Acknowledgment of Culture and Stereotypes: Black Participants’ Perceptions of Specific Therapist Behaviors

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ACKNOWLEDGMENT OF CULTURE AND STEREOTYPES: BLACK PARTICIPANTS’ PERCEPTIONS OF SPECIFIC THERAPIST BEHAVIORS

A Thesis Presented
by
TSOTSO T. ABLORH

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ACKNOWLEDGMENT OF CULTURE AND STEREOTYPES: BLACK PARTICIPANTS’ PERCEPTIONS OF SPECIFIC THERAPIST BEHAVIORS

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The current study sought to understand what types of behavior from therapists are most likely to lead to positive outcomes for Black clients with a variety of cultures and ethnicities. Responses to three categories of therapist behavior were examined: 1) Culturally Sensitive behaviors, which exemplify methods encouraged by common multicultural training, 2) Counterstereotypical behaviors, involving particular attention to the impact of a context of racial stereotypes, and 3) Well-Intentioned but Harmful Approaches or Methods (WHAMs), which include microaggressive behaviors common to well-meaning therapists. Participants responded using four variables associated with positive mental health outcomes: trust, belief in genuine investment, disclosing deeper feelings, and likelihood to return.

Results indicated that the three therapeutic behavior categories were not psychometrically distinct; however, Culturally Sensitive and Counterstereotypical behaviors generally received significantly higher ratings of likelihood to return, trust, belief in genuine investment, and likelihood of disclosing deeper feelings than WHAM behaviors. Complex patterns of responses were found related to participant ethnicity.

This research indicates a positive effect of understanding, acknowledging, and addressing the context of negative and seemingly positive stereotypes that people of African descent are forced to navigate. Future studies could improve upon this one by further qualitatively investigating how Black people perceive each specific behavior included in the vignettes.
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CHAPTER 1
SPECIFIC AIMS

Researchers have consistently found concerning health disparities for racial and ethnic minorities (Alegría, Chatterji, et al., 2008; Larrison & Schoppelrey, 2011; Maura & Weisman de Mamani, 2017), as well as specifically for Black people in the United States (Hamilton et al., 2015; Kane et al., 2014; Lagomasino et al., 2011; Shin et al., 2016; Tillman et al., 2010). Among the large body of literature about mental health disparities for Black people, there is evidence that Black people experience more self- and public stigma about mental health than other racial groups (Abdullah & Brown, 2011), as well as greater attrition in therapy (Owen et al., 2012), less recognition of ADHD and affective symptoms by clinicians (Coker et al., 2016; Lau et al., 2012; Morgan et al., 2013), and more frequent diagnoses of psychotic and externalizing disorders (Hamilton et al., 2015; Nguyen et al., 2007). Mental health disparities exist for Black people at all levels (in well-resourced and under-resourced institutions, as well as institutions serving predominantly racial minority populations) and at all stages in the process of receiving mental health care (admission, referral, care given during appointments, diagnoses, follow-up, post-hospitalization care, and treatment outcomes; Hamilton et al., 2015; Kane et al., 2014; Lagomasino et al., 2011; Maura...
Psychologists have been studying and discussing differences in the quality of care for Black people for more than 30 years (e.g., Morten & Atkinson, 1983) to better understand what mechanisms and factors may lead to worse mental health outcomes for Black people.

Some researchers point to client characteristics and behaviors such as mental health stigma, beliefs about disclosing personal information, low mental healthcare utilization, and early termination of therapy as the primary source of mental health disparities for Black people. However, there is evidence that differentially negative outcomes by race are partially accounted for by therapist behaviors and traits (Larrison & Schoppelrey, 2011; Owen et al., 2012). Specifically, researchers suggest that systemic and institutionalized racism within the healthcare system, microaggressions from specific therapists, negative stereotypes individuals hold about people of African descent, and differences in therapists’ interpersonal behavior contribute to disparities directly and precipitate client traits associated with worse mental health outcomes (Constantine, 2007; Gómez, 2015; Owen et al., 2012). While it is important to understand client-level factors as well, this study focused on therapist behaviors as they can be impacted more directly by psychologists. I suggest that intervening on therapist behaviors, particularly therapists’ awareness and acknowledgment of a context of stereotypes for people of color, would ameliorate institutional distrust and improve clients’ willingness to disclose deeper feelings, belief in genuine investment from therapists, and likelihood of returning to therapy. Consequently, this study aimed to take a first step towards
improving therapists’ interactions by better understanding how people identifying as “Black” respond to different types of therapist behaviors.

**Overall Aim**

The overall aim of this study was to explore how Black participants respond to hypothetical therapists’ therapeutic approaches in order to better understand practices that will promote continuing in therapy and thereby, better mental health outcomes. The therapeutic approaches examined here fall into three categories: 1) Culturally Sensitive approaches, 2) alternative approaches that acknowledge marginalization (Counterstereotypical), and 3) potentially microaggressive approaches (Well-Intentioned but Harmful). Distinctions between these three categories of behavior and their impact on Black participants were examined through participants’ self-reports of four client response variables: their likelihood to return to therapy, and three factors important to the maintenance of a positive therapeutic alliance (degree of trust in the therapist, willingness to disclose deeper feelings, and belief in genuine investment from these hypothetical therapists). The four client response variables were included in a new measure, called the Perception of Therapist Behavior measure, which is described in more detail later. Each client response variable is related to therapy outcomes that impact mental health outcomes, specifically retention in therapy and therapeutic alliance (Abdullah & Brown, 2011; Chang & Yoon, 2011; Gómez, 2015; Maura & Weisman de Mamani, 2017; Tillman et al., 2010).
**Overall Hypothesis**

I hypothesized that Black participants would report greater likelihood to return to therapy as well as higher trust, belief in genuine investment, and willingness to disclose deeper feelings with hypothetical therapists who demonstrate their understanding and valuing of how culture and stereotypes impact the participant (by exhibiting Culturally Sensitive or Counterstereotypical behavior) than with those who engage in Well-Intentioned but Harmful Approaches or Methods. In addition, it was possible that participants would respond differently to Counterstereotypical approaches than to Culturally Sensitive methods in terms of the four client response variables.

**Aim 1**

To develop a preliminary measure of Black people’s reactions and thoughts about therapist behaviors that impact mental health outcomes (Perceptions of Therapist Behavior measure). Given that information about Black people’s reactions to specific therapist behaviors frequently comes from convenience samples of participants already attending therapy, this study sought to measure reactions to hypothetical therapists in order to capture responses from a wide range of Black people, including those who do not engage in the current forms of therapy available. The measure development process included reviewing the literature, developing a consultation team, deriving categories of therapist behavior, and deriving variables related to client perception and therapeutic outcomes. Figure 1 depicts the structure of the variables explored in this study within the Perceptions of Therapist Behavior measure.
Aim 2

To perform validity checks on the three derived categories of therapist behavior, as well as on the four client response variables. This included exploring whether the three therapist behavior categories were psychometrically distinct and conceptually exploring relations between therapeutic alliance and retention. Specifically, I 1) examined associations between the four client response variables within each category of therapist behavior (that is, across vignettes within each category of therapist behavior) as well as between each client response variable across the three categories of therapist behavior (Culturally Sensitive, Counterstereotypical, and WHAM or Well-Intentioned but Harmful Approaches or Methods) to assess whether responses to vignettes within one behavior category correlate more with each other than with responses to vignettes in other behavior categories and 2) explored
associations of the three alliance-related variables (trust, belief in genuine investment, and disclosing deeper feelings) with likelihood to return for each vignette to determine whether the alliance-related variables have a positive relation with the retention-related variable (likelihood to return).

**Aim 2 Hypotheses**

a) I expected participants’ responses to each client response variable to be more strongly positively correlated within the therapist behavior categories than across them, indicating that the three therapist behavior categories delineated in this study are distinct in their impacts on people of African descent (as depicted in Figure 2) (i.e., if belief in genuine investment were to correlate more strongly between two Culturally Sensitive vignettes than between a Culturally Sensitive vignette and a WHAM vignette).

b) I predicted that the three alliance-related variables would positively correlate with participants’ expected likelihood to return to therapy for each vignette (depicted in Figure 2). This would suggest that alliance as it is measured in this study relates positively to retention, similarly to previous studies.

**Figure 2**

*Relation between Therapist Behavior Category and Client Response Variables*

- **Therapist Behavior Category**
  - Alliance-related variables
    - Trust
    - Belief in genuine investment
    - Disclosing deeper feelings
  - Retention-related variable
    - Likelihood to return
Aim 3

To understand how Counterstereotypical behavior, Culturally Sensitive practices, and Well-Intentioned but Harmful Approaches or Methods (WHAM) of therapists’ behavior in relating to clients of color compare to each other along the dimensions of the client response variables from Black Americans’ perspectives. I explored the descriptive statistics for responses to the four client response variables (trust, belief in genuine investment, disclosing deeper feelings and likelihood to return). Secondly, I explored how Counterstereotypical behavior compared to currently accepted culturally sensitive practices to begin to understand possible advantages of each approach from the perspective of Black Americans and whether explicitly addressing stereotypes could improve therapeutic alliance and retention. Although Culturally Sensitive and Counterstereotypical approaches could solely be compared to each other, WHAM was used as a mode of comparison in order to assess a larger range of responses from participants and determine the relative effectiveness of Culturally Sensitive and Counterstereotypical practices. WHAM is used rather than active attempts to harm, since a primary goal of therapy is to help clients.

It is possible for Counterstereotypical behavior to co-occur with current Culturally Sensitive practices as many of these behaviors could also demonstrate a non-negative view of the client’s cultures. However, research and training has not focused on actively demonstrating one’s awareness and beliefs about stereotypes (Cardemil & Battle, 2003; Graham et al., 2013; Hays, 2008; D. W. Sue et al., 1992), despite evidence indicating that a
demonstrated lack of awareness of stereotypes is a common characteristic in White therapists with unsatisfied racial and/or ethnic minority clients (Chang & Berk, 2009).

**Aim 3 Hypotheses**

a) I hypothesized that participants’ responses to Counterstereotypical and Culturally Sensitive behaviors would be above neutral on average, while responses to WHAM behaviors would be below neutral.

b) I hypothesized that Black participants would give more positive ratings for all client response variables when a hypothetical therapist used Culturally Sensitive practices than when the hypothetical therapist used WHAMs. Since Culturally Sensitive methods have been previously linked to better client satisfaction in therapy, this outcome would suggest that these hypothetical questions are capturing some element of actual client satisfaction. Furthermore, I expected that Counterstereotypical behavior would also result in more positive hypothetical ratings from participants than WHAM for all client response variables (Figure 3).

![Figure 3](image)

**Figure 3**

*Hypothesized Relative Ratings of Therapist Behavior Categories*

More positive response

More negative response

Trust  
Disclosing deeper feelings  
Belief in genuine investment  
Likelihood to return

- Culturally Sensitive  
- Counterstereotypical  
- WHAM

*Note: Relative ratings of Culturally Sensitive and Counterstereotypical behaviors will be explored.*
Aim 4

To explore the relations between previous experiences of microaggressions and discrimination, as well as experiences of therapy, with participant responses to the four client response variables. The negative impact of microaggressions and discrimination on attitudes about mental health (Krill Williston et al., 2019), the occurrence of microaggressions in therapy (Chang & Berk, 2009; Chang & Yoon, 2011), and the destructive impact of microaggressions on the therapeutic alliance (Chang & Berk, 2009; Constantine, 2007) have been well-documented. Existing research presents conflicting interpretations of existing commonalities between Black clients who attend therapy and how attending therapy affects Black clients’ attitudes about therapists (Diala et al., 2000; Gómez, 2015; D. W. Sue, 2001). However, there is little previous information on the impact of discriminatory experiences outside of therapy or number of previous therapy sessions on the efficacy of different therapeutic methods. The purpose of this exploratory aim was to examine participants’ responses to each type of therapeutic behavior category based on 1) their previous experiences of microaggressions and 2) the number of therapy sessions they have previously attended.
CHAPTER 2

BACKGROUND AND SIGNIFICANCE

Terminology

The terms “Black” and “of African descent” will be used interchangeably throughout this work to refer to all people of sub-Saharan African ancestry. This includes those with distant or recent ancestry tied to Africa, the Caribbean, Central America, and South America, as well as those of distant African ancestry located in Europe and the United States. When describing existing research, the terms used by the respective authors to describe participants’ race will be used. Consequently, the term “African American” will be used in cases in which participants were referred to as African American by the author(s), even though people of other ethnic or geographic backgrounds may have been present but not specified.

Many existing studies focus solely on people identifying as African American in the United States; other studies use the term African American to refer to all Black people in the US, regardless of their immigration status, country of origin, or how they self-identify. The present study was open to all people self-identifying as Black in the US because the relations between racism, discrimination, stigma, stereotyping, and mental health disparities examined
here happen within a historical context that affects all Black people in the United States, across immigration status, ancestry, and country of origin. Although people identifying or identified as Black are in aggregate affected similarly by differential treatment and resources for mental health, it is important to keep in mind that Black people in the United States are extremely heterogeneous in their behaviors, experiences, and cultural influences and that the mechanisms described here function primarily due to categories created, perceived, and assigned by others.

**Mental Health Disparities for Black People**

Mental health disparities for people of African descent persist across age groups (Lau et al., 2012), across diagnostic patient populations (Maura & Weisman de Mamani, 2017; Tillman et al., 2010), and even regardless of access to health insurance coverage and higher socioeconomic status (Gómez, 2015; Hamilton et al., 2015; Michalopoulou et al., 2009).

