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Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships

DORIS F. CHANG[1] & PATRICIA YOON[2]

[1]*New School for Social Research, Psychology, New York, USA* & [2]*City University of New York, The Graduate Center, New York, USA*

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Abstract

In this consensual qualitative research study, 23 ethnic minority clients were interviewed to assess perceptions of race in their recent therapy with a White therapist. Participants' responses were coded into an average of seven (out of 22) categories. The majority believed that White therapists could not understand key aspects of their experiences and subsequently avoided broaching racial/cultural issues in therapy. However, many felt that racial differences were minimized if the therapist was compassionate, accepting, and comfortable discussing racial, ethnic and/or cultural (REC) issues. A subgroup expressed positive expectancies of racial mismatch, and perceived disadvantages associated with racial matching. Results suggest that participants' constructions of race are multidimensional and support recommendations that therapists acquire skills for addressing racial perceptions that may impact the therapy relationship.

Keywords: culture and psychotherapy; alliance; qualitative research methods; racial/ethnic minorities

Within the clinical arena, racial differences between therapist and client have long been considered a potentially important variable affecting the therapy relationship (Helms & Cook, 1999; Jones, 1978). Given the violent and traumatic history of race relations in the United States, as well as the underrepresentation of racial minority treatment providers, most discussions of race in therapy center on the challenges in establishing a productive working relationship in White therapist-minority client dyads in particular (Atkinson, Morten, & Sue, 1998; Carter, 1995; Helms, 1984; Sue & Sue, 2008). Well-documented psychiatric abuses of Black Americans have caused many to be mistrustful of the mental health care system (Thompson, Bazile, & Akbar, 2004; Whaley, 2001), which may complicate the rapport-building process with a therapist perceived to be an outgroup member (Ridley, 1984; Watkins & Terrell, 1988). In addition, client-therapist differences in cultural values, understanding of the presenting problem, and role expectations may also interfere with clients' engagement in therapy and perceptions regarding the credibility of services (Kim, Ng, & Ahn, 2005; Mau & Jepson, 1988; Wong, Kim, Zane, Kim, & Huang, 2003; Worthington & Atkinson, 1996).

As for therapists themselves, research has documented the discomfort that White therapists display in cross-racial interactions and their subsequent avoidance of racial and cultural material in therapy (Turner & Armstrong, 1981; Utsey, Gernat, & Hammar, 2005; Vasquez, 2007). These defensive reactions have been shown to adversely impact communication and the ability to collaborate effectively across racial lines (Dovidio, Gaertner, Kawakami, & Hodson, 2002; Norton, Sommers, Apfelbaum, Pura, & Ariely, 2006). Together, these cultural and interpersonal barriers to the development of cross-racial therapy relationships may help explain the tendency of racial and ethnic minorities to underutilize mental health services, to report treatment dissatisfaction, and drop out of treatment at higher rates compared to their White counterparts (Maramba & Hall, 2002; Snowden, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

Given the myriad ways in which perceived racial and cultural differences may impact mental health treatment, there is growing consensus among multicultural counseling experts that explicit acknowledgement of therapist-client differences may help to facilitate the development of the therapeutic alliance and improve client satisfaction with treatment

Correspondence concerning this article should be addressed to Doris F. Chang, Department of Psychology, New School for Social Research, 80 Fifth Avenue, 7th Floor, New York, NY 10011, USA. Email: changd@newschool.edu

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(Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002; Helms & Cook, 1999; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Li, Kim, & O'Brien, 2007; Maxie, Arnold, & Stephenson, 2006; Sue & Sundberg, 1996; Zhang & Burkard, 2008). However, a number of writers have cautioned against a one-size fits all approach to dealing with race in the consulting room (Cardemil & Battle, 2003; Tang & Gardner, 2006). Individual differences such as clients' racial identity status (Helms & Cook, 1999), degree of cultural mistrust (Ridley, 1984), and ethnocultural transference reactions (Comas-Diaz & Jacobson, 1991; Holmes, 1992; Tang & Gardner, 2006) have been identified as important considerations for therapists deciding whether and how to address the issue of race. In the present study, we suggest that clients' perceptions of the significance and impact of race in the therapy relationship may likewise shape their expectations and overall experience of cross-racial therapy.

Clients' Constructions of Race in the Therapy Relationship

Understanding how a racial/ethnic minority client makes sense of race and racial similarity/dissimilarity in the treatment relationship can help guide the therapist to respond in a manner that is facilitative of the working alliance and the client's personal growth. A number of studies involving subjects in therapy and quasi-therapeutic situations suggest that racial and ethnic minority clients do have differing expectations and views of treatment based on therapist race, although these race-based attitudes may be subtle, vary across individuals, and change over time (Atkinson & Matsushita, 1991; Gim, Atkinson, & Kim, 1991; Jones, 1978; Thompson & Alexander, 2006; Thompson, Worthington, & Atkinson, 1994). In one of the earliest naturalistic studies of psychotherapy process in cross-racial dyads, Jones analyzed 10 sessions of dynamic, insight-oriented psychotherapy for each of 14 patients (seven Black, seven White) seeing either a Black or White therapist. Transcripts of each therapy hour were analyzed by two experienced psychotherapists using a Q-sort developed to examine general psychotherapy processes as well as issues pertaining to race. Results indicated no differences in treatment outcome or retention rates across racial pairings; however, significant differences emerged along a number of process domains for Black clients as a function of therapist race. For example, when Black clients were paired with White therapists, they were more likely to express hostility towards the therapist and act out their feelings over time. In contrast, Black clients in racially congruent dyads were more likely to express feelings of vulnerability and express erotic transference, which, according to Jones' analysis, led to a more rapid emergence of issues of central psychological concern in the therapy.

Together, these findings suggest that client appraisals and meaning-making around racial similarity/difference in the therapy relationship are important individual difference variables that may significantly impact the therapeutic process. Yet little is known about how actual therapy participants experience and actively construct race in the relationship. Even psychoanalytic explorations of race, which offer rich narratives of the unfolding relationship in cross-racial and same-race therapy dyads, are limited by their traditional focus on racial transference. In particular, many of these writings emphasize the transferential (and countertransferential) implications of negative racial stereotypes and conflicted views of the racial other (Comas-Diaz & Jacobson, 1991; Holmes, 1992; Schachter & Butts, 1968; Tang & Gardner, 2006). As such, racial transference reactions are commonly conceptualized as defensive in nature, a form of resistance rather than an important aspect of experience in itself (Hamer, 2002). However, the past 20 years have seen a gradual shift towards recognizing race as having both an external reality as well as a psychic reality that affects unconscious and conscious ideas about the therapist and the therapy relationship (Eng & Han, 2000; Hamer, 2002; Holmes, 1992; Layton, 2006; Leary, 1995).

