen as unprofessional or engaging in ethically questionable practices	Variant	Typical
2. Personal Characteristics			
A. Attentive/Disengaged	Therapist was viewed as caring, sensitive, and attentive	Typical	--
	Therapist was not sufficiently attentive or engaged	Variant	Typical
B. Accepting/Critical	Therapist was viewed as validating and nonjudgmental	Variant	--
	Therapist seen as too critical or dismissive of client's concerns	--	Variant
	CLIENT FACTORS		
1. Perceptions of the Salience of Racial Difference*	Client emphasized therapeutic skills and the nature of the therapeutic task as being more important than racial/ethnic differences	General	--
	Client perceived that racial/ethnic differences were irrelevant to the client's presenting problem and therapy goals	Typical	--
	Client perceived significant benefits of working with a racially different therapist	Typical	--
2. History of Intra-Racial/Ethnic Oppression*	Client described experiences of alienation from members of his/her own racial/ethnic group	Variant	--
	RELATIONSHIP FACTORS		
1. Client's Efforts to Bridge Differences*			
A. Compartmentalization of Race	Client acknowledged the influence of race/ethnicity in his/her life but minimized its effect on the therapy relationship	Typical	--
B. Identification with the Therapist	Client emphasized shared aspects of identity with the therapist.	Typical	--

Category	Description	Satisfied (*n*=8)	Unsatisfied (*n*=8)
2. Therapist's Efforts to Bridge Differences*	Client felt that therapist was culturally responsive and able to work through misunderstandings due to REC differences.	Typical	--
3. Therapist's Responsiveness to Client Expressions of Dissatisfaction	Client's concerns were satisfactorily addressed by the therapist	Typical	--
	Client's concerns were unsatisfactorily addressed by the therapist	--	Typical

Note: Frequency of core ideas was analyzed separately for satisfied and unsatisfied cases. *General*= appearing in all cases (8); *Typical*= appearing in half but not all cases (4–7), *Variant*= appearing in 2–3 cases.

*Emic aspects of negotiating the therapeutic alliance in cross-racial therapy relationships.