**Treatment-Seeking, Access, and Attrition**

Many studies suggest Black people receive less mental health help than European Americans and sometimes than other racial minority groups (Hamilton et al., 2015; Lau et al., 2012; Maura & Weisman de Mamani, 2017). Evidence suggests African American and Latino adolescents have the least access to mental and physical health care, which researchers found to be partially statistically explained by lack of any type of insurance, while African American youth utilize health care services the least when compared to other racial groups (Lau et al., 2012). Research by Alegria, Chatterji, and colleagues (2008) including data from 8,762 adults indicates that while racial minorities were diagnosed with
depressive disorders less often than non-Latino Whites, those who were diagnosed were less likely to have received adequate care for depression in the last year. In addition, Black people were far less likely to have access to or receive adequate care for their depressive symptoms than Asian people. Hamilton and colleagues (2015) found that clients of African descent were overrepresented in inpatient settings even when considering access to healthcare and housing. This overrepresentation may point to inadequate care or utilization in outpatient settings resulting in the need for hospitalization. Factors that could contribute to the poor outcomes mentioned above (such as discrimination from providers, institutional distrust from clients, and logistical systemic barriers like insurance) will be discussed later in greater detail. Awareness not only of poor outcomes, but of what creates them, is important to improving therapists’ understanding of Black clients.

Studies also suggest people of African descent seek and stay in mental health care significantly less than White Americans (Diala et al., 2000; Maura & Weisman de Mamani, 2017; Tillman et al., 2010). In a study of factors related to treatment retention for people experiencing depression, Fortuna et al. (2010) found that African-Americans were particularly less likely than other racial minority clients to attend four or more therapy sessions when compared to Whites. Davis and Ancis (2012) conducted a review of literature on treatment retention for Black women dealing with substance use disorders. They suggest that there is strong evidence that retention for substance abuse treatment is worse for Black people than for White people, that information about the impact of gender is difficult to interpret due to the frequent exclusion of low-income and Black participants, and that
improving the therapeutic alliance between African-American women and therapists is extremely important for improving retention.

**Mental Health Outcomes and Satisfaction**

Studies show that Black clients have worse global functioning, symptom improvement, satisfaction with therapy, belief that therapy was successful, and general quality of life than White clients and frequently than other clients of color (Alegria et al., 2010; Diala et al., 2000; Eack & Newhill, 2012). Additionally, Diala et al. (2000) found that in samples of over 5,000 people across the US, people of African descent were less likely to use professional mental health care services than White people, despite having more positive attitudes about those services than White participants prior to using them. However, Black people in their study also reported less positive attitudes about mental health services than White people after using them. This seems to suggest that Black clients are having experiences in therapy that lead to more negative attitudes. These disparities are present across age, gender, and symptom presentation (Eack & Newhill, 2012; Lau et al., 2012; Maura & Weisman de Mamani, 2017; Tillman et al., 2010).

**Disparities in Prevalence and Type of Health Problems**

Researchers have found a higher prevalence of specific mental health and behavioral problems, as well as worse physical health, mental health, and general sense of well-being among people of African descent when compared to European Americans (Alegria et al., 2010; Gómez, 2015). For instance, in a secondary data analysis with 48,752 respondents that was largely based on parent reports and records of diagnoses, Lau, Lin, and Flores (2012)
found that African American adolescents had the highest prevalence of behavioral problems, speech problems, and difficulties with emotions, concentration, behavior, and interpersonal relations when compared to adolescents of other races. However, African American adolescents were simultaneously found to have the lowest rates of diagnosis for ADHD, learning disabilities, developmental delay, depression, and anxiety disorders and were less likely to be viewed by parents and providers as having emotional, developmental, or behavioral problems “needing treatment or counseling”. This pattern of findings suggests that, although parents and providers are aware of emotional difficulties faced by African American adolescents, the same emotional difficulties are resulting in diagnoses and access to institutional resources far more often in their White counterparts. The seeming contradiction of high rates of externalizing problems and low diagnosis of internalizing and developmental disorders may be partially due to clinician biases in the diagnosis and detection of anxiety, depression, and developmental disorders in Black people that have been documented by previous researchers (Begeer et al., 2009; Hamilton et al., 2015). Racial differences in diagnoses may result from real differences or from bias and lack of recognition of certain types of difficulties. However, lack of recognition of difficulties may lead to worse mental health care and outcomes. Taken together, these findings indicate that intervening with therapist and physician attitudes may be important to improving mental health outcomes for Black people.
Client, Cultural, and Environmental Barriers to Care and Well-Being

Researchers have noted a large variety of individual-level and environmental characteristics that make Black people less likely to seek and remain in mental health help and counseling, including stigma, beliefs about mental health, distrust of the mental health care or general health care system, not having insurance, and difficulty physically reaching places mental healthcare is offered (fewer geographically proximal mental health services, worse public transportation infrastructure in their neighborhood, or lower access to cars because of financial resources; Abdullah & Brown, 2011; Hamilton et al., 2015; Lau et al., 2012; Tillman et al., 2010). These access factors are predictive of mental health outcomes (Burris, 2012; Hamilton et al., 2015; Tillman et al., 2010), have cultural or historical origins, are frequently impacted by systemic barriers (like zoning and insurance policies), and are often influenced by experiences with discrimination in general and with healthcare professionals (Gómez, 2015; Hamilton et al., 2015; Larrison & Schoppelrey, 2011; Owen et al., 2012). This pattern of factors underscores the importance of researching solutions to mental health disparities for Black people that are environmental and institutional, rather than relying on additional effort from Black clients who are faced with fewer resources in addition to mental health difficulties.

Stigma

Psychologists have found mental health stigma to be higher in people of African descent in the United States (Carpenter-Song et al., 2010; Conner et al., 2009) and have found a connection between mental health stigma and fewer help-seeking behaviors.
(Alvidrez et al., 2008; Corrigan, 2004). Others have also suggested stigma about mental health and experiences that precipitate stigma as an important cause of lower mental health help-seeking attitudes specifically for people of African descent (Alvidrez et al., 2008; Maura & Weisman de Mamani, 2017; Tillman et al., 2010).

Mental health stigma poses a barrier to receiving care for people of many cultural backgrounds (Abdullah & Brown, 2011); however, relations between mental health stigma, discrimination, and stereotyping pose disproportionate barriers to progress in therapy for racial minorities. Krill Williston, Martinez, and Abdullah (2019) found that, among people of color, racial discrimination was significantly correlated with negative views of mental health problems, treatment, and treatment-seeking. Consequently, the current study also considered the possible influence of previous experiences of discrimination in general life on participant’s perceptions of therapists.

While Krill Williston and colleagues’ study did not analyze differences in stigma by race or ethnicity, mental health stigma and its interactions with experiences of discrimination impact people of color differently based on their cultural backgrounds (Abdullah & Brown, 2011). Abdullah and Brown suggest that people of African descent, in particular, may internalize self- and public stigma more than people of other races, leading to more negative attitudes about seeking mental health-related help. Public stigma refers to general discriminatory responses to those with mental illnesses from the general public (such as losing housing or greater interactions with the criminal justice system), whereas self-stigma refers to the internalization of public stigma (Abdullah & Brown, 2011; Corrigan, 2004).
Previously, mental health stigma was conceptualized to depend heavily on client race and ethnicity. However, Abdullah and Brown (2011) propose a model in which both self- and public stigma are more dependent on cultural influences, such as African beliefs about role flexibility, and the degree of one’s identification with cultural values, rather than static labels of racial categories. Additionally, S. Sue (1999) suggests ethnicity is not the cause of differences found in psychological studies, but rather is a proxy for other factors like culture and contextual factors. Culture also influences clients’ expectations for interventions. Gómez (2015) suggests that because Black Americans tend to believe in behavioral, cognitive, and emotional explanations for mental illnesses, the current dominance of the medical model may make seeking mental healthcare more stigmatized and even less likely for people of African descent. Learning what people of African descent find helpful and important in therapy is necessary in order to reduce stigma and provide care they will use. Consequently, this study actively sought perspectives about specific therapeutic interactions from a heterogeneous sample of people of African descent to acknowledge within-racial-group differences and captured information on tailoring therapy to the experiences and needs of clients, rather than to a monolithic Black person.

**Racial Discrimination and Microaggressions**

Discrimination comes in many forms, is psychologically harmful, and may contribute to worse mental health and well-being for people of African descent in general (Brondolo et al., 2014; Paradies, 2006; Paradies et al., 2015; D. W. Sue et al., 2007). Paradies (2006) acknowledges that there are multiple definitions of racism or racial discrimination used in
research but generally describes racism as unfair treatment based on race that is perpetrated systemically or individually as a result of an ideology of inferiority or superiority of specific racial groups. Racial microaggressions refer to “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (D. W. Sue et al., 2007, p. 273). D.W. Sue and colleagues further divide the enormous myriad of common types of microaggressions into three categories: microinsults (behavior or words that demean or convey rudeness or insensitivity), microassaults (explicit, derogatory verbal or non-verbal attacks meant to hurt the victim), and microinvalidations (comments or behaviors that negate, exclude the thoughts, feelings, and experiences of people with marginalized identities).

As mentioned earlier, people of African descent in the United States experience greater psychological distress than White people and members of other racial minority groups even when controlling for factors like income (Gómez, 2015). Like many other researchers, I suggest that the burden of everyday discrimination and microaggressions may play a large role in maintaining mental health disparities for Black people and needs to be addressed by clinicians (Brondolo et al., 2014; Paradies et al., 2015), including racial discrimination and microaggressions perpetrated during the course of therapy (Chang & Yoon, 2011; Gómez, 2015; D. W. Sue et al., 2007). The current study sought to understand how therapists can interact with clients of African descent in non-microaggressive ways that are desirable by clients’ standards. One step in this goal was examining the impact of racial
microaggressions perpetrated in therapy by looking at well-intentioned but racially insensitive and harmful therapist behaviors.

Paradies (2006), in a review of 138 quantitative studies on health and self-reported racism in racial minorities, found consistent evidence that experiences of racism are associated with negative health-related behaviors (such as substance use) and negative mental health outcomes. These findings were replicated in a larger meta-analysis that indicated associations with depression, anxiety, psychological stress, poorer general health, and poorer physical health (Paradies et al., 2015). Associations between racism and these health outcomes were not moderated by age, sex, birthplace, nor education level. Rather, the findings suggest that experiences of racism themselves are associated with poorer physical and mental health. This may be both because the experiences themselves erode mental health and because the effects of racism (such as lower access to resources) negatively impact health.

Brondolo and colleagues (2014) present a model of the social-cognitive pathways leading from racism to depression. They suggest that lifetime exposure to racism, as well as acute race-related incidents, can directly impact an individual’s schemas, cognitive flexibility, and appraisals in ways that affect downstream cognitive processes related to the development and maintenance of depression. In addition, I suggest that experiences of racism may directly cause disruptions to interpersonal relations (in personal or therapeutic relationships), reducing social supports and buffers available to people encountering racism. However, there may be many more pathways by which racism affects health. For instance,
experiences of racism may lead to more negative appraisals and expectations of therapists, particularly if microaggressions occur in therapy. This would reduce Black clients’ likelihood of trusting therapists, developing helpful therapeutic alliances, and attending therapy at all. Reducing occurrences of racism, especially those that occur in therapy, is therefore imperative to improving mental health for people of African descent. The current study examined this possibility by investigating correlations between Black participants’ previous experiences of racism and their responses to hypothetical therapists.

**Discrimination, Stigma, and Beliefs about Mental Health**

Researchers have found associations between experiences of discrimination, mental health stigma, and help-seeking behavior. Among racially and ethnically diverse people of color, a higher frequency of recent discriminatory experiences has been shown to predict anticipatory concerns about stigma from family friends about mental health problems, although it does not uniquely predict negative beliefs about mental health help-seeking (Krill Williston et al., 2019). Experiences of discrimination, fear of confirming negative stereotypes about Black people to healthcare professionals, and a historical context of institutionalized racism may also contribute to existing cultural stigma about mental health and create a confluence of factors that discourage people of African descent across other demographic variables from seeking mental healthcare and from trusting mental health professionals (Gómez, 2015; D. W. Sue et al., 2007; Tillman et al., 2010).