This view of race as an integral part of a minority patient's day-to-day reality that must be addressed in the therapy context is consistent with multicultural counseling guidelines (Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue, Arredondo, & McDavis, 1992). However as Carter (1990) observed, the psychoanalytic focus on unconscious processes and the therapist as the translational agent has traditionally denied a space for clients to give voice to their own constructions and conscious responses to racial material in the relationship. As a result, studies of cross-racial therapy relationships have tended to privilege the voice of the therapist or the researcher (e.g., Jones, 1978; Knox et al., 2003; Turner & Armstrong, 1981) resulting in an inadequate understanding of clients' explicit understandings of the meaning of race in their experience of treatment (Fuertes et al., 2002).

A few qualitative studies have attempted to redirect attention to the client as an active participant in the negotiation of racial differences in therapy (Chang & Berk, 2009; Pope-Davis et al., 2002). Chang and Berk (2009) conducted a phenomenological study of racial/ethnic minority patients' experiences of cross-racial therapy with a

White therapist. Using a matched pairs design, the authors found marked differences in how satisfied and dissatisfied clients conceptualized the meaning of racial difference. Compared to dissatisfied clients, satisfied clients minimized the importance of therapist race, and instead emphasized the skill of the therapist or the non-race-related nature of their presenting concerns and treatment goals. Satisfied clients were also more likely to perceive significant benefits of working with a racially different therapist and highlight their intergroup similarities rather than their differences. Finally, satisfied clients tended to limit, or compartmentalize, the role of race in the consulting room even as it remained a salient component of their identity. Although the design of this study does not permit causal inferences to be drawn, results do suggest specific ways of viewing racial differences in the relationship that may have been conducive to the development of a productive working relationship.

The Present Study

Clients' reluctance to disclose feelings about racial differences (Cardemil & Battle, 2003) makes it difficult for therapists to anticipate and address clients' various implicit race-based expectations, assumptions, and concerns. To help guide the development of specific strategies for negotiating different perceptual and relational barriers stemming from racial difference, the present study seeks to clarify the connotative meaning of race from the client's perspective and its perceived impact on the therapy relationship.

Although previous studies of university populations have laid the groundwork for understanding how individuals conceptualize dyadic differences (Pope-Davis et al., 2002; Williams & Levitt, 2008), comparatively little is known about how racial and ethnic minorities seeking treatment in the community perceive and experience race in therapy. Whereas Chang and Berk's (2009) analysis reported only the specific racial attitudes that distinguished satisfied from dissatisfied clients in cross-racial therapy, the present study makes use of a larger sample of participants to describe the full range and complexity of minority clients' racial constructions invoked by the therapy context. Rather than depicting only those appraisals unique to different outcome groups, this study addresses a different question, namely: What are the most common appraisals of race reported by this diverse group of racial/ethnic minorities with histories of cross-racial therapy? By depicting the range and salience of commonly held meanings and experiences of dyadic difference and similarity, the present study complements Chang and Berk (2009) to provide a more comprehensive taxonomy of clients' constructions of race in the therapy relationship.

A qualitative approach was adopted for its ability to render explicit operative tacit assumptions about racial difference, and in particular Whiteness, as they shaped minority clients' perceptions of their White therapists. Hypothesizing that the meaning of racial difference would involve implicit contrasts with individuals' schemas around racial similarity, we also examined clients' impressions and expectations of what it might be like to work with a therapist from their own racial or ethnic group. Descriptive information regarding the numbers of satisfied and dissatisfied clients reporting a particular idea is provided to facilitate interpretation and provide an index of homogeneity of response.

Methods

Data for the present study were drawn from a large consensual qualitative research (CQR) study of psychotherapy process and outcome in cross-racial therapy dyads (see Chang & Berk, 2009 for details). Sharing an emphasis with phenomenology and other qualitative approaches on the reflexivity of the researcher and an analytic process of description, reduction, and interpretation (Wertz, 2005), CQR (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Hill, Thompson, & Williams, 1997) provides a rigorous strategy for determining the representativeness of key themes across cases and minimizing interpretive biases through a process of consensus building across multiple researchers.

Participants and Recruitment

The participants for the present study were drawn from a larger dataset of 33 participants, and included all cases of racial/ethnic minorities who had been in treatment with a non-Hispanic White therapist. The participants consisted of 23 ethnic minorities (13 females, 10 males), 16 of whom were also included in a separate matched pairs study (Chang & Berk, 2009) focusing on client, therapist, and relational factors that distinguished satisfied from unsatisfied clients in cross-racial therapy.

Multilingual advertisements in English, Spanish, Chinese, Japanese, and Korean were used to recruit a racially, ethnically, linguistically, and socioeconomically diverse community of participants in the New York City area. Screening criteria included a perceived racial difference with their therapist (independently confirmed by comparing the participant's self-report of his or her race/ethnicity and that of the therapist) and termination within the prior 12

months. Hispanic participants were included if they identified either a racial or ethnic difference with their therapist. Exclusion criteria included active psychosis, suicidality, other acute symptoms, and current involvement in psychotherapy.

Participant characteristics. The participants consisted of five Asian Americans (four female, one male), nine African Americans (five female, four male), five Hispanic Americans (two female, three male), and four multiracial/multiethnic (two female, two male) participants. Ages ranged from 19 to 55, with an average age of 33.7 years. Six participants had obtained a graduate degree (26.1%), five had graduated from college (21.7%), eight had completed some college (34.8%), and four had graduated from high school (17.4%). Seventy percent of the participants were born in the United States ($n = 16$), and 30% were immigrants ($n = 7$). Five of the seven participants who were immigrants were born in countries in Asia. Seven of the 16 participants (43.8%) born in the United States had at least one parent who was born in another country. In addition, 39.1% of the participants ($n = 9$) identified themselves as gay, lesbian, bisexual, or queer (GLBQ).

Participants completed a checklist of presenting problems that led them to seek treatment. The most commonly reported problems included the following (not mutually exclusive) conditions: "mood swings and depression" (52.2%), "loneliness and isolation from other people" (52.2%), "family conflicts" (47.8%), "career and work-related stress" (47.8%), "feeling anxious for either known or unknown reasons" (34.8%), "dating concerns" (34.8%), "traumatic experience such as physical/sexual abuse, injury, or accident" (26.1%), "problems related to alcohol or drug abuse" (26.1%), "difficulties related to sexual orientation" (26.1%), "academic stress" (26.1%), "other interpersonal difficulties" (21.7%), and "feeling tense in social situations (shyness)" (21.7%).

Therapist characteristics. Participants were asked to describe their experiences working with a specific therapist whom they perceived as racially different from themselves. Besides identifying their therapists as "White," 12 participants also described their therapist's ethnicity, which included Jewish, Greek, Italian, German, Yugoslavian, Ukrainian, and Russian. The majority (73.9%, $n = 17$) of the participants saw female therapists. Eleven participants saw their therapists for at least 1 year (47.8%), seven remained in therapy for 6 to 11 months (30.4%), and five participants were treated for less than 6 months (21.7%). The treatment setting was almost equally divided, with 52.2% of participants seeing their therapist in a private practice ($n = 12$), and 43.5% receiving treatment in a clinic or outpatient hospital setting ($n = 10$).

Participants' satisfaction with their therapy experience was assessed via a single self-report question and confirmed via independent analysis of their summative statements provided in the context of the interview (see Chang & Berk, 2009, for a detailed description of this procedure). Thirteen out of 23 participants (56.5%) described themselves as generally dissatisfied with their therapy experience, with the remaining 10 participants describing themselves as generally satisfied (43.5%). There were no differences between satisfied and unsatisfied participants in terms of age, education, treatment duration, and immigrant status. One notable finding, however, was that 53.8% of the negative outcomes were reported by participants who identified themselves as GLBQ ($n = 7$) compared to only 20.0% of positive cases ($n = 2$). In addition, four out of five (80.0%) Asian Americans and three out of four (75.0%) multiracial/multiethnic participants reported general dissatisfaction with their therapy experience.

Interviewers, judges, and auditor characteristics. Interviews were conducted by a diverse pool of interview staff to facilitate racial/ethnic matching with study participants. The 12 interviewers included three African Americans (two women, one man), three Asian Americans (two women, one man), two Hispanics (one woman, one man), three Euro-Americans (two women, one man), and one Arab American woman. The team of judges consisted of five core members plus up to two additional judges who rotated in as members graduated or left the project. Over the course of these analyses, the judges included one White male, one White Jewish female, three Hispanic females, three Asian-American females, two multiracial Asian-American females, and one African female. Four individuals served as both interviewer and judge. The principal investigator, a Chinese American clinical psychologist, served as an interviewer for three participants and as a judge for the first three transcripts, and assumed the role of primary auditor for the duration of the study.

Procedures

After eligibility was determined through a telephone interview or screening survey completed by email, details of the study were provided and interested participants were invited in for an interview. Informed consent was obtained in person by study

personnel and participants were paid $30 upon completion of a semi-structured interview lasting 1 to 3 hours. Participants were matched to interviewers based on race, ethnicity (for Hispanic participants), gender, and language preference; multiracial participants were asked to indicate their preference regarding the race of their interviewer. All interviews were audio-recorded for transcription and analysis.

To build rapport and collect basic demographic information, the interview began with a series of open-ended questions assessing participants' age, country of birth, parents' country of birth, immigration history (if relevant), occupation, and educational history. Participants were then asked to complete a brief survey that inquired into the nature of the problems that prompted them to seek therapy when they did. As described by Chang and Berk (2009), a modified phenomenological interview followed, beginning with a "grand tour" question in which participants were invited to tell the story of their therapy without explicitly instructing 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 chronological narrative of the participants' therapy, highlighting the most salient events in their recollection of that experience. The initial "grand tour" question was followed with a semi-structured interview that explored key time points in the chronology of the relationship, perceptions of the therapist, the therapeutic relationship, and specific behaviors and interventions considered to be helpful or unhelpful.

Significance of race in the therapy relationship. Explicit inquiries regarding participants' subjective experience and constructions of racial difference in the therapy relationship did not occur until the first phase of the interview was completed. The second phase of the interview introduced these issues (if not already raised by the participant) via exploratory questions regarding racial/cultural identity (not reported here) and the perceived significance and impact that racial differences had on the therapy. Questions assessing the effects of race on the therapy relationship explored both the perceived advantages and disadvantages of mismatching. Participants were also invited to imagine what their experiences might have been like had they seen a therapist that shared a similar racial or ethnic background.

Data Analysis

The interview transcripts were coded and analyzed using CQR (Hill et al., 1997, 2005) with the aid of the qualitative software package Atlas.ti (Muhr, 2004). In an effort to reduce interpretive bias, CQR relies on a consensus building process between the researchers and an auditor who reviews the analysis at each stage of interpretation. Training of judges consisted of reading instructional guides to the CQR method (Hill et al., 1997, 2005), reading exemplar studies using CQR, and working in a team with a more experienced judge. Full details regarding the members of the study team and application of CQR is detailed in Chang and Berk (2009).

Researcher Biases

To facilitate the research team's ability to empathically enter into clients' subjective experiences of therapist race, researchers, interviewers, and judges wrote reflective essays about their own cultural identities and a priori expectations about the study's research questions before initiating the study. The essays were discussed as a group to facilitate communication and to make explicit hidden biases pertaining to race, ethnicity, culture, and the therapy relationship (e.g., "bracketing"). Although true objectivity and neutrality in qualitative data interpretation is unattainable, judges within each coding group made every effort to monitor themselves and each other to minimize the extent to which interpretations of participants' data were being impacted by individuals' own assumptions and biases. The auditor also regularly reviewed the judges' coding work in order to provide an outside perspective and reduce the tendency towards groupthink.

DC is a licensed clinical psychologist and an assistant professor of clinical psychology. A second generation Chinese-American, she has lived and worked in a variety of multicultural contexts. Recalling her own identity development process, she expected that most participants would acknowledge the potential impact that race may have on interracial relationships, although they may be reluctant to address those differences in the context of therapy. PY is a first generation Korean-American doctoral candidate in clinical psychology. Drawing from her own ongoing negotiations of identity across multiple social contexts, she anticipated that the majority of participants might attest to race as being an important factor in their therapy relationship, but that there would be variation in the degree to which they could acknowledge its relevance.