Tillman and colleagues' (2010) literature review of factors contributing to African American women’s low rate of disclosure after experiencing sexual assault provides an
example of how stigma about mental health, historical racism, discrimination, and fears of future discrimination can combine to create a client characteristic (avoidance of disclosure) that leads to negative mental health outcomes for Black people. They suggest that Black women avoid disclosing their sexual assault (and consequently seeking mental health help) to avoid negative societal consequences for themselves and their perpetrators. Tillman et al. explain that stereotypes of Black women as a ‘Jezebel’ (sexually promiscuous, immoral, woman lacking control over sexual urges; Collins, 2000 as cited in Tillman et al., 2010, p. 63) originate from the slavery era, when slave owners would use these stereotypes as justification for raping and forcibly breeding enslaved Black women to oppress both Black women and men (C. Johnson, 2009). These stereotypes are still perpetuated today, contributing to Black women’s expectations that they will not receive support or that they will be blamed or penalized for disclosing sexual abuse. In addition, Tillman et al. found evidence that Black women do not disclose particularly when the perpetrator is also Black in order to protect the perpetrator from institutionalized racism and the disproportionate incarceration of Black people. Discrimination and a historical context of institutional betrayal incentivize people of African descent to avoid interactions with the healthcare system, as well as potentially portraying themselves (and other Black people) in line with existing negative stereotypes about Black people (a phenomenon known as stereotype threat; Steele, 1997).
Clinician-Related Barriers to Care

Clinician-related barriers to care are important to consider. Larrison and Schoppelrey (2011) studied 14 therapists and their clients to find the degree of impact of therapist effects on mental health outcome racial disparities. They found evidence of racial disparities in clients’ self-reported symptoms. Using a hierarchical linear model, they determined that therapist effects accounted for 28.7% of the variability in racial disparities within mental health outcome (Larrison & Schoppelrey, 2011). Owen et al. (2012) found evidence that therapist differences accounted for a significant amount of variability in racial disparities related to unilateral termination for Black clients, when controlling for client race/ethnicity, diagnosis, marital status, and level of symptomatology. Many researchers argue that despite support of multicultural training through government funding and attention from the American Psychological Association, mental health disparities continue to persist largely due to continued microaggressions, racial bias, and the perpetuation of Eurocentric views from clinicians (Chang & Berk, 2009; Gómez, 2015; Hook et al., 2016; D. W. Sue, 2001; D. W. Sue et al., 2007).

Historically White Perspectives

White, Eurocentric perspectives dominate therapists’ clinical training and practice (D. W. Sue, 2001) and are partially perpetuated by continuing disparities in the number and proportion of racial minority psychologists and psychiatrists (Gómez, 2015). D. W. Sue (2001) situates therapy in a historical context and suggests that therapies have been
developed primarily by European Americans, embody European and White American values, and tend to pathologize perspectives that fall outside of those associated with privilege.

Additionally, despite people of African descent comprising approximately 12% of the US population (United States Census Bureau, 2010), they only comprised 5.3% of the psychologist workforce in 2013 (Lin et al., 2015) and 9.1% of students in degree programs that could lead to licensure in 2014 (Michalski et al., 2016). It is deeply important that more potential Black therapists be bolstered at every step in the educational process, including being supported to apply to graduate schools, accepted to training programs, and given sufficient support and mentorship to be licensed for the sake of equity and to allow clients of any race who prefer therapists of African descent to have one. Nonetheless, given the likelihood, based on these demographic patterns, that Black clients will currently be treated by White therapists, the current study focused on perspectives of Black people about therapy, with particular attention to therapeutic dyads involving White therapists.

**Bias and Discrimination**

A widespread issue that may contribute to negative views of help-seeking and poorer mental health outcomes for people of African descent is experiences of discrimination that occur in and around therapy. These include discrimination around the diagnosis and recognition of symptoms, the provision of referrals or interventions, and the receipt of microaggressions in therapy.

**Diagnoses and Recognition of Symptoms.** Many researchers have found differential diagnoses of depressive, anxiety, psychotic, and neurodevelopmental disorders (Hamilton et
al., 2015; Lagomasino et al., 2011; Lau et al., 2012). Hamilton and colleagues found that Black clients in psychiatric settings received more diagnoses of schizophrenia and higher ratings of hallucinatory, suspicious, and hostile behavior than White clients, but fewer diagnoses of co-morbid personality disorders, fewer ratings of depressive symptoms than White clients, trends which have consistently been replicated across other studies (for a review, see Maura & Weisman de Mamani, 2017). Hamilton et al. (2015) suggest that since antipsychotic medications have higher antidepressant effects on African Americans, the higher rate of antipsychotic prescription to Black people may be responsible for the reduction in depressive symptoms within their sample. Since research indicates that Black clients frequently receive inaccurately high dosages of psychopharmaceutical interventions (Maura & Weisman de Mamani, 2017), I suggest Hamilton and colleagues’ finding of reduction in depressive symptoms may be an accidental effect of the over-prescription of antipsychotic medication. Although depressive symptom reduction is positive, this combination of findings suggests a gross misuse and lack of understanding of interventions on Black clients. Other examples of racially differential diagnosis and treatment include studies indicating that clinicians under-recognize existing depressive and anxious symptoms in Black clients (Lagomasino et al., 2011), tending to recognize externalizing symptoms like hostility more than internalizing symptoms like feelings of worthlessness (Begeer et al., 2009; Nguyen et al., 2007).

Diagnosis-related racial disparities for people of African descent also persist outside of the United States. For example, a study in the Netherlands found that children of
Moroccan descent (the largest African immigrant population in the Netherlands) were underrepresented in autism spectrum disorder (ASD) institutions. Furthermore, pediatricians’ spontaneous clinical judgments less frequently included mentions of ASD symptoms for Moroccan children than for children of European descent (Begeer et al., 2009), indicating the potential for referral biases.

**Differences in Referrals and Interventions Offered or Given.** African Americans and people of African descent in general are frequently offered or given fewer, less appropriate, and lower quality interventions even when receiving care than people of other races, especially when compared to White people. A study in which actors, posing as potential therapy clients, called 371 counselors and psychologists found that they were 12% more likely to receive a call back when leaving a non-Latino White-sounding name than when leaving a Black-sounding name (Shin et al., 2016). Lau et al. (2012) found that African American adolescents reported not receiving all of their needed medications even after having seen healthcare providers and having unmet dental needs the most frequently when compared to all other racial groups (Lau et al., 2012). As mentioned above, African Americans are more frequently given antipsychotic medication by psychiatrists and general physicians and at higher dosages (Hamilton et al., 2015; Maura & Weisman de Mamani, 2017), which may relate to negative stereotyping of Black people as more psychotic and externalizing. This will be discussed in greater detail later. In addition, Maura and Weisman de Mamani suggest that over-prescription negatively impacts recovery for Black people. Lagomasino et al. (2011) found that both psychiatrists and primary care doctors gave Black
people less care in terms of acknowledgement, counseling given at the time, referrals to outside counseling, and antidepressant prescriptions, for depressive and anxious symptoms.

**Microaggressions**

Chang and Berk (2009) and Constantine (2007) found that microaggressive behaviors from therapists result in difficulties in the therapeutic alliance and lower satisfaction with counseling from Black clients. Evidence suggests the types of racial microaggressions as defined by D. W. Sue et al. (2007; microinsults, microassaults, and microinvalidations) and other discriminatory behaviors are perpetrated by mental health professionals with alarming regularity (Burris, 2012; Chang & Berk, 2009; Hook et al., 2016), that they produce negative counseling processes and outcomes (Constantine, 2007), and that roughly 81% of therapy clients of color experience at least one microaggression in therapy with no significant difference in the percentage of people experiencing microaggressions in therapy for Black participants versus for participants of color in general (Hook et al., 2016).

Gómez (2015) suggests that in our current social and political context, in which the myth of a post-racial society persists despite evidence that attitudes about Black people have worsened since 2008 (Valentino & Brader, 2011), microaggressions function as a way for people with privilege to both 1) perpetrate racism without taking responsibility for their contributions to continuing inequalities and 2) punish those who confront microaggressions. This makes awareness and acknowledgment of microaggressions extremely important now, particularly in healthcare settings where validation and understanding is expected and where healthcare providers are likely to be in a position of racial privilege relative to their clients.
There is overwhelming evidence that therapists contribute to negative outcomes for Black people in the United States through diagnoses, willingness to treat, as well as differences in the implementation of interventions, microaggressions committed in the therapy room, and minimizing of Black perspectives in favor of Eurocentric viewpoints. It is important that psychologists find ways to decrease these disparities through interventions that work for people of African descent. Research should focus on understanding what works from the perspective of racial minorities so as not to place a burden on people of color to think or behave more like White clients.

The evidence that therapists contribute to negative health outcomes for clients of African descent makes it imperative to understand how therapists interact with Black clients and what aspects of those interactions are important to outcomes. This study sought to understand what behaviors from therapists, regardless of intention, are positively received by Black clients.

**The Importance of the Therapeutic Alliance**

**Definitions**

The therapeutic alliance is a concept that originated with Sigmund Freud and psychodynamic theory, involving the concepts of transference and the client’s attachment to the therapist (Horvath & Luborsky, 2005). Horvath and Luborsky document the progression and coinciding conceptions of the *therapeutic or working alliance*, including Carl Rogers’ theory which states there are certain conditions that are both necessary and sufficient to the client’s improvement through therapy. Rogers’ conditions, as paraphrased by Horvath and
Luborsky, are that the therapist be congruent (or genuine), empathetic, and unconditionally accepting of the client. They review many studies demonstrating associations between multiple measures of therapeutic alliance and client outcomes.

Alliance can be established throughout interactions with clients in many ways such as through words, actions, non-verbal cues, attentiveness, and active listening. Ackerman and Hilsenroth (2003) suggest the therapists’ ability to be “flexible, honest, respectful, trustworthy, confident, warm, interested, and open” (p. 1) also positively impact the therapeutic alliance.

**Impact of Therapeutic Alliance on Outcomes**

Psychologists have found evidence that the degree to which therapists are able to maintain a positive therapeutic alliance with clients predicts positive treatment outcomes (Baldwin et al., 2007; Burris, 2012; Horvath & Luborsky, 2005). Baldwin et al. (2007) found that variability in therapist-related factors (such as training, identities, and behavior) within the therapeutic alliance predicted client outcomes whereas variability in client-related factors (ability or manner of forming bonds) and behavior did not. They concluded that client outcome is primarily determined by the counselor’s skill in using counseling techniques, monitoring the alliance, and repairing any ruptures in the alliance. Horvath and Luborsky additionally identify two crucial times when the alliance is particularly vulnerable and important to outcomes: (1) during the first 5 sessions while trust and collaboration are being established and (2) when the therapist begins to challenge the client with more active interventions.
While Baldwin et al., (2007), as well as Horvath and Luborsky (2005), refer to studies with primarily White samples, Burris (2012) conducted a review of literature pertaining to Black people in the US. Burris suggests that microaggressions in therapy, as well as color-blind attitudes (the idea that all racial groups are already equal and should be treated the same, usually involving denial of the impacts of racial inequalities and the pervasiveness of racial bias), erode the therapeutic alliance, but that strategies that directly address race are important to a healthy alliance and positive mental health outcomes for Black clients.

Components of Therapeutic Alliance Important to Mental Health Outcomes

The components of the therapeutic alliance examined in this study align with Carl Rogers’ views of what makes therapy successful and with research associating these facets with positive outcomes in therapy: 1) perceptions that the therapist is trustworthy, 2) willingness to disclose deeper feelings to the therapist, and 3) belief in the therapist’s genuine investment in their well-being. Fourthly, their likelihood to return to sessions was examined as an additional outcome. There is evidence that trust, disclosure, and belief in genuine investment from therapists are important components to maintaining the therapeutic alliance and encourage retention in therapy (Abdullah & Brown, 2011; Chang & Yoon, 2011; Gómez, 2015; Maura & Weisman de Mamani, 2017; Tillman et al., 2010), while returning to therapy has been associated with positive therapeutic alliances (Wintersteen et al., 2005).

These facets have also emerged (as mentioned earlier) as disparities particularly important in determining therapeutic outcomes for Black clients: 1) mistrust and fears of institutional betrayal (Gómez, 2015; Maura & Weisman de Mamani, 2017), 2) unwillingness
to disclose or stigma about disclosure about personal information, difficulties, or feelings (Abdullah & Brown, 2011; Tillman et al., 2010), 3) doubts about the therapist’s ability to care across racial difference (due to microaggressions or overt racism; Chang & Berk, 2009; Constantine, 2007; Gómez, 2015), and 4) attrition from therapy (Abdullah & Brown, 2011). Moreover, a qualitative and exploratory study of Black client experiences in first sessions found that clients actively looked for evidence of safety in disclosing to the provider, being able to trust the provider, and perceiving empathy from the provider in addition to other indicators of personal connection (Earl et al., 2011).

**Race and the Therapeutic Alliance**

Researchers continue to speculate and study the impact of therapist and client race as well as racial match on the therapeutic alliance (Cabral & Smith, 2011; Chang & Yoon, 2011; Morten & Atkinson, 1983).

Levine and Ambady (2013) found in a review of the impact of non-verbal behavior from both clients and medical professionals that White doctors are likely to behave (non-verbally) in ways that are associated with worse health outcomes. They report that White doctors tend to interact with racial minority clients in ways that convey disengagement and inattentiveness, and suggest that this may occur due to doctors’ implicit beliefs in negative stereotypes, additional cognitive load due to concerns about appearing prejudiced, and lack of understanding of cues from clients that do not align with dominant cultural expectations in the US; results that persisted even when doctors reported valuing equality and did not consciously hold negative opinions of racial minorities. This is consistent with Hook et al.'s
(2016) finding that, of the microaggressions about which they asked clients, avoiding discussion of cultural issues was one of the most frequently reported, as well as Chang and Yoon's (2011) finding that White therapists’ avoidance of racial topics impeded the maintenance of a positive working alliance. Furthermore, Constantine (2007) provides evidence that racial microaggressions in therapy between White counselors and African American clients predict both a worse therapeutic alliance and lower client satisfaction. Together, these findings suggest that microaggressions may transpire in White therapist/Black client dyads even when therapists mean well. While avoidance of racially and culturally related topics is a common and important type of microaggression in therapy, it is not examined in this initial study. The reinterpretation of a race-related topic to one unrelated to race is included in one of this study’s vignettes. There is no vignette for avoidance of racially or culturally related topics as it may require more subtlety and thereby be less reliable as a manipulation.