Domain coding. In the first step of CQR, judges separately coded participants' responses into broad domains or categories. The present study focuses only on those related to conceptualizations of race and the perceived impact of racial and ethnic differences in the therapy. Although all participants were selected for having reported a visible racial difference with their therapist, the ways in which they discussed their differences blurred the theoretical distinctions among race, ethnicity, and culture (REC). Cross and Cross (2008) similarly 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, italics added). Reflecting participants' tendency to invoke multiple interpretations of race—as skin color, as power, as ethnicity, as culture—responses were organized into the following three domains pertaining to the impact of REC differences, or "mismatch," on the therapy relationship: REC Mismatch as a Barrier, REC Mismatch as a Facilitator, and REC Mismatch as having Minimal Impact on the Therapy Relationship. Three additional domains were created to describe participants' perceptions regarding how a REC similarity, or "match," might impact the therapy relationship: e.g., REC Match as a Barrier, Facilitator, or having Minimal Impact on the Therapy Relationship. These six domains were initially developed based on open coding of interview transcripts and finalized when subsequent transcripts did not yield additional domain categories. Domain coding for each interview was first undertaken by individual judges who then convened to arrive at a single consensus version. The consensus version was then presented to the external auditor to be reviewed; the auditor's comments were discussed by the original coding team and revisions were undertaken to achieve a final consensus version.

Core ideas. In the second phase of analysis, judges individually prepared written summaries of the major themes that emerged within each of the domains for each participant and then discussed these core ideas in teams until consensus was reached. Again, the consensus version was submitted to the auditor for review, with feedback discussed and integrated to obtain a final consensus version of the core ideas for each participant.

Cross-Analysis

In the final stage of CQR analysis, thematic categories that emerged across cases were identified for each domain. These categories were classified according to their frequency in the total sample. Per the most recent CQR guidelines (Hill et al., 2005), categories were considered *general* if they applied to all cases ($n = 23$), *typical* if they applied to at least half of the cases ($n = 12$–22 cases), *variant* if they applied to a minority of cases ($n = 3$–11), and *rare* if they applied to two cases. As with each stage of CQR, the cross-analysis was audited by the first author and discussed by the team until consensus was reached.

Auditing and Consensus Building

When disagreements and discrepancies arose in the coding process, judges provided supporting evidence from the transcript and discussed ways to refine the category until consensus was reached. Most instances of discrepancies between judges and auditor stemmed from the challenge of distilling transcript passages down to their essence. For example, while coding under the domain of "Match as Facilitator," one judge articulated the category: "Racial/ethnic match allows the assumption of a shared understanding about the real complexities of racial/ethnic identity." Although the other judge did not initially detect this particular theme, there was enough evidence to develop the category and present it to the auditor for review. The auditor in turn, questioned whether this idea might be subsumed under a previously created category, "Matched therapists would be able to better understand key aspects of their experience as a person of color." Judges and auditors convened and following a group discussion, agreed to subsume the category.

Validity Checks

To assess the stability of the findings, initial analyses were first completed on data provided by 16 participants (Chang & Berk, 2009), followed by the addition of seven more cases. Results indicated that the initial categorical structure had reached saturation, with few changes in the frequency classifications associated with each category and no new categories generated. To obtain some evidence of validity for the main study findings, the research team conducted member checking. Participants who consented to be contacted after the completion of the study were invited to attend a discussion of the preliminary findings from several studies drawing from the larger dataset. Five participants attended the meeting and were given the opportunity to offer feedback and suggest interpretations of the main study findings (e.g., typical categories), which were based on an initial analysis of 16 cases. Participants

who were unable to attend the meeting were sent a summary of the preliminary results and were encouraged to send their feedback by e-mail although none did. The participants' feedback from the member-checking meeting informed our interpretations of the main results.

Results

As mentioned, although the interview attempted to elicit participants' appraisals of the meaning of race in the therapy relationship, participants' analyses blurred the distinctions among race, ethnicity, and culture. They revealed complex and at times contradictory perceptions of their role and impact, as evidenced by the classification of each individual's responses into an average of seven different thematic categories (out of a total of 22) across the six domains of REC Mismatch (Barrier, Facilitator, Minimal Impact) and REC Match (Barrier, Facilitator, and Minimal Impact). Client perspectives on racial mismatch and racial match are summarized in Table I and II, respectively. Below, we highlight the most common categories that emerged in the analysis.

Perspectives on Racial Mismatch

Mismatch as a barrier to the therapy relationship. Of the 23 participants, nineteen perceived mismatch as a significant barrier to the therapy relationship (see Table I). This view was expressed by a majority of both satisfied ($n = 7$ of 10) and dissatisfied ($n = 12$ of 13) cases, suggesting that REC differences are viewed as inherently divisive but may be overcome under certain conditions. Two categories emerged as typical, with the majority of participants conveying a feeling of disconnection and cultural distance in relation to their non-Hispanic White therapists.

Participants felt that their White therapists simply could not understand their experiences as people of color (Typical). The majority of participants ($n = 16$) felt that they could not be understood on a deep, emotional level because their therapists were limited in their ability to appreciate how their minority status and identity as a racial and ethnic minority shaped their lives. A mixed Latino/Jewish male described feeling as though his therapist could not understand his efforts to achieve a positive ethnic identity: "Yeah. It's so hard, I feel, for her to empathize with my struggling for identity. Trying to reclaim my Latino identity while at the same time upset that I am always the darkie."

A Black male explained how his White therapist seemed to only have second-hand knowledge of the inner city community he grew up in and how that limited her ability to understand him: "Pursuing an education ... that was few and far between in the African-American community. She just couldn't understand that. That I had an older brother, I had to be tough. I had to be rough. I had two sisters, I had to protect them... She just didn't understand the importance that it had in the Black community ... She just couldn't get that at a level where I needed her to."

Participants refrained from talking about certain racial/cultural issues (Typical). One consequence of these feelings of isolation and cultural distance was that the majority of participants ($n = 14$) refrained from bringing up racial and cultural issues with their therapist. Specifically, they found it difficult to discuss experiences of racial oppression, specific cultural practices, and family or community dynamics due to concerns that their therapists would not respond with empathy, validation, or cultural sensitivity. For example, an Asian-White mixed-race participant expressed concern that her White female therapist would not validate her experiences of racial prejudice, which led her to avoid broaching such issues with her:

> [Racism] is always presented as a Black-White issue ... kind of this really mean, hostile stuff that happens to Black people ... So the kind of racism that happens to Asian people within that perspective wouldn't be recognized and a lot of things are just kind of unsettling, like, "Was that racist?" ... So because the things that would happen to me are really petty, but impactful, if I told a White person this happened, they'd be like, "Oh, that's nothing." They don't understand ... that these are collective experiences that build up ... I'd have to explain it to them first and then explain why it's offensive to me, so those kinds of issues could arise with her too.