One might argue that these findings suggests that cross-racial therapeutic dyads are doomed to fail; however, there is evidence of positive impacts of cross-racial therapeutic dyads (Chang & Yoon, 2011), as well as evidence of training and approaches that mitigate the negative impacts of our racially hierarchical context on White clinicians and their clients of color. For instance, Burris (2012), as well as Cardemil and Battle (2003), suggest directly broaching the subject of race with clients in order to foster a better working alliance. This is especially important because some clients avoid bringing up race themselves for fear of offending White therapists or having their negative race-related experiences invalidated.
Additionally, there is evidence that therapists with lower color-blind racial attitudes in cross-racial therapeutic dyads tend to have more positive therapeutic alliances (Burris, 2012) and that these attitudes predict successful treatment above and beyond multicultural training the therapist has received (A. Johnson & Jackson Williams, 2015).

While there are many factors that can contribute to mental health outcome disparities for people of African descent, this study focuses on the impact of therapist-related factors, and particularly therapist behaviors, as they are more easily intervened on through psychological means. The current study focuses on therapist biases and other processes that occur in the therapy room based on the evidence that therapists themselves (their behavior and characteristics) account for a higher proportion of racial mental health disparities related to client-therapist interactions than client characteristics (Larrison & Schoppelrey, 2011), the frequency of microaggressions that occur in the therapy room (Burris, 2012), and indications that Black people on average have more negative attitudes towards seeking help after going to therapy (Diala et al., 2000).

**Solutions to Therapist-Related Impacts on Racial Disparities Proposed by Previous Research**

Researchers have explored many possible solutions to the negative impact of practitioners’ racial biases on accuracy of referral and diagnosis, the therapeutic alliance, and client outcomes. The two that are most impactful to this study are racial or ethnic matching and cultural competency or humility. Nonetheless, methods such as using more concrete
rating scales to decrease differential diagnoses (Begeer et al., 2009), using integrated primary care to lower the impact of mental health stigma and reduced access to traditional mental health settings (Satcher & Rachel, 2017), and many others are also currently being explored and implemented. Among the most commonly proposed solutions to therapist biases are racial and ethnic matching and cultural sensitivity training.

**Racial and Ethnic Matching**

*Research.* Many scholars have proposed racial and/or ethnic match between therapist and client as a solution for the impact of racial bias on interactions between Black clients and therapists of other racial identities. However, researchers have found mixed results when investigating if and how racial and/or ethnic matching of therapist-client dyads impacts variables related to mental health outcomes for clients of color, including client satisfaction, client perceptions of the therapist, retention, assessment, and measures of client functioning. While studies primarily use the term racial/ethnic matching, determination of match is almost exclusively based on race and not ethnicity. If racial matching were an effective solution to racial disparities in mental health outcomes for Black people when compared to other racial groups, it would suggest less necessity to research cross-racial dyads in therapy. However, given the evidence that racial matching is not a viable solution, understanding how to help cross-racial therapeutic dyads function becomes imperative.

While multiple studies have found that more than 50% of people of color prefer a therapist of the same race or strong effect sizes for racial matching preference, they also acknowledge the enormous variability in Black clients’ preferences and perceptions of racial
matching (Cabral & Smith, 2011; Chang & Yoon, 2011; Horst et al., 2012; Morten & Atkinson, 1983). Some studies indicate greater positive outcomes in racially-matched therapeutic dyads in terms of retention (Wintersteen et al., 2005), measures of global functioning (Kim & Kang, 2018), and positive perceptions of the therapist (Cabral & Smith, 2011). However, many studies indicate factors more important than racial matching or that may be responsible for the positive effects of racial matching, such as therapists’ level of racial identity development (Morten & Atkinson, 1983), behaviors that facilitate harmonious interactions (Wintersteen et al., 2005), multicultural training, and culturally adapted treatments (Swift et al., 2015).

Cabral and Smith (2011) conducted one of the most detailed meta-analyses to date on racial/ethnic matching for clients of color. Cabral and Smith conclude that racial/ethnic matching has little importance to mental health outcomes for most racial minorities with the exception of people of African descent and that clients benefit from therapy with clinicians of other races despite their preferences being unmet and that these effects are decreasing with time. However, they suggest that factors like institutional distrust and wariness about bias from clinicians may have a large impact on Black people’s perceptions and interactions with therapists of other races.

**The Need to Focus on Therapist Behaviors and Training.** Research indicates that racial and ethnic matching is not currently a solution that can plausibly remove mental health treatment outcome disparities for people of African descent because (a) not all Black people want a Black therapist (Cabral & Smith, 2011; Chang & Yoon, 2011), (b) separating people
by skin color when they have no preference for it is unethical and integration has benefits (McArdle & Acevedo-Garcia, 2017), (c) racial matching is not numerically plausible for most Black clients given the disproportionately low number of Black therapists relative to the number of Black people in the US with a diagnosed mental disorder and the slow increase in Black licensed clinicians (Alvarez et al., 2019; Lin et al., 2015; Michalski et al., 2016), (d) Black clinicians can also exhibit microaggressive behaviors towards Black clients (Chang & Yoon, 2011; Gómez, 2015; Hook et al., 2016), and (e) other factors like multicultural training, color-blind attitudes, and therapist’s stage of racial development have a larger effect on client outcomes than racial match (Chang & Berk, 2009; Chang & Yoon, 2011; Gómez, 2015; Horst et al., 2012; Morten & Atkinson, 1983; Rosen et al., 2012; Swift et al., 2015; Wintersteen et al., 2005).

The current study begins to address the need to look beyond racial categories and into therapist behaviors, attitudes, and training to ameliorate racial mental health disparities. I suggest that people of African descent will be best served now and, in the future, if therapists of all races are trained to relate to them in ways that embody and express awareness, genuineness, and non-stereotypical beliefs; while simultaneously giving clients with preferences for a racially matched clinicians access to enough Black clinicians for them to find one who fits their needs well. This requires changes to training and therapeutic methods for clinicians who do not identify as Black, in addition to drastically increasing the number of clinicians of African descent.
Cultural Sensitivity, Competence, and Humility

Psychologists have suggested multicultural approaches and cultural competency as important interventions for therapists’ biases and microaggressions in therapy (Cabral & Smith, 2011; Chang & Berk, 2009; Gómez, 2015); these approaches have been proposed under multiple names and with multiple definitions, including cultural humility, cultural competence, and cultural sensitivity. Responses from people of African descent to culturally sensitive behaviors are explored in the current study, since these methods are endorsed by many clinicians and there is evidence that they positively impact client outcomes. They are compared to other methods in the present study in order to confirm previous evidence that they improve the therapeutic alliance and to explore how culturally sensitive methods compare to methods targeting concepts other than culture in the eyes of Black people.

Many researchers define cultural competence in terms of D.W. Sue et al. (1992) conceptualization of three domains: 1) beliefs and attitudes (largely, awareness of them), 2) knowledge, and 3) skills. Others additionally emphasize consideration of one’s relative privilege or disadvantages compared to one’s client (Cardemil & Battle, 2003; Graham et al., 2013; Hays, 2008), such as Hays’ (2008) ADDRESSING framework. The ADDRESSING framework encourages psychologists to consider diversity and life experiences related to ten dimensions of identity: Age and generational influences, Development disabilities, acquired Disabilities, Religion and spiritual orientation, Ethnicity (and race), Socioeconomic status, Sexual orientation, Indigenous heritage, National origin (including generational status), and Gender.
Clients of color report more satisfaction and better mental health outcomes with therapists they find to be more culturally competent (Chang & Berk, 2009; Hook et al., 2016; D. W. Sue, 2001). Cultural humility as defined by Hook et al. (2013) is an other-focused orientation to therapy involving respect and egalitarian views of the clients’ cultural values, background, and experiences. Hook et al. (2016) found that perceived cultural humility was associated with fewer microaggressions from therapists and lower negative impact from microaggressions. They suggest this is because counselors engaging in cultural humility are able to acknowledge their limitations and mistakes, more effectively repairing ruptures in the therapeutic alliance.

Culturally competent behavior is well-accepted as a method of reducing mental health disparities for racial minority clients in general; this has been demonstrated by the US government’s and American Psychological Association’s endorsement of multicultural training (American Psychological Association, 2003; D. W. Sue, 2001). However, many licensed practitioners have received little cultural competency training (Mallinger & Lamberti, 2010), meta-analyses have found that cultural competence training at sites does not consistently lead to culturally competent behaviors (Gainsbury, 2017), and there is evidence that many therapist traits predict the use of multicultural skills and multicultural competency more than their history of multicultural training (A. Johnson & Jackson Williams, 2015; Ottavi et al., 1994) This suggests that multicultural training is complex and currently missing important aspects of what makes a multicultural attitude meaningful for Black Americans.
Despite the effectiveness of multicultural approaches, a study of more than 300 psychiatrists found that most were “not familiar” or “only a little familiar” with literature on racial disparities and only one fourth had participated in any program related to reducing racial disparities (Mallinger & Lamberti, 2010). While the study did not ask about multicultural training specifically, the lack of awareness and interest in disparities demonstrates that multicultural methods are not being widely nor consistently implemented throughout the field of mental health.

D. W. Sue (2001) and Gómez (2015) suggest that therapy for clients of color and the implementation of culturally competent methods are hindered by ethnocentricity, monocultural policies and practices, and Eurocentric ideas that are invisible but deeply incorporated into the healthcare system and psychological training. D.W. Sue additionally suggests that the multiple and sometimes non-specific definitions of competency present a challenge as well. This has only increased with time as additional names and approaches for culturally informed practices are developed. I suggest more research is needed to determine what components of cultural competency need to be emphasized or learned in order to consistently produce culturally competent behaviors from clinicians.

In addition, evidence suggests that for White clinicians, their stage of racial identity development (or understanding of themselves as having racial group membership and that race is used to label others) and colorblind attitudes about race predict multicultural competence (in terms of knowledge, awareness, and skills) above and beyond multicultural training (A. Johnson & Jackson Williams, 2015; Ottavi et al., 1994). This suggests that
multicultural training in its current form is not sufficient to increase the use of multicultural skills and reduce microaggressions in therapy. Additional knowledge and awareness of the impact of racial labeling is necessary.

Cultural competence encourages therapists to gain knowledge, awareness, and skills regarding how cultural dynamics affect themselves, their clients, and their interactions. However, it has not specifically emphasized knowledge, awareness, and skills as they pertain to stereotypes despite evidence that stereotypes have a profound impact on both clients and therapists at many stages in mental health care. The prevalence of microaggressions from therapists that specifically relate to stereotypes and their negative impact outcomes and satisfaction (Chang & Berk, 2009; Chang & Yoon, 2011) also indicate a need for training and attention to stereotypes. Given the effectiveness of culturally sensitive approaches, it is included as one of the three types of therapist behaviors investigated in the current study.

Stereotypes

**Common Stereotypes for Black People and Their Impact**

One of the aims of the current study was to understand how different forms of discrimination impact the therapeutic alliance and how racial disparities related to them can be ameliorated. Consequently, it is also important to understand what stereotypes of people of African descent exist as well as their effects. Common stereotypes about Black people in the United States include being superhuman, hypersexual, aggressive, violent, delinquent, strong, and intellectually inferior (Hamilton et al., 2015; Rogers & Way, 2016; Steele, 1997; Tillman et al., 2010; Trawalter & Hoffman, 2015); many of which were propagated during
slavery to justify White people’s inhumane treatment of Black people in the United States (Tillman et al., 2010; Trawalter & Hoffman, 2015). Despite slavery’s abolishment, these stereotypes continue to be used to justify other types of racial injustices and profoundly impact the attitudes of people of all races and the lives of Black people in the United States.

Trawalter and Hoffman suggest that stereotypes that Black people are superhuman and impervious has led to a continued general belief that Black bodies are inherently different and can withstand pain and abuse that normal (White) bodies cannot. They elaborate that these beliefs permeate our society, leading to inequalities and cruelties such as chemical plants closer to the homes of Black people, prescribing less pain medication than appropriate for the level of pain described, and police brutality.

The context of gender discrimination in the US has also led to specific stereotypes of Black people that differ by gender (Evans et al., 2011; C. Johnson, 2009). Common stereotypes for Black males include being aggressive, hypersexual, and violent, criminal, athletic (Rogers & Way, 2016) and particularly intellectually inferior (Evans et al., 2011). These stereotypes seem to tie into ideas from slavery that Black men do not have normal human emotional reactions or reasoning, that they possess superhuman strength, and are ideal for manual labor.

C. Johnson (2009) describes common stereotypes for Black women, including “Mammy,” “Jezebel,” and “Sapphire.” She describes the “Mammy” as matriarchal, loyal to her White employer, desexualized and depicted as easily juggling endless responsibilities while caring for both her own family and a White person’s family. In contrast, the “Jezebel”
stereotype is hyper-sexualized and lacking in sexual restraint, which functions as a rationalization for sexual assault perpetrated against Black women. The “Sapphire”, which C. Johnson explains is the most recent (originating in the 1940s and 50s), refers to an emasculating, angry, sassy, crude, and argumentative woman. Usurping her role in society and family and seizing power, she is asexual, controlling, and never satisfied. C. Johnson argues that this is the most threatening stereotype of Black women to people with privilege, justifying and encouraging brutalities committed against Black women. Harris (as cited in C. Johnson, 2009) suggests that the overwhelming depictions and pigeonholing of Black female characters as “strong” reduces them to a single trait, completely overshadowing their complexity, femininity, humanity.

The strong Black woman stereotype describes a near superhuman woman who, despite all obstacles, is denied and denies herself emotional weakness or softness and is frequently perceived as emasculating (C. Johnson, 2009). Another conceptualization involves being strong, independent, and self-sacrificing (C. M. West, 2008). Tillman et al. (2010) suggest that although ascribing to the “strong Black woman” stereotype is sometimes a source of resilience, allowing women to persevere in the face of adversity; the stereotype is often associated with a “culture of silence” for survivors of sexual assault in which the assault is accepted as another hardship to be endured. However, this culture of silence and its negative impacts extend to the broader population of people of African descent as well. A large body of research suggests that stereotypes of strength for both Black women and men (physical or emotional) frequently serve to silence acknowledgement of their needs and
humanity, leading to negative long-term impacts on physical health, mental health, and vocational success, as well as excessive use of force from law enforcement officers (Czopp, 2010; Goff et al., 2014; C. Johnson, 2009; Reynolds-Dobbs et al., 2008; Tillman et al., 2010; Trawalter & Hoffman, 2015; Waytz et al., 2015; L. M. West et al., 2016).

While the stereotypes mentioned above are the most common, they are also primarily negative. If mental health professionals do not explore and consciously acknowledge the ways in which stereotypes affect them and the rest of society, they may inadvertently behave as if stereotypes are more likely to apply to their Black clients. Furthermore, a myriad of the inadequate treatment given to Black clients fit into the mistreatment encouraged by common negative stereotypes of Black people, including lack of belief in their internalizing symptoms, overdiagnosis of disorders involving hostility, and a pervasive devaluing of Black perspectives, desires, and interpretations. Consequently, the present study attempted to acknowledge the impact of stereotypes and investigate how they impact interactions with White therapists, specifically how therapists’ acknowledgment of stereotypes and their impact on clients may benefit the therapeutic alliance.

**Stereotypes and Cultural Competence**

Stereotypes likely influence therapists’ formal and informal judgments of clients. Burris (2012) suggests that the process of making clinical judgments is susceptible to inferential errors (such as confirmatory bias, diagnostic overshadowing, illusory correlation), which are influenced by racial biases. I suggest that a clinician’s implicit stereotypes are likely to influence this process as well, making awareness and acknowledgment of
stereotypes important to reducing racial bias in assessment, diagnosis, and consequently the interventions used in the therapy room with clients.

As mentioned earlier, psychiatrists and psychologists are prone to judging Black children and adults to have more externalizing symptoms (like hostility, suspiciousness, and anger), but fewer internalizing symptoms (like feelings of worthlessness, sadness, and anhedonia; Begeer et al., 2009; Lagomasino et al., 2011; Nguyen et al., 2007). This trend is in line with the common negative stereotypes in the US of Black people as aggressive, violent, and superhuman (lacking the ability to be hurt or feel pain to the same degree as White people).

Cardemil and Battle (2003), as well as other researchers, suggest that therapists proactively and openly discussing race and ethnicity in therapy is important to promoting trust and a better therapeutic alliance, particularly with clients of color (Burris, 2012; Chang & Yoon, 2011; Graham et al., 2013). Furthermore, in a study of ethnic minority clients’ interactions with White therapists, the majority believed that White therapists’ lack of understanding of important parts of the client’s experience was demonstrated by therapists’ avoidance of discussing racial/cultural issues (Hook et al., 2016). I suggest that actively and openly discussing stereotypes when they are relevant is likely necessary since they are part of clients’ contexts in addition to culture. As such, I expected that methods that actively address stereotypes would lead to more positive assessments of hypothetical therapists in the current study. Evidence suggests that stereotypes are a prominent part of experiences of discrimination (Paradies, 2006; Trawalter & Hoffman, 2015), mental health service and
utilization disparities (Hamilton et al., 2015; Tillman et al., 2010), negative experiences in mental health settings (Levine & Ambady, 2013), and the general context in which people of African descent live in the US (Steele, 1997). Leaving this out of therapists’ understanding and skills presents a gap that is likely obvious to Black clients and could negatively impact the therapeutic alliance if not addressed. Therefore, the current study examined how behaviors that actively address stereotypes may positively impact Black people’s perceptions of White therapists along dimensions that impact the therapeutic alliance.

**Proposed Interventions Acknowledging and Addressing Stereotypes**

I propose that stereotypes are an integral part of the experience of being a racial minority, and particularly a person of African descent, in the United States. As such, multicultural training needs to acknowledge and specifically address stereotypes in order to be effective. It is possible that research about training and philosophies explicitly focused on stereotypes has not been explored nor emphasized to avoid further marginalizing and stereotyping clients with oppressed identities. For instance, Cardemil & Battle (2003), in their discussion of engaging in conversations about race and ethnicity in therapy, stress the importance of understanding that “clients may be quite different from other members from their racial/ethnic group” (p. 280). However, I argue that it is possible and important to recognize that stereotypes frequently do not apply to clients while demonstrating awareness and knowledge of stereotypes affecting clients, as well as skills in intervening with the negative impacts of living in a context of stereotypes. The current study, therefore, examined
therapist behaviors that acknowledge the detrimental context of stereotypes in which people of African descent live without suggesting that they apply to the client.

Because microaggressive behaviors from therapists occur with alarming frequency (Hook et al., 2016) but often inadvertently (Graham et al., 2013; D. W. Sue, 2001; D. W. Sue et al., 2007), it is important to also consider how well-meaning but microaggressive behaviors may be perceived by Black people, as well as how they may differ or be similar to effective behaviors meant to address culture or stereotypes. This study explored these well-meaning behaviors and behaviors that address stereotypes in comparison with existing Culturally Sensitive methods in order to understand what behaviors are helpful to the therapeutic alliance and mental health outcomes in a way that acknowledges nuances in Black people’s experiences. Specifically, I examined how participants of African descent respond to hypothetical behaviors from White therapists that are Culturally Sensitive, that actively address stereotypes (Counterstereotypical), or that have the potential to be microaggressive (Well-Intentioned but Harmful). Responses were gathered about the 1) trust, 2) willingness to disclose deeper feelings, 3) belief or doubts about genuine investment, and 4) likelihood of returning to therapy the participant feels with each hypothetical therapist. Responses to each vignette as well as to vignettes by behavior category were then compared in order to understand any differences that may exist in the effectiveness of each type of therapist behavior. Black people who have attended therapy, as well as those who have not, were recruited for this study’s sample.
The potential impact of previous experiences of discrimination and previous experiences in therapy on each other as well as on perceptions of therapists were also considered in this study. Evidence suggests that discrimination both in and outside of therapy is negatively associated with perceptions of therapists (Chang & Berk, 2009; Constantine, 2007; Krill Williston et al., 2019), that microaggressions frequently occur in therapy (Burris, 2012; Hook et al., 2016), and that Black people have more negative expectations of therapy on average after attending therapy (Diala et al., 2000). Although it seemed likely that discrimination and therapy attendance would affect clients’ opinions about therapist behaviors, it was unclear how these variables might impact each other or perceptions of specific types of interventions.

As a whole, this study sought to explore the impact of addressing stereotypes in comparison to existing culturally sensitive methods and existing microaggressive behaviors, while acknowledging the heterogeneity and complexity of people of African descent.

**The Current Study**

As a first step in exploring these important questions, this study required developing a new measure to assess responses from participants of African descent to hypothetical vignettes that fall into three types of therapist behavior categories (Culturally Sensitive, Counterstereotypical, and Well-Intentioned but Harmful). The measure includes four identical client response questions for every vignette: three inquiring about therapeutic alliance-related factors (trust, disclosing deeper feelings, belief in the therapists’ genuine investment), and one outcome variable (likelihood to return) (Aim 1). I explored descriptive
statistics for responses to the measure to provide preliminary evidence of its validity, particularly the validity of the three therapist behavior categories as theoretically distinct and independent (Aim 2). Main analyses included comparing participant responses across the four client response variables (trust, disclosing deeper feelings, belief in the therapists’ genuine investment, and likelihood to return for a hypothetical second session). I predicted that responses to the Culturally Sensitive and Counterstereotypical therapist behaviors would be significantly more positive than responses to WHAMs (Aim 3). Finally, I explored the association between history of therapy and experiences of discrimination with participant responses as they might account for variability in responses to therapeutic alliance-related variables and anticipated willingness to attend therapy (Aim 4).
CHAPTER 3
RESEARCH DESIGN AND METHODS

Measure Development: Perceptions of Therapeutic Behaviors Questionnaire

The measure developed in this project is called the Perceptions of Therapeutic Behaviors Questionnaire. The process of measure development included 1) a literature review to determine client response variables and distinct categories of therapist behaviors that may particularly affect mental health outcomes for people of African descent in the US, 2) development of vignettes describing hypothetical therapist behaviors, and 3) consultation with a group of Clinical Psychology researchers and clinicians to condense and verify the relevance of the list of client response variables and therapist behavior vignettes. Text for all six developed vignettes can be found in Appendix A.

Stereotypes

The literature review indicated that being stereotyped and concerns about being seen as fitting negative stereotypes about one’s racial group significantly affect mental health, well-being, and interactions with health providers for people of color in general, as well as specifically for Black people (Bryant-Davis & Ocampo, 2005; Steele, 1997; Tillman et al., 2010; Waytz et al., 2015). In addition, qualitative reports indicated that knowledge and skills
in addressing stereotypes were related to client satisfaction (Chang & Berk, 2009).
Consequently, a category of therapist behavior involving stereotypes was explored and
refined further.

*Cultural Sensitivity*

Culturally sensitive methods were included as they are currently most widely
accepted as important and necessary to reducing racial disparities created by inappropriately
differential treatment of clients by race, having received support from the US government
and American Psychological Association (American Psychological Association, 2003; D. W.
Sue, 2001). Furthermore, stereotypes were explored here as a component of culturally
sensitive methods that may not be sufficiently accentuated in existing culturally sensitive
training. Finding differences in how clients respond to Culturally Sensitive methods when
compared to methods involving stereotypes might indicate benefits in emphasizing the
impact of stereotypes in addition to the impact of culture.

*Good Intentions*

Therapists engage in extensive training and emotionally grueling work in order to
help clients. Most therapists want to help their clients, however, approximately 81% of
people of color have experienced microaggressions in therapy (Hook et al., 2016).
Researchers suggest that personal implicit biases (D. W. Sue et al., 2007), as well as biases in
the type of training offered to clinicians (Gómez, 2015; D. W. Sue, 2001), can lead to
inadvertent microaggressions in therapy. Some professionals may think racism propagates in
therapy from clinicians who are overtly biased. However, considering that most therapists
want to help their clients, the most frequent contributors to microaggressions in therapy may actually be those who accept clients of color and want to help. I found examples of well-intentioned behaviors from therapists that are still microaggressive from a combination of reviewing literature and gathering anecdotes from practicing therapists and Black people who have had therapy in order to help therapists who mean well understand the difference between behaviors perceived as helpful and those perceived as microaggressive by people of African descent.

**Behavior Category and Vignette Development**

Ideas for behaviors described in the vignettes and definitions of behavior categories originated from a combination of therapists of color’s experiences with microaggressions from their own therapists, a literature search on culturally sensitive and microaggressive behaviors documented in studies and case studies (Chang & Berk, 2009; Chang & Yoon, 2011; Graham et al., 2013; D. W. Sue et al., 2007), and consultation with practicing professors and students in a Clinical Psychology PhD program.

I generated approximately 15 scenarios involving therapist behaviors relevant to addressing or ignoring culture and/or stereotypes from an initial literature search and stories from clinicians of color. I then extrapolated vignettes for cultural sensitivity from research on client of color satisfaction in therapy and positive experiences with therapists across racial difference, extrapolated behaviors related to stereotypes largely from what clients reported was missing from sessions, and extrapolated harmful behaviors from research on microaggressions and behaviors clients reported as negative.
Therapists in each vignette were given names in order to aid participants in imagining an interaction with a real person. All hypothetical therapist names were chosen to be ambiguous in terms of gender (i.e., Toby) in order to reduce the potential impact of gender as a confound. Instructions for the measure included imagining an interaction with a White therapist. Cross-racial dyads in other combinations of racial identities are also important to explore in the future. This preliminary study focused on White-identifying therapist and Black-identifying client dyads given the overwhelming health disparities for Black clients and disproportionate prevalence of White clinicians.

A meeting was then held that included three clinical psychology professors and five clinical psychology PhD students to streamline the vignettes, narrow the number of outcome and therapeutic alliance factors, and more specifically define and distinguish the three categories of therapist behavior.

Together, we narrowed the therapist behavior vignettes to six (two vignettes per category) and subsequently underwent several line-edit revisions (see Appendix for final measure). Therapist behavior categories are defined as follows:

**Culturally Sensitive Behaviors**

Current Culturally Sensitive practices are operationalized in this study as practices designed to acknowledge the impact of a client’s and therapist’s cultural backgrounds on therapy, the client’s perceptions, and the client’s context, without assigning a positive or negative valence to cultural characteristics. These behaviors demonstrate awareness, knowledge, or skills in addressing culture in accordance with D.W. Sue et al. (1992)
conceptualization. Vignettes describing Culturally Sensitive behavior include only those practices or approaches for which there is empirical evidence that they improve the therapeutic alliance, client satisfaction, or client mental health outcomes.

Culturally Sensitive vignettes in this study focus on 1) respectfully working through a misunderstanding related to racial/ethnic/cultural difference (Chang & Berk, 2009) and 2) demonstrating an awareness, interest, and sense of responsibility in gaining non-superficial knowledge of the client’s cultural background (Chang & Yoon, 2011; Graham et al., 2013).