A Puerto Rican female participant felt that her White therapist lacked cultural knowledge about Latino families and Nuyorican families in particular. She reported that her therapist insisted that she directly raise certain issues with her family in a "roundtable" discussion style, which she felt was culturally inappropriate. The participant also felt that her therapist misunderstood her usage of slang as well as her body language, which contributed to her reluctance to discuss certain aspects of her life history that she felt her therapist would likewise fail

Table I. Perceptions regarding the significance and impact of racial mismatching in therapy

Category description		Frequency
Mismatch as a barrier		
1.	Participants assumed that White therapists could not understand their experiences as people of color	Typical
2.	Participants refrained from talking about certain racial/cultural issues	Typical
3.	Therapists were seen as possessing superficial, "textbook" knowledge about issues pertaining to their communities	Variant
4.	Therapists were dismissive of participants' experiences of racial/ethnic oppression	Variant
5.	Therapists' communication style was seen as culturally incompatible	Variant
6.	Participants felt that a foreign-born therapist would not be able to understand or relate to their experiences	Variant
7.	Therapists' lack of cultural knowledge or sensitivity was seen as inhibiting growth and progress in therapy	Variant
Mismatch as a facilitator		
1.	Certain issues were easier to discuss with White therapists	Variant
2.	White therapists were seen as offering an informed or insider's perspective on issues related to clients' presenting problem	Variant
3.	Participants developed a positive ethno-cultural transference based on positive racial/ethnic stereotypes of White majority therapists	Variant
4.	Therapists from a different background were able to appreciate the uniqueness of their individual experiences	Rare
Mismatch as having minimal impact		
1.	Certain therapist characteristics or skills were seen as more important	Typical
2.	Participants emphasized other demographic similarities with the therapist	Variant
3.	REC differences were seen as secondary to participants' presenting problems	Variant
4.	Participants and their therapists were able to work through difference that arose	Variant

Note. Categories were considered *general* if they applied to all 23 cases, *typical* for at least half or 12–22 cases, *variant* if they applied to 3–11 cases, and *rare* if they applied to two cases.

to appreciate (e.g., growing up in the projects, knowing people who are in jail).

In a few instances, respondents were concerned about offending the therapist because of their demographic characteristics. For example, one mixed Native American and Lebanese female who was dealing with issues of trauma and PTSD felt that her therapist was unable to understand the historical trauma that was so integral to her heritage. She feared that her therapist, whom she perceived as coming from a different social class and cultural value framework, might take offense at the characterization of Native people as historically oppressed by White "conquerors." As a result, the participant felt compelled to avoid discussing this important aspect of her cultural identity with her therapist.

Table I lists five additional variant categories describing how REC differences were perceived by participants as barriers to the formation of a strong working relationship. Participants in the study described their therapists as possessing "superficial," "textbook" knowledge of their communities, expressing racial/cultural biases or stereotypes, and minimizing participants' experiences of oppression. A minority also noted that their therapists' lack of culture-specific knowledge significantly limited their ability to adequately address their presenting problem, inhibiting growth and progress in therapy. Participants also wondered whether their therapists' apparent lack of engagement was due to discomfort or difficulty relating to someone of a different race, ethnicity, or culture. Cultural differences in language usage and communication style (e.g., direct versus indirect communication, proxemics) were also seen as impediments to the relationship. This was particularly true for participants who worked with therapists whom they knew or assumed to be born outside the USA. These therapists, from countries including Russia and Germany, were also believed to have a limited ability to understand or relate to the experiences of participants who were born and raised in the USA.

Mismatch as a facilitator of the therapy relationship. While the majority of participants viewed REC differences as problematic in their most recent experience of cross-racial therapy, seven noted that those differences were in fact helpful in building a positive relationship. This perspective was expressed by half of those reporting a satisfying experience ($n = 5$ of 10) but only a minority ($n = 2$ of 13) of those reporting a dissatisfying experience of cross-racial therapy. Three variant categories and one rare category emerged in the analysis. One

subgroup of participants stated a clear preference for working with a racially different therapist, believing that certain issues were easier to discuss with a White therapist. Here participants' positive expectancies regarding their White therapist were explicitly linked to their discomfort around seeing a therapist from their own group (see also "Match as a barrier to the therapy relationship"). For instance, a Korean-American female who had been abused by her uncle had concerns about seeing a Korean therapist who "would then turn around and blame me. Like, oh [the abuse happened] because you weren't being a dutiful daughter." In addition, several Black and Asian-American respondents felt it was much easier to talk about issues related to sexuality and sexual identity with a White therapist.

White therapists from the study were also seen as offering a unique perspective perceived to be useful in working through issues related to acculturation and navigating majority culture. A number of participants also expressed a positive ethno-cultural transference towards their White therapists based on racial and/or ethnic stereotypes. One Black man described his initial impressions of his therapist as "the little, Jewish grandmother. A broad, considerate person ... she's going to give you some soup to soothe your pain and aches." Although this therapist ultimately did not live up to his fantasy of her, his positive stereotype-based expectancies contributed to the development of a strong working relationship during the initial phase of therapy. Respondents also viewed their White therapists as more open-minded, more accepting of different lifestyle choices, and more expert than their minority counterparts. In particular, participants who worked with Jewish therapists viewed them as especially credible helpers given their cultural associations with Freud and the psychoanalytic tradition. Lastly, several participants noted that working with a racially and culturally different therapist allowed them to feel special and their experiences to be validated as unique. One Hispanic male felt that his White therapist responded with a level of concern and interest in his experiences of discrimination, which he imagined would have been normalized by someone who shared his background.

Mismatch as having a minimal impact on the therapy relationship. Sixteen of the 23 participants stated that there were some aspects of racial/ethnic mismatch that had only a minimal impact on the therapy relationship. Notably, all of those who had a satisfying experience of cross-racial therapy endorsed this view, compared to less than half ($n = 6$ of 13) of those who had negative experiences. Analyses revealed one typical and three variant categories for this domain.

Participants perceived certain therapist characteristics and/or skills as more important than REC (Typical). The one category that emerged as typical across the sample involved participants' perception that certain therapist characteristics and skills were more important than demographic differences in fostering a strong working relationship. These included therapist characteristics such as having a sense of compassion, caring without judgment, and being open to and comfortable talking about difficult issues. One Hispanic male articulated this perspective:

> If you're a good psychiatrist, and I guess you're open-minded ... the same good advice should work for everybody. [Pause] I mean, if I go in to see a [non-Hispanic] psychiatrist, and I'm having problems with a relationship, I don't understand how, like, them giving me advice is going to be any different than a Hispanic person telling me the same exact thing.

Although most of the respondents who shared this view tended to endorse a universalist perspective on healing, some cited culture-specific interventions that helped to minimize the impact of perceived difference. Three additional variant categories also emerged, primarily in the narratives of participants who were satisfied with their treatment experience. First, some participants emphasized demographic characteristics and personal experiences that they had in common with their therapist (e.g., education, sexual orientation, travel experiences, etc.) rather than focusing on their REC differences. Some participants from the sample also viewed REC differences as less important than their reasons for seeking help in the first place. Finally for some participants, REC differences were minimized as a result of their active efforts and their therapist's ability to work through any resulting problems that arose.

Perspectives on Racial Match

In a later exploratory part of the interview, participants were asked to imagine what it might have been like to work with a therapist from a similar racial, ethnic or cultural background. While responses varied widely (see Table II), the majority assumed that REC matching would reduce barriers to understanding and facilitate the development of the therapeutic relationship.

Table II. Perceptions regarding the significance and impact of racial matching in therapy

Category description		Frequency
Match as a facilitator		
1.	Matched therapists would be able to better understand key aspects of their experience as a person of color	Typical
2.	Matched therapists would be more knowledgeable and capable of helping them deal with issues of oppression	Variant
3.	It would be easier to discuss sensitive issues with someone from their own group	Variant
Match as a barrier		
1.	Matching would increase self-consciousness about personal issues that conflict with values and attitudes endorsed by members of their own group	Variant
2.	Matching could lead to overidentification, inviting comparisons that could adversely affect the therapy	Variant
Match as exerting minimal impact		
1.	It is more important that match be specific and relevant to participants' particular experiences, issues, and concerns	Variant
2.	Therapists' abilities to provide practical solutions and intervention strategies are more important than racial/ethnic matching	Rare

Note. Categories were considered *general* if they applied to all 23 cases, *typical* for at least half or 12–22 cases, *variant* if they applied to 3–11 cases, and *rare* if they applied to two cases.

Match as a facilitator of the therapy relationship. Fifteen participants believed that seeing a therapist of the same race or ethnicity would enhance the therapy experience. A greater proportion of participants dissatisfied with their recent experience of racial/ethnic mismatch expressed this view compared to those who reported being satisfied ($n = 10$ of 13 vs. 5 of 10, respectively). This domain yielded one typical category and two variant categories.

Participants believed that racially/ethnically similar therapists would be better able to understand key aspects of their experience (Typical). This category may be seen as a corollary to the previously discussed typical category, "Participants felt that their White therapists simply could not understand their experiences as people of color." These categories co-occurred in 11 of the 23 cases, suggesting a logical relationship between the two. An Asian male believed that having a therapist of the same ethnicity or race would mean that he "would not constantly have to explain 'Asian culture is not like this. That's just a stereotype'." Similarly, a Black woman felt that it would have been helpful if her therapist had been Black because "I think we could have gotten to some critical issues quicker than me having to talk about it with someone White. Someone of your own cultural background would understand it better."

Notably, a fair number of participants from this sample assumed that racially or ethnically similar therapists would be more knowledgeable and capable of helping them to deal with issues related to oppression and minority status. A Black woman imagined that a Black therapist who had been through similar struggles would be able to give her more specific advice that related to her situation, instead of just "following a script." She felt strongly that it is difficult for people of another race to understand the specific struggles that those of another race are facing:

> with race, it's just there, it's not like something you describe, and it's there, you wear it as a person, and I think you wear it in your life, and hence you wear it when you come into therapy so maybe you need someone that is wearing the same thing as you.

Finally, a number of participants also perceived that a match would provide a level of comfort that was essential in openly discussing sensitive issues like race and sexual orientation.

Match as a barrier to the therapy relationship. Nine participants imagined that racial matching in therapy would present challenges to the therapy relationship. Of those who viewed matching to be problematic, four had a satisfying experience, while five had an unsatisfying experience with a White therapist. Analyses yielded two variant categories, which frequently co-occurred with categories in the domain *REC Mismatch as a Facilitator.* First, participants were concerned that a match would increase self-consciousness about personal issues that conflict with values and attitudes widely endorsed by members of their own racial or ethnic group. As mentioned earlier, several Asian and Black participants cited particular discomfort discussing issues related to their own sexuality, given cultural taboos and stigma surrounding homosexuality and

extramarital sex in particular. For instance, a Filipino woman admitted that she might feel "ashamed and shy" to tell a Filipino therapist that she lives with her boyfriend given taboos regarding premarital sex. A Black gay male described why he deliberately avoided seeing a Black therapist:

> A Black female would have been out of the question primarily because most of the time they are church-going females and it would have been difficult for me. I have sexuality issues that I'm dealing with ... That would have been difficult for me to discuss openly—about hurt, loneliness, what I'm looking for. That would have been difficult for me to face a Black woman and say those things to her.

Second, participants believed that a match could lead to overidentification by one or both parties, inviting comparisons that could adversely affect the therapy relationship. For example, a Black male participant explained how he did not want to "sit across from a mirror image" because "if I'm looking across at a young African-American male and they are doing something that I feel as though I should be doing or I should have done or they've gone to a level of education that I haven't obtained yet then I would feel a little bad and a little envious." A Hispanic male also appreciated that his therapist was not from his own community, because it allowed him to receive sympathy and support for his experiences of discrimination, which he felt might be glossed over by a Hispanic therapist who may have become desensitized to these issues.

Match as having minimal impact on the therapy relationship. Similar to those who were indifferent to the effects of racial mismatch under certain conditions, six participants felt that seeing a racially similar therapist would have little to no impact on the therapy alliance. This was true for two of those satisfied and four of those dissatisfied with their cross-racial therapy experience. Several of these participants felt that it was more important that a match be specific to their experiences and presenting concerns. For instance, the mixed Latino-Jewish male noted that while his therapist was Jewish, she could not personally relate to his experience of having to prove his Jewish heritage related to "not looking Jewish enough." In another case, a Chinese female clarified that even if she had seen a Chinese therapist, she could not assume that they would have had experiences in common. Finally, a small minority of participants believed that therapists' abilities to provide practical solutions and intervention strategies were more important than shared REC.