Counterstereotypical Behaviors

Counterstereotypical behavior is defined here as actions and statements made by the therapist that directly indicate awareness of or beliefs contrary to negative stereotypes of the client’s ethnic or racial group. This is conceptualized as demonstrating awareness, knowledge, and/or skills related to how a context of stereotypes impact the client, the therapist, their beliefs, and their interactions with each other (in parallel with D.W. Sue et al.’s (1992) conceptualization of multicultural approaches).

Counterstereotypical vignettes in this study focus on 1) acknowledging the impact of stereotyping and discrimination and 2) demonstrating non-superficial understanding of how a context of stereotypes can contribute to the client’s beliefs about themselves and the world. These topics were extrapolated from research indicating clients are dissatisfied with therapists who show only superficial or stereotypical knowledge of their communities, or demonstrate a lack of awareness of how stereotypes and bias affect clients (Chang & Berk,
as well as research on the negative impacts of being stereotyped or taking on negative racial stereotypes (Steele, 1997; L. M. West et al., 2016).

**Well-Intentioned but Harmful Approaches or Methods (WHAM)**

Well-Intentioned but Harmful Approaches or Methods are those in which therapists seek to 1) demonstrate cultural awareness 2) demonstrate a rejection of negative stereotypes and/or 3) intervene to improve the mental health of the client but are inadvertently microaggressive and marginalizing. Some examples of how this inadvertent marginalization may occur include demonstrating a belief in negative stereotypes, a lack of understanding of important cultural contexts, or a disbelief in the client’s perceptions of the impact of culture, stereotypes, or discrimination on their situation.

WHAM vignettes in this study focus on 1) inappropriately applying therapeutic techniques in a way that invalidates the client’s perception of issues related to race (Chang & Berk, 2009; Graham et al., 2013; D. W. Sue et al., 2007), 2) emphasizing the social and cultural distance between the therapist and client (Chang & Berk, 2009; Chang & Yoon, 2011), both of which include specific behaviors such as asking for culture or race-related information in a way that burdens the client to represent or provide information about the experiences of all people from their racial or ethnic group.

**Client Response Variables**

The following questions about each vignette were initially generated from literature on the therapeutic alliance and client outcomes:

- How likely would you be to go back to see this therapist?
- How much would you trust him/her?
- How much do you think this therapist would be able to relate to you or your experiences?
- How much do you think this therapist would understand your culture?
- How much do you think this therapist would understand concerns that are culturally or racially specific for you?
- How much do you think this therapist would understand your experiences of discrimination you have faced due to your culture or race?
- How helpful would this person be to you in the long-term?
- How much do you think this therapist cares what happens to you?
- How likely would you be to share your deeper feelings with this therapist?

Client response variables were narrowed down in the consultation meeting with clinical psychology professors and PhD students to three therapeutic relationship factors (trust, disclosing deeper feelings, belief in therapists’ genuineness) and one outcome factor (likelihood to return) that encompassed the most important aspects of all factors on the first list according to the therapist group’s experiences with clients and existing literature.

The four final client response variables are as follows:

- Retention-related variable:
  - Likelihood to return: How **likely** would you be **to go back** to see this therapist? (Extremely unlikely - Extremely likely)

- Alliance-related variables:
o Trust: How much would you trust this therapist? (Not at all - A great deal)

o Belief in genuine investment: How genuinely invested do you think this therapist would be in you? (Not at all invested - Deeply invested)

o Disclosing deeper feelings: How likely would you be to share your deeper feelings with this therapist? (Extremely unlikely - Extremely likely)

Sample

Three hundred twenty-nine participants entered the online survey, one of whom chose not to consent to the study and discontinued. The consent and advertisements for the study listed identifying racially as Black as one of the criteria for participation. Participants’ racial identities were assessed with two items. First, they were asked an open-ended question as follows: “Racial categories are based on visible attributes (often skin or eye color and certain facial and bodily features) and self-identification. These groupings have social meanings that affect how people see themselves and are seen and treated by others. Race is not the same as ethnicity or culture. In your own words, what is/are your racial identification(s)?” Second, they responded to a single selection question (“which group below most accurately describes your racial identification”), which included the following nine options: Native American/American Indian/Alaska Native/Indigenous, Asian/Asian American, Black, Latino/a/x/Hispanic (Non-White), Middle Eastern/North African (Non-White), Pacific Islander/Native Hawaiian, White, Multiracial, Not listed. Those identifying as Multiracial were asked to further specify their racial identification in an additional multiple selection question, including the seven prior response options (“please select all racial categories that
you consider to be a part of your racial identity”). Of the 329 who began the survey, 179 were excluded because they identified racially with categories that did not include “Black.” This was remarkable because the racial inclusion criteria and the purpose of the study in understanding the experiences of Black people were prominently placed on all recruitment materials and on the survey itself. Those who did not identify as Black or of African descent but attempted to take the survey predominantly identified racially as “Asian/Asian American” (32.4%), “Latino/a/x/Hispanic (Non-White)” (24.5%), and “White” (23%). However, the large percentage of those selecting “Latino/a/x/Hispanic (Non-White)” is likely partially explained by evidence that a high proportion of Latinx and Caribbean people who identify as being of African-descent but do not always identify with the label “Black” when given a single-selection racial identification question (Ablorh, 2020; Eisenhower et al., 2014; Newby & Dowling, 2007; ya Azibo et al., 2011).

The remaining 149 participants included those who identified as solely as “Black” in the first question or selected “Black” as one of the follow up categories after selecting “Multiracial” in the first question. Forty-one participants were excluded because they did not give any racial identification information. Of the 149 people who self-identified as “Black,” 98 reached and filled out some portion of the primary measure of interest (Perceptions of Therapist Behavior). Participants’ ages ranged from 18-69 with a mean age of 23.76 years ($SD = 8.94$), a significant positive skew of 2.73 ($SE = .25$), and a kurtosis of 9.02 ($SE = .50$). Two participants were omitted from further analyses as their ages were significant outliers (age 60 and age 69) and because being at such a different stage of life, as well as having
generationally different experiences, are likely to impact responses to target variables. The omission of these outliers brought the skew and kurtosis into normal ranges (skew – 1.78, SE = .25; kurtosis – 2.27, SE = .50). The final sample included 96 participants who identified as “Black” or “Multiracial” and completed the PTB questions.

The final sample was predominantly female (80.2%; n = 77), heterosexual (75%; n = 72), and born in the United States (66.7%; n = 64). A range of religions and spiritual practices were represented, with Christianity (47.9%; n = 46) as the most common. In terms of education, 99% (n = 95) of respondents had received a high school diploma or equivalent and 68.8% (n = 66) had completed some amount of post-secondary education. Demographic information for the sample in terms of gender, sexual orientation, racial identification, race perceived by others, household income, highest level of education, religion or spiritual practice, country of birth, generational status, and ancestry are included below in tables 1 through 5. For race perceived by others, participants were asked to identify one or more races other people most frequently perceive them to be. Response options for this question were the same as for the open-ended racial identification question in which they were asked how they racially identify. The question for household income was phrased as “Currently, what is your total household annual income (all earners)?”
Recent ancestry was presented as a single-selection question (“which of the following best describes your ancestry”). This item had limitations worth noting: although participants could also select “not listed/more complex” and describe having parents or grandparents with multiple ancestries; this would have been more easily expressed by allowing multiple responses. Asking for the “best” description in a single-selection question may have led some with more complex ancestry to feel pressured to select one, making it more difficult to be certain how much of the sample has more complex ancestry. Final participants’ ages ranged from 18 to 43, with a mean age of 22.86 ($SD = 6.6$) as displayed in Figure 4 above.
### Table 1
Demographic Characteristics: Gender and Sexual Orientation

<table>
<thead>
<tr>
<th>Gender (multiple selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>77</td>
<td>80.2</td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>18.8</td>
</tr>
<tr>
<td>Not listed (specify if you choose)</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>72</td>
<td>75</td>
</tr>
<tr>
<td>Bisexual</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Pansexual</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Queer</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Not listed (e.g., questioning) specify if you choose</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Asexual</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Table 2
Demographic Characteristics: Racial Identification and Race Perceived by Others

<table>
<thead>
<tr>
<th>Race (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>87</td>
<td>90.6</td>
</tr>
<tr>
<td>Multiracial (please specify):</td>
<td>9</td>
<td>9.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiracial Identification (multiple selection; 9 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>Latino/a/x/Hispanic (Non-White)</td>
<td>6</td>
<td>66.7</td>
</tr>
<tr>
<td>Middle Eastern/North African (Non-White)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>3</td>
<td>33.3</td>
</tr>
<tr>
<td>Asian/Asian American</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Native American/American Indian/Alaska Native/Indigenous</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Not listed</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pacific Islander/Native Hawaiian</td>
<td>1</td>
<td>11.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race Perceived by Others (multiple selection; 56 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>72</td>
<td>75.0</td>
</tr>
<tr>
<td>Latino/a/x/Hispanic (Non-White)</td>
<td>32</td>
<td>33.3</td>
</tr>
<tr>
<td>Multiracial</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>Middle Eastern/North African (Non-White)</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>White</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Asian/Asian American</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Native American/American Indian/Alaska Native/Indigenous</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Not listed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pacific Islander/Native Hawaiian</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>System Missing</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
### Table 3

#### Participant Demographic Country of Birth and Ancestry

<table>
<thead>
<tr>
<th>Country of birth (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the United States (one of the 50 states)</td>
<td>64</td>
<td>66.7</td>
</tr>
<tr>
<td>Outside the U.S. or its territories. (Please specify what country):</td>
<td>17</td>
<td>17.7</td>
</tr>
<tr>
<td>Declined to answer</td>
<td>15</td>
<td>15.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generational Status (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First generation American (I was 13 or older when I moved to the US)</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>1.5 generation American (I moved to the US at age 12 or younger)</td>
<td>11</td>
<td>11.5</td>
</tr>
<tr>
<td>2nd generation American (I was born in the US and have at least one parent who relocated to the US)</td>
<td>31</td>
<td>32.3</td>
</tr>
<tr>
<td>3rd generation American (My grandparent(s) moved to the US)</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>4th generation American (My great-grandparent(s) moved to the US)</td>
<td>6</td>
<td>6.3</td>
</tr>
<tr>
<td>5th or more generation American</td>
<td>28</td>
<td>29.2</td>
</tr>
<tr>
<td>Not listed/More complex situation: (please describe)</td>
<td>7</td>
<td>7.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ancestry (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancestors were brought to the United States during the trans-Atlantic slave trade</td>
<td>36</td>
<td>37.5</td>
</tr>
<tr>
<td>Recent generations from the Caribbean</td>
<td>28</td>
<td>29.2</td>
</tr>
<tr>
<td>Recent generations from Africa</td>
<td>19</td>
<td>19.8</td>
</tr>
<tr>
<td>Not listed/More complex ancestry</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>Recent generations from Latin America or South America</td>
<td>3</td>
<td>3.1</td>
</tr>
</tbody>
</table>

### Table 4

#### Demographic Characteristics: Spirituality

<table>
<thead>
<tr>
<th>Religion or Spiritual Practice (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christianity</td>
<td>46</td>
<td>47.9</td>
</tr>
<tr>
<td>None</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>Not listed (please specify)</td>
<td>8</td>
<td>8.3</td>
</tr>
<tr>
<td>Agnosticism (not sure if there is a God)</td>
<td>6</td>
<td>6.3</td>
</tr>
<tr>
<td>Atheism (do not believe God or other deities exist)</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Islam</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Vodun, Voodoo, Vodou, or Vudú</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Akom</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Native American or Indigenous religion (please specify)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Declined to answer</td>
<td>16</td>
<td>16.7</td>
</tr>
</tbody>
</table>
Recruitment

As part of a larger study on experiences with race, identity, marginalization, and well-being, participants were recruited from two universities in the Boston area, greater Boston area communities, and through social media forums such as Facebook. Inclusion criteria included being 18 years or older and racially identifying as Black. Although all participants identify racially as Black, there is a great deal of heterogeneity in the sample in terms of ethnicity and other racial identification.

1. UMass Boston and Suffolk University campus communities: For on-campus recruitment, the researchers (a) sent emails to students in the general student community through the established mechanisms for approved studies, (b) posted

<table>
<thead>
<tr>
<th>Household Income (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $15,000</td>
<td>14</td>
<td>14.6</td>
</tr>
<tr>
<td>$15,001 – $25,000</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>$25,001 – $35,000</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>$35,001 - $50,000</td>
<td>17</td>
<td>17.7</td>
</tr>
<tr>
<td>$50,001 - $75,000</td>
<td>15</td>
<td>15.6</td>
</tr>
<tr>
<td>$75,001 - $100,000</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>$100,001 - $200,000</td>
<td>11</td>
<td>11.5</td>
</tr>
<tr>
<td>More than $200,000</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Declined to answer</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest Level of Education (single selection; 96 responses)</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some high school</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>High School diploma</td>
<td>29</td>
<td>30.2</td>
</tr>
<tr>
<td>Some college</td>
<td>37</td>
<td>38.5</td>
</tr>
<tr>
<td>Associate's degree</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>Trade school certification (post high school)</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>College degree (B.A., or B.S.)</td>
<td>13</td>
<td>13.5</td>
</tr>
<tr>
<td>Master's degree (e.g. M.A., M.B.A., or M.S.)</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Professional or doctoral degree (e.g. M.D., J.D., or Ph.D.)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
flyers on campus, and (c) specifically posted flyers and distributed emails through student groups like the Black Student Center, African Student Union, Caribbean student organizations, and Multicultural Center, and (d) recruited students through psychology courses offering course credit for participation.