Discussion

The present study explored individuals' constructions of a very specific, and intimate type of interracial interaction—that of the psychotherapy relationship. We sought to map the range of racial/ethnic minority clients' reactions to working with a non-Hispanic White therapist, while also drawing out their implicit comparisons to an imagined therapy relationship with a racially matched therapist. The resulting taxonomy of therapy-related racial attitudes reveals a broad range of racial associations, suggesting the multidimensional nature of clients' understandings of race, and the conditions under which it seems to matter greatly or not at all.

The results of this study should be interpreted with several limitations in mind, most importantly the retrospective nature of clients' accounts. What this study captures is not the moment-to-moment, or even session-by-session, shifts in participants' racial constructions, but rather their summative evaluations of their overall interracial experience. Because participants' evaluations of race in the relationship are likely to affect and be affected by their degree of satisfaction with the treatment itself, we purposely sampled both satisfied and dissatisfied clients so as not to bias our results. Furthermore, we sought to guard against recall biases by inquiring about both the positive and negative aspects of their experience. In addition, while we acknowledge that clients may not be able to fully access their racial transference reactions, evidence suggests that individuals' explicit beliefs and attitudes about race, ethnicity, and culture are predictive of a number of important clinically relevant attitudes and judgments including preferences regarding therapist race (Pomales, Claiborne, & LaFromboise, 1986; Townes, Chavez-Korell, & Cunningham, 2009), perceived credibility of different treatment modalities (Wong et al., 2003), and evaluations of the therapist (Kim et al., 2005; Pomales et al., 1986). A related issue is that this study's emphasis on clients' subjective experiences of race does not capture the manner in which race and racial differences were intersubjectively negotiated within each dyad. As such, we understand the results to represent participants' internal representations of their experiences of race, inclusive of any filters on memory or expression. Other aspects of the study design should also be considered when interpreting the results. For example, by beginning the interview with questions about family history, including country of origin, we may have inadvertently created an unknown set of demand characteristics. In addition,

given participants' inability to precisely describe the nature or orientation of mental health treatment received, we are unable to consider the extent to which different treatment modalities may condition different experiences of race in the relationship.

With these caveats in mind, study findings reveal that race was a salient aspect of participants' experience of cross-racial therapy, affecting decisions regarding self-presentation and self-disclosure, as well as feelings of trust and comfort in the relationship. Data analysis revealed 15 unique categories regarding racial mismatch and seven unique categories regarding racial match. Of these, three categories were expressed by the majority of participants, with the remaining 19 emerging in less than half of the group. Given space restrictions, we will limit our discussion to these three most salient categories, keeping in mind that the larger number of variant categories suggests that participants' views of race were multifaceted and uniquely configured beyond these shared dimensions.

First, despite the recruitment of high numbers of individuals who were satisfied with their recent experience of cross-racial therapy, the vast majority of participants felt that racial differences presented barriers to the development of the relational bond, and harbored the belief or wish that seeing a therapist of the same background would engender a deeper understanding. This is consistent with previous findings that many minorities prefer to see a therapist of the same race or ethnicity (Atkinson, 1983; Helms & Carter, 1991), reflecting the common assumption that within-group members are more likely to share similar attitudes, values, and experiences.

Indeed, participants felt strongly that White therapists could not appreciate how their minority status and culture shaped their psychological development (e.g., identity and values) as well as their external reality of prejudicial and discriminatory treatment. For the majority of participants, this perceived gulf in lived experience led them to avoid discussing certain racial, ethnic, or cultural issues out of concern that their therapist would respond with insensitivity, lack of interest, or ignorance. In other words, it appears that the minority clients in this study purposely concealed aspects of their personal histories and experiences to decrease their (real or imagined) exposure to racial microaggressions, defined as subtle but pervasive acts that communicate, intentionally or unintentionally, demeaning messages to people of color (Constantine, 2007; Sue et al., 2007).

Although we do not know what therapist behaviors or interpersonal dynamics may have contributed to client decisions to withhold information, the literature suggests that this high rate of deliberate concealment of personally relevant information is atypical. Most studies have found that the majority of clients do not purposely hide information from their therapists (Hill, Thompson, Cogar, & Denman, 1993; Kelly & Yuan, 2009). However, as Hill, Gelso, and Mohr (2000) noted, the construct of client concealment is multidimensional, encompassing a broad range of phenomena including "hidden reactions," "things left unsaid," and "secrets," with different motivations for each. Although none of the recent reviews on this topic refer specifically to clients' concealment of racial, ethnic, and cultural content, a common theme is that clients conceal what is shameful or negative (Hall & Farber, 2001; Hill et al., 1993) so that the therapist will adopt or maintain a favorable impression of them (Kelly, 2000).

In this study however, participants' decisions to conceal or minimize aspects of their experience as a racial/ethnic minority rarely stemmed from internalized feelings of shame or stigma. Rather clients described the delicate balance between wishing to reveal their true selves in the sanctuary of the therapy space, while at the same time needing to protect themselves against exposure to oppressive or discriminatory treatment from the therapist. As such, the therapy context was viewed as a microcosm of race relations in society, and activated a host of coping strategies for dealing with the anxieties of cross-racial interactions.

Invoking the construct of "healthy cultural paranoia" observed in Black Americans (Ridley, 1984), or its reformulation as "cultural mistrust" (Whaley, 2001), minority clients' concealment behaviors may reflect a practical strategy for negotiating interracial relationships, particularly those in which there is an explicit power differential. As Hill et al. (2000) noted, clients are often cautious at the beginning of therapy with regard to what they reveal about themselves, starting with small disclosures as a means of testing the therapist's reactions before proceeding to more intimate self-disclosures. As such, self-concealment "may represent healthy ego functioning for clients to be aware of what they can handle in terms of disclosure and what therapists can handle in terms of being able to respond to disclosures" (p. 496). A qualitative study of clients' experiences of cross-cultural therapy found that they demonstrated similar judiciousness in deciding what and how much to self-disclose based on their appraisals of the therapist's strengths and abilities (Pope-Davis et al., 2002).

In Chang and Berk's (2009) analysis, which included many of the same participants as in the present investigation, clients' efforts to keep racial, ethnic, and cultural issues from seeping into the therapy work despite their personal significance was conceptualized as compartmentalization. Echoing Pope-Davis et al. (2002)'s findings, compartmentalization was associated with higher levels of

satisfaction with cross-racial therapy, leading the authors to conclude that it was an adaptive response to the therapist's limited cultural knowledge and skill set. However, they also noted that individuals who were satisfied working cross-racially, due to their personal racial attitudes, may have been more willing and able to present edited versions of themselves in order to accommodate the therapist's lack of cultural competence and expertise.

In contrast, clients who were dissatisfied with cross-racial therapy had higher expectations that the therapist would be more culturally aware and willing to delve into racial, ethnic, and cultural issues. For these cases, decisions to restrict information about one's experiences as a minority were made reluctantly, often following failed attempts to elicit the therapists' cultural empathy. For these individuals, the personal costs of self-concealment were much higher and had an adverse impact on the working alliance. These differential findings are in keeping with the mixed results in the literature on self-concealment, and suggest that although self-concealment was a common experience of minority clients in the present study, the motivations, costs, and consequences of self-concealment may vary substantially across individuals (Hill et al., 2000).

A second key finding of the present study was that in spite of the negative connotations of racial mismatch, approximately 70% of the participants felt that racial differences receded in importance if the therapist was perceived as compassionate, unconditionally accepting, and comfortable talking about REC-relevant issues. Other conditions that reportedly reduced the impact of race on the therapy relationship included clients' ability to identify with the therapist on other dimensions (e.g., gender, class, sexual orientation), a presenting problem that was seen as acute or culture-general (e.g., depression, anxiety), and the ability of the therapist and client to negotiate cultural misunderstandings if and when they arose. Other studies examining clients' negotiations of therapist-client differences have similarly found that emphasizing similarities and focusing on factors that support the therapeutic relationship helped to create a feeling of safety during moments of perceived difference (Pope-Davis et al., 2002; Williams & Levitt, 2008). Variation on these individual difference and therapeutic process variables may help explain why racial mismatch itself is not a robust predictor of treatment outcome (Maramba & Hall, 2002; Sue & Zane, 1987), highlighting the therapeutic alliance as an important target for intervention in cross-racial therapy (Vasquez, 2007).

Lastly, a distinct subgroup of participants expressed positive expectancies and experiences of racial mismatch, while emphasizing the disadvantages of a racial match. For these participants, therapists' Whiteness decreased the felt sense of shame and stigma stemming from culturally incongruent aspects of the self. Perceptions of similarity along other dimensions of identity were especially important in the early and middle phases of therapy, where the emphasis was on increasing self-acceptance. However, as Chang and Berk (2009) reported, some clients reached a point in the work when they began to desire greater cultural understanding and assistance integrating previously split-off aspects of their racial and cultural identity. Despite their satisfaction with cross-racial therapy, these clients in particular expressed an interest in seeing a racially similar therapist the next time around.

Implications for Clinical Practice, Training, and Research

Additional research, including quantitative studies, is needed to replicate these qualitative results; however, our finding that the majority of minority participants viewed racial differences as an impediment to the therapy relationship supports recommendations that therapists seriously consider how to assess and address these concerns with their clients (Day-Vines et al., 2007; LaRoche & Maxie, 2003). Clients' decisions to withhold racial, ethnic, and cultural aspects of themselves out of worry, and in some cases fear for the therapist's response, highlights the need for White therapists in particular to convey their interest and comfort discussing how sociocultural factors may shape clients' life experiences, their presenting concerns, and the therapy relationship (Cardemil & Battle, 2003; Fuertes et al., 2002; Knox et al., 2003; Maxie et al., 2006). Depending on therapists' therapeutic orientation and individual patient characteristics, therapists may elect to communicate their openness and awareness in different ways, including explicit conversations about racial differences (Day-Vines et al., 2007; Fuertes et al., 2002; Knox et al., 2003), statements and questions that communicate a cultural orientation (Thompson et al., 1994), acceptance and validation of client disclosures about issues related to race, ethnicity, and culture (Day-Vines et al., 2007), and the inclusion of decorative elements in the therapeutic environment that convey a multiracial and multicultural focus (Zhang & Dixon, 2001). A growing body of evidence suggests that therapists who convey cultural responsiveness in such ways are rated as significantly more credible and competent by clients of color (Atkinson, Casas, & Abreu, 1992; Constantine, 2002; Gim et al., 1991).

However, therapist effectiveness in cross-racial situations requires more than the implementation of specific behaviors and the acquisition of specific cultural knowledge. As studies have demonstrated, many White clinicians feel uncomfortable broaching the topic of race in therapy, whether directly or indirectly, due to their own cultural and racial socialization (Utsey et al., 2005). Fittingly, a number of participants in our study described their sensitivity to behaviors suggesting that their therapists were not genuinely interested in their experiences beyond their "textbook" training in multicultural issues. These results suggest that the training of culturally competent therapists and counselors should also include consciousness-raising and the opportunity to examine and work through one's own racial anxieties. This preparation may help therapists to address racial dynamics as needed with greater comfort and cultural empathy (Comas-Diaz, 2006; Vasquez, 2007). Opportunities to dialogue with other therapists who are experienced working with particular cultural groups, or who may have insight into the challenges of negotiating intergroup relationships, may also provide modeling for counselors-in-training.

Besides their implications for clinical training and practice, the results of this study highlight several important areas for future research. Perhaps most critically, process and outcome studies involving actual cases of cross-racial therapy are needed to evaluate the relationship between clients' appraisals of race in the relationship, their in-session affect and behavior, and how these components interact with therapist appraisals, affect, and behavior to affect the therapeutic alliance. Whereas this study revealed the multidimensional nature of participants' racial constructions, process studies that specifically examine how racial meanings are intersubjectively negotiated in different cross-racial dyads would illuminate how the salience of different racial constructions may be responsive to different therapist interventions. Given the complexity of race relations across communities, studies should also explore the racial constructions and relational dynamics of specific client-therapist racial/ethnic pairings (e.g., Asian-Black, Black-Hispanic, White-Asian), particularly those involving racial/ethnic minority therapists. Studies that examine appraisals of other visible therapist identities (i.e., gender and age) as they intersect with race may also offer a more accurate representation of clients' appraisal processes, particularly in the early stages of impression formation. Also needed are assessment tools and strategies for identifying important individual characteristics that may require different approaches for addressing dyadic differences in therapy. For example, the findings of the present study suggest the potential usefulness of a racial attitudes scale that examines attitudes, beliefs, and concerns specific to the therapy context. The intimate yet hierarchical nature of the therapy relationship combined with the particular tasks of therapy appear to elicit context-specific appraisals regarding racial difference and similarity beyond the general attitudes captured in other widely used racial attitude scales (e.g., Helms, 1995; Helms & Parham, 1996; Neville, Lilly, Duran, Lee, & Browne, 2000). These findings raise the possibility that clients' therapy-specific racial constructions may moderate the relationship between racial mismatching and therapy process and outcome, a premise that should be explored further in survey research involving larger client samples.

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