2. Community flyering: In the greater Boston area, the researchers asked permission and posted flyers in barbershops and salons that cater to Black people, community health centers, and on community information boards/tables in places like the YMCA, libraries, community centers, and grocery stores.

3. Email recruitment: The researchers emailed local chapters of organizations such as the NAACP, Transformation Center, Young Black Women’s Society of Boston, Urban League of New England, etc.

4. Social media recruitment: The researchers posted advertisements on the laboratory Facebook and Twitter pages.

5. Referrals from participants (snowball recruitment): we asked participants to share the link to the study with others who may be interested/eligible.

**Procedure**

Participants were asked to complete an online battery of questionnaires as part of a larger study on the experiences, thoughts, and well-being of people of African descent. The questionnaire included measures of microaggressive experiences, perceptions of therapist behaviors, and demographic information relevant to this study and as listed below, in addition to other measures included in the larger study.
**Measures**

*UMass Boston Comprehensive Demographics Questionnaire (Suyemoto et al., 2016).*

Faculty and students in the UMB clinical psychology program collaborated to develop a comprehensive demographics questionnaire that thoroughly assesses the constructs of race, ethnicity, sexuality, immigrant status and socio-economic status.

Race- and ethnicity-related items within this questionnaire include self-report measures of single and multiracial identity, race perceived by others, and ethnicity. This measure also includes questions about participants’ history of experiences with mental health, such as whether or not they have ever attended therapy.

*The Racial Microaggressions Scale (RMAS; Torres-Harding et al., 2012).*

The RMAS measures perceptions of racial microaggressions experienced by people of color. The authors use D. W. Sue et al.'s (2007) definition of racial microaggressions as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group.” There are six subscales: 1) foreigner/not belonging; 2) criminality/assumption of criminal status; 3) sexualization/exoticized; 4) low achieving/undesirable culture; 5) invisibility; 6) environmental. The RMAS illustrated good internal consistency for the aforementioned subscales for a racially and ethnically diverse sample of people of color (.78, .85, .83, .87, .89, .81 respectively). The scale showed good convergent and concurrent validity with the same sample (Torres-Harding et al., 2012). The
six subscales also demonstrated good internal consistency within this study’s sample (.79, .84, .85, .91, .81, .92 respectively).

**Perceptions of Therapeutic Behaviors**

This measure, developed for this study (included in the Appendix), consists of questions about hypothetical therapy experiences to explore factors that may impact attrition and the therapeutic alliance in interracial client-clinician dyads. Participants are given six scenarios that could occur in therapy. Two vignettes demonstrate a therapist’s behavior in accordance with each of the therapeutic behavior categories: Culturally Sensitive, Counterstereotypical, and WHAM. After each scenario, four questions inquire about feelings, reactions, and impressions of the therapist in the scenario along four client response variables: trust, disclosing deeper feelings, belief in the therapists’ genuine investment, and likelihood to return to see the therapist. These questions assess the participants' expectations and attitudes towards therapists who exhibit different types of behaviors, using the categories of Culturally Sensitive, Counterstereotypical, and WHAM behaviors as described above.
CHAPTER 4

RESULTS

Preliminary Analyses

Before conducting hypothesis testing, data were analyzed for adherence to assumptions of normality. Measures for Perceptions of Therapist Behaviors (PTB) and the RMAS were normally distributed. Despite omission of outliers ages 60 and over, age continued to have a strong positive skew. A natural log transformation was used to correct for the skew. Ninety-six participants, all of whom filled out some portion of the PTB measures, were included in the final sample. Pairwise deletion was used for missing data in order to include more of the available data. Missingness was non-random in this data, so listwise deletion may have resulted in omission of subjects who shared demographic or psychological characteristics. The rate of missingness for vignette ratings ranged from 3.1% to 32.3%. All participants included in this sample reported their single-selection ancestry; while rates of missingness for number of previous therapy sessions and microaggressions were 46.9% and 8.3%-14.5%, respectively. Valid n for each vignette rating can be found in Table 10.
Aim 1

Aim 1 was fulfilled through the development and creation of the Perceptions of Therapist Behavior measure.

Aim 2 Hypotheses – Correlations of Therapist Behavior Category Ratings and of Client Response Variables

Correlations were conducted within client response variable (trust, belief in genuine investment, and disclosing deeper feelings, and likelihood to return) across all six vignettes to explore hypothesis 2a, which predicted that the therapist behavior categories would be statistically distinct from each other (Tables 6-9). Correlations between responses to the two vignettes within therapist behavior category were not sufficiently larger than correlations between categories to consider therapist behavior categories distinct. Visual examination showed that correlations were often higher or the same for vignettes across therapist behavior category than within category. Correlations within category also did not exceed \( r = \pm 0.6 \). Because the proposed therapist behavior categories were not statistically distinct, later analyses were conducted considering differences across all six vignettes, rather than across the three therapist behavior categories.
### Table 6

**Vignette Correlations: Likelihood to Return (Retention Variable)**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Vignette A (Drew) Culturally Sensitive</th>
<th>Vignette F (Francis) Culturally Sensitive</th>
<th>Vignette B (Kerry) Counterstereotypical</th>
<th>Vignette D (Devon) Counterstereotypical</th>
<th>Vignette C (Alex) WHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette A (Drew) Culturally Sensitive</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette F (Francis) Culturally Sensitive</td>
<td>.36**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette B (Kerry) Counterstereotypical</td>
<td>.26*</td>
<td>.26*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette D (Devon) Counterstereotypical</td>
<td>.15</td>
<td>.49**</td>
<td>.23**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette C (Alex) WHAM</td>
<td>.30**</td>
<td>.21</td>
<td>.22</td>
<td>.06</td>
<td></td>
</tr>
<tr>
<td>Vignette E (Toby) WHAM</td>
<td>.16</td>
<td>.27*</td>
<td>.41**</td>
<td>.10</td>
<td>.27*</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

### Table 7

**Vignette Correlations: Trust**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Vignette A (Drew) Culturally Sensitive</th>
<th>Vignette F (Francis) Culturally Sensitive</th>
<th>Vignette B (Kerry) Counterstereotypical</th>
<th>Vignette D (Devon) Counterstereotypical</th>
<th>Vignette C (Alex) WHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette A (Drew) Culturally Sensitive</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette F (Francis) Culturally Sensitive</td>
<td>.42**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette B (Kerry) Counterstereotypical</td>
<td>.36**</td>
<td>.35**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette D (Devon) Counterstereotypical</td>
<td>.29**</td>
<td>.52**</td>
<td>.33**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette C (Alex) WHAM</td>
<td>.41**</td>
<td>.14</td>
<td>.31**</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Vignette E (Toby) WHAM</td>
<td>.26*</td>
<td>.43**</td>
<td>.40**</td>
<td>.15</td>
<td>.24</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).
### Table 8
**Vignette Correlations: Belief in Genuine Investment**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Vignette A (Drew) Culturally Sensitive</th>
<th>Vignette F (Francis) Culturally Sensitive</th>
<th>Vignette B (Kerry) Counterstereotypical</th>
<th>Vignette D (Devon) Counterstereotypical</th>
<th>Vignette C (Alex) WHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette A (Drew) Culturally Sensitive</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette F (Francis) Culturally Sensitive</td>
<td>.41**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette B (Kerry) Counterstereotypical</td>
<td>n</td>
<td>85</td>
<td>.36**</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>Vignette D (Devon) Counterstereotypical</td>
<td>n</td>
<td>85</td>
<td>.35**</td>
<td>.35**</td>
<td></td>
</tr>
<tr>
<td>Vignette C (Alex) WHAM</td>
<td>n</td>
<td>74</td>
<td>- .05</td>
<td>22</td>
<td>.09</td>
</tr>
<tr>
<td>Vignette E (Toby) WHAM</td>
<td>n</td>
<td>80</td>
<td>79</td>
<td>79</td>
<td>81</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).**  
*. Correlation is significant at the 0.05 level (2-tailed).  

### Table 9
**Vignette Correlations: Willingness to Disclose**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Vignette A (Drew) Culturally Sensitive</th>
<th>Vignette F (Francis) Culturally Sensitive</th>
<th>Vignette B (Kerry) Counterstereotypical</th>
<th>Vignette D (Devon) Counterstereotypical</th>
<th>Vignette C (Alex) WHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette A (Drew) Culturally Sensitive</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette F (Francis) Culturally Sensitive</td>
<td>.48**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette B (Kerry) Counterstereotypical</td>
<td>n</td>
<td>74</td>
<td>.22</td>
<td>.28*</td>
<td></td>
</tr>
<tr>
<td>Vignette D (Devon) Counterstereotypical</td>
<td>n</td>
<td>74</td>
<td>.32**</td>
<td>.54**</td>
<td>.31**</td>
</tr>
<tr>
<td>Vignette C (Alex) WHAM</td>
<td>n</td>
<td>75</td>
<td>81</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Vignette E (Toby) WHAM</td>
<td>n</td>
<td>64</td>
<td>68</td>
<td>67</td>
<td>69</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).**  
*. Correlation is significant at the 0.05 level (2-tailed).
Secondly, alliance-related variables were expected to be associated with the retention-related variable. Within vignette, correlations between the three alliance-related variables (trust, belief in genuine investment, and disclosing deeper feelings) and likelihood to return were conducted to test whether the alliance variables are related to participants’ likelihood of engaging in therapy. In accordance with hypothesis 2b, all correlations between likelihood to return (retention variable) and each alliance-related variable (trust, belief in genuine investment, and disclosing deeper feelings) were statistically significant within vignette ($p < .001, r > .57$; see Table 10 for correlation coefficients), suggesting that factors that influence the therapeutic alliance are significantly associated with retention. Although this is not a causal analysis, it provides support for previous research indicating that trust, belief in genuine investment, and disclosing deeper feelings are important to the retention of clients, particularly those of African descent (Abdullah & Brown, 2011; Chang & Berk, 2009; Constantine, 2007; Gómez, 2015; Maura & Weisman de Mamani, 2017; Tillman et al., 2010; Wintersteen et al., 2005).

Table 10
Correlation of Therapeutic Alliance Variables with Retention Variable for Each Vignette

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Vignette A (Drew)</th>
<th>Vignette F (Francis)</th>
<th>Vignette B (Kerry)</th>
<th>Vignette D (Devon)</th>
<th>Vignette C (Alex)</th>
<th>Vignette E (Toby)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Culturally Sensitive</td>
<td>Culturally Sensitive</td>
<td>Counterstereotypical</td>
<td>Counterstereotypical</td>
<td>WHAM</td>
<td>WHAM</td>
</tr>
<tr>
<td>Trust</td>
<td>.64 **</td>
<td>.80 **</td>
<td>.84 **</td>
<td>.76 **</td>
<td>.89 **</td>
<td>.84 **</td>
</tr>
<tr>
<td>n</td>
<td>90</td>
<td>86</td>
<td>87</td>
<td>88</td>
<td>70</td>
<td>71</td>
</tr>
<tr>
<td>Belief in Investment</td>
<td>.58 **</td>
<td>.87 **</td>
<td>.78 **</td>
<td>.74 **</td>
<td>.82 **</td>
<td>.55 **</td>
</tr>
<tr>
<td>n</td>
<td>88</td>
<td>86</td>
<td>85</td>
<td>89</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Willingness to Disclose</td>
<td>.60 **</td>
<td>.82 **</td>
<td>.77 **</td>
<td>.68 **</td>
<td>.78 **</td>
<td>.85 **</td>
</tr>
<tr>
<td>n</td>
<td>78</td>
<td>83</td>
<td>84</td>
<td>87</td>
<td>65</td>
<td>68</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
Aim 3 Hypotheses – Comparing the Impact of Therapist Behavior Categories and Individual Vignettes

Descriptive statistics (mean, standard deviation, and tests of heterogeneity and normality) were conducted for each of the four client response variables within each of the six vignettes, resulting in 24 sets of descriptive statistics (see Table 11 below).

Hypothesis 3a predicted that both WHAM vignettes would be below neutral (below 5 on a 10-point scale) and that all other vignettes would be rated above neutral for all client response variables. The plot below, Figure 5, depicts average ratings by vignette and behavior category. In partial support of Hypothesis 3a and 3b, Culturally Sensitive and Counterstereotypical vignettes resulted in ratings above neutral and higher than WHAMs. Although ratings for vignettes did not correlate more consistently within behavior category than across them (shown earlier in Tables 6-9), mean ratings for Counterstereotypical and Culturally Sensitive vignettes were descriptively higher than those for WHAMs. Contrary to hypothesis 3a, a WHAM vignette also received ratings above neutral. The WHAM Vignette E was the only vignette receiving lower than neutral (5) ratings.
Table 11
Descriptive Statistics by Vignette and Client Response Variable

<table>
<thead>
<tr>
<th>Therapist Behavior Category</th>
<th>n</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Skewness Statistic</th>
<th>Std. Error</th>
<th>Kurtosis Statistic</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Likelihood to Return</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vignette A (Drew)</td>
<td>93</td>
<td>0.00</td>
<td>10.00</td>
<td>6.40</td>
<td>2.86</td>
<td>-0.35</td>
<td>0.25</td>
<td>-0.72</td>
<td>0.50</td>
</tr>
<tr>
<td>Vignette B (Kerry)</td>
<td>88</td>
<td>0.00</td>
<td>10.00</td>
<td>7.05</td>
<td>2.70</td>
<td>-0.64</td>
<td>0.26</td>
<td>-0.34</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette C (Alex)</td>
<td>76</td>
<td>0.00</td>
<td>10.00</td>
<td>4.29</td>
<td>2.84</td>
<td>0.12</td>
<td>0.28</td>
<td>-0.81</td>
<td>0.54</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>74</td>
<td>0.00</td>
<td>10.00</td>
<td>5.09</td>
<td>3.00</td>
<td>-0.23</td>
<td>0.28</td>
<td>-0.67</td>
<td>0.55</td>
</tr>
<tr>
<td>Vignette F (Francis)</td>
<td>86</td>
<td>1.00</td>
<td>10.00</td>
<td>6.99</td>
<td>2.29</td>
<td>-0.32</td>
<td>0.26</td>
<td>-0.71</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette D (Devon)</td>
<td>90</td>
<td>1.00</td>
<td>10.00</td>
<td>7.56</td>
<td>2.21</td>
<td>-0.56</td>
<td>0.25</td>
<td>-0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Vignette C (Alex)</td>
<td>73</td>
<td>0.00</td>
<td>10.00</td>
<td>10.00</td>
<td>4.27</td>
<td>0.25</td>
<td>0.28</td>
<td>-0.85</td>
<td>0.54</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>75</td>
<td>0.00</td>
<td>10.00</td>
<td>5.92</td>
<td>2.44</td>
<td>-0.51</td>
<td>0.26</td>
<td>0.34</td>
<td>0.52</td>
</tr>
<tr>
<td>Vignette F (Francis)</td>
<td>85</td>
<td>1.00</td>
<td>10.00</td>
<td>7.16</td>
<td>2.28</td>
<td>-0.55</td>
<td>0.26</td>
<td>-0.49</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette D (Devon)</td>
<td>88</td>
<td>1.00</td>
<td>10.00</td>
<td>7.15</td>
<td>1.99</td>
<td>-0.21</td>
<td>0.26</td>
<td>-0.39</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette C (Alex)</td>
<td>74</td>
<td>0.00</td>
<td>10.00</td>
<td>5.11</td>
<td>2.76</td>
<td>-0.21</td>
<td>0.28</td>
<td>-0.38</td>
<td>0.55</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>92</td>
<td>0.00</td>
<td>10.00</td>
<td>6.62</td>
<td>2.56</td>
<td>-0.22</td>
<td>0.25</td>
<td>-0.73</td>
<td>0.50</td>
</tr>
<tr>
<td>Vignette F (Francis)</td>
<td>87</td>
<td>1.00</td>
<td>10.00</td>
<td>7.16</td>
<td>2.28</td>
<td>-0.55</td>
<td>0.26</td>
<td>-0.49</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette D (Devon)</td>
<td>88</td>
<td>1.00</td>
<td>10.00</td>
<td>7.15</td>
<td>1.99</td>
<td>-0.21</td>
<td>0.26</td>
<td>-0.39</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette C (Alex)</td>
<td>75</td>
<td>0.00</td>
<td>10.00</td>
<td>4.27</td>
<td>2.65</td>
<td>-0.09</td>
<td>0.28</td>
<td>-0.76</td>
<td>0.55</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>83</td>
<td>0.00</td>
<td>10.00</td>
<td>5.92</td>
<td>2.44</td>
<td>-0.51</td>
<td>0.26</td>
<td>0.34</td>
<td>0.52</td>
</tr>
<tr>
<td>Vignette F (Francis)</td>
<td>91</td>
<td>0.00</td>
<td>10.00</td>
<td>6.62</td>
<td>2.56</td>
<td>-0.22</td>
<td>0.25</td>
<td>-0.73</td>
<td>0.50</td>
</tr>
<tr>
<td>Vignette D (Devon)</td>
<td>87</td>
<td>1.00</td>
<td>10.00</td>
<td>7.16</td>
<td>2.28</td>
<td>-0.55</td>
<td>0.26</td>
<td>-0.49</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette C (Alex)</td>
<td>75</td>
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<td>10.00</td>
<td>4.27</td>
<td>2.65</td>
<td>-0.09</td>
<td>0.28</td>
<td>-0.76</td>
<td>0.55</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>83</td>
<td>0.00</td>
<td>10.00</td>
<td>5.92</td>
<td>2.44</td>
<td>-0.51</td>
<td>0.26</td>
<td>0.34</td>
<td>0.52</td>
</tr>
<tr>
<td>Vignette F (Francis)</td>
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<td>1.00</td>
<td>10.00</td>
<td>7.16</td>
<td>2.28</td>
<td>-0.55</td>
<td>0.26</td>
<td>-0.49</td>
<td>0.51</td>
</tr>
<tr>
<td>Vignette D (Devon)</td>
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<td>10.00</td>
<td>7.15</td>
<td>1.99</td>
<td>-0.21</td>
<td>0.26</td>
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<td>Vignette C (Alex)</td>
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<td>10.00</td>
<td>4.27</td>
<td>2.65</td>
<td>-0.09</td>
<td>0.28</td>
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<tr>
<td>Vignette E (Toby)</td>
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<td>0.00</td>
<td>10.00</td>
<td>5.92</td>
<td>2.44</td>
<td>-0.51</td>
<td>0.26</td>
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<td>Vignette F (Francis)</td>
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<td>10.00</td>
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<td>0.26</td>
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<tr>
<td>Vignette D (Devon)</td>
<td>88</td>
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<td>10.00</td>
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<td>0.26</td>
<td>-0.39</td>
<td>0.51</td>
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<tr>
<td>Vignette C (Alex)</td>
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<td>0.00</td>
<td>10.00</td>
<td>4.27</td>
<td>2.65</td>
<td>-0.09</td>
<td>0.28</td>
<td>-0.76</td>
<td>0.55</td>
</tr>
<tr>
<td>Vignette E (Toby)</td>
<td>83</td>
<td>0.00</td>
<td>10.00</td>
<td>5.92</td>
<td>2.44</td>
<td>-0.51</td>
<td>0.26</td>
<td>0.34</td>
<td>0.52</td>
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*Note:* Matching subscripts indicate vignettes that have no statistically significant difference within each client response variable.
Prior to examining statistically significant differences between vignettes, possible associations between demographic variables and responses to vignettes were explored to determine variables that should potentially be controlled for in subsequent analyses. Among the demographic variables explored were gender, age, race perceived by others, sexual orientation, generational status, ancestry, income level, and religion. Levine’s test of homoscedasticity indicated no significant differences in variance for demographic variables. There were no significant differences in responses to PTB prompts based on sexual orientation, generational status, household income, level of education, religious designation, age, gender, race, race perceived by others, nor country of origin. Significant differences in ratings of hypothetical therapists were found by ancestry (trust – \( F(4,72) = 2.50, p = .05, \eta^2 = \))
.12; belief in genuine investment – \( F(4,77) = 3.08, p = .021, \eta^2 = .14 \); and disclosing deeper feelings – \( F(4,64) = 2.69, p = .039, \eta^2 = .14 \). LSD post hoc tests indicated this effect was driven by significantly lower ratings of therapists from participants of recent African ancestry and with “not listed/more complex” ancestry (\( p < .05 \)) when compared to those descended from enslaved people or of recent Caribbean descent.

To further explore hypothesis 3b, four one-way repeated measures ANOVAs (one per client response variable) were conducted to determine possible differences in ratings depending on vignette. Analyses indicated that assumptions of sphericity had been violated (Mauchly’s test \( p < .01 \)). Repeated measures ANOVAs with a Greenhouse-Geisser correction indicated significant differences in ratings by vignette for all four client response variables (trust \( F(4.17, 246.22) = 18.49, p < .0005, \eta^2 = 0.24 \); belief in genuine investment \( F(4.06, 255.84) = 18.26, p < .0005, \eta^2 = 0.23 \); and disclosing deeper feelings \( F(4.06, 210.96) = 14.83, p < .0005, \eta^2 = 0.22 \); likelihood to return \( F(4.35, 265.14) = 18.15, p < .0005, \eta^2 = 0.23 \)). Statistically significant differences in vignette ratings by client response variable is indicated in Table 10 using superscripts. LSD post-hoc tests indicated these effects were largely driven by the mean ratings for the two WHAM vignettes being significantly lower than means of the other four vignettes for multiple client response variables (\( ps < .03 \)); providing support for Hypothesis 3b, despite therapist behavior categories not being psychometrically distinct from one another. In addition, Vignette C (WHAM) was rated consistently lower than Vignette E (WHAM) for all four response variables (\( p < .03 \)), and Vignette A (Culturally Sensitive) was rated significantly lower than Vignettes D
(Counterstereotypical) and F (Culturally Sensitive) for trust and lower than Vignettes B, D, (Counterstereotypical) and F (Culturally Sensitive) for likelihood to disclose deeper feelings $(p < .05)$. Comparing the Culturally Sensitive and Counterstereotypical vignettes (per exploratory Hypothesis 3c, which aimed to explore the relations between ratings of these two categories) presents a complicated pattern that would likely require further studies to fully clarify.

The relation of ancestry and ratings of client response variables was further explored because preliminary analyses indicated differences in average ratings by ancestry. Since mean ratings when the client response variables were averaged for each participant were consistently lower for those with recent African and “more complex” ancestry compared to those descended from enslaved people or with recent Caribbean ancestry, the model included ancestry as a dichotomous variable that compared these two groups [(1) those with recent African and “more complex” ancestry and (2) those descended from enslaved people or with recent Caribbean ancestry]. Conceptually, these groups may differ in responses to therapist interactions, potential experiences of racism, and interventions addressing racism due to differences in US acculturation and differences in types of generational trauma. Those of African and “more complex” ancestry may be less acculturated to North America and the US specifically than those descended from enslaved people or of recent Caribbean ancestry. While both groups experience continued threats to basic safety for being Black in the US, institutional racism, and generational trauma from prolonged cultural racism inside their countries of origin; the former group may have more generational trauma connected to the
occupation of European colonists, friends and family being kidnapped, and wars to regain independence from colonial settlers, while the latter group may have more generational trauma connected to enslavement and extreme forms of institutional and structural racism inside the US.

People with recent Latin or South American ancestry were not included in this particular analysis as their client response variable ratings did not differ significantly from any other groups. Differences in client response variable ratings by vignette remained significant after controlling for ancestry as a dichotomous variable [trust $F(4.09, 228.86) = 13.85, p < .0005, \eta^2 = .20$, belief in genuine investment $F(3.97, 238.13) = 11.83, p < .0005, \eta^2 = .17$, and disclosing deeper feelings $F(4.006, 196.27) = 10.41, p < .0005, \eta^2 = .18$; likelihood to return $F(4.28, 248.36) = 11.02, p < .0005, \eta^2 = .16$]. Results also indicated a significant interaction between vignette and ancestry for likelihood to return [$F(4.28, 248.36) = 11.02, p < .029, \eta^2 = .04$] as depicted in Figure 6 below. The 95% confidence intervals around the estimated marginal means revealed non-overlapping confidence intervals for Vignettes A (Culturally Sensitive), B (Counterstereotypical), C (WHAM), and E (WHAM). This indicates that for all vignettes except for Vignettes D (Counterstereotypical) and F (Culturally Sensitive), people of recent African or “more complex” ancestry rated themselves less likely to return than those of recent Caribbean descent or descended from people enslaved and brought to the Americas.
**Aim 4 Hypothesis – Relation with Therapy Attendance and Discriminatory Experience Histories**

*Experiences of Microaggressions*

Associations between client response variable ratings and participants’ experiences and appraisal of microaggressions was explored, using the RMAS as a measure of microaggression frequency and resulting stress (represented in Tables 12 and 13). Ratings of belief in genuine investment for the Culturally Sensitive Vignette A (hypothetical therapist Drew) exhibited modest, negative, and significant associations with experiences of racial microaggressions. Specifically, in this Culturally Sensitive vignette, ratings of belief in genuine investment were lower among participants who had experienced a greater frequency of microaggressive assumptions of criminality ($r = -.25$, $p < .05$) and microaggressive
assumptions of being foreign ($r = -.25, p < .05$), and who had higher appraisals of stress from foreign-related microaggressions ($r = -.22, p < .05$). With the exception of Vignette A, there were no other significant correlations between responses to vignettes and experiences nor appraisals of microaggressive occurrences.

Table 12

<table>
<thead>
<tr>
<th>Type of Microaggression</th>
<th>Invalidation</th>
<th>Criminality</th>
<th>Low Status</th>
<th>Sexualization</th>
<th>Foreignness</th>
<th>Environmental</th>
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<tbody>
<tr>
<td>Likelihood to Return</td>
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<td>.03</td>
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<td>84</td>
<td>84</td>
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<td>83</td>
</tr>
<tr>
<td>Trust</td>
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<td>-.14</td>
<td>.01</td>
<td>.04</td>
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<td>.03</td>
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<tr>
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<td>84</td>
<td>84</td>
<td>84</td>
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<td>83</td>
</tr>
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<td>-.25*</td>
<td>-.05</td>
<td>.04</td>
<td>-.25*</td>
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</tr>
<tr>
<td>Disclose Deeper Feelings</td>
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<td>.07</td>
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<td>.08</td>
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<td>75</td>
<td>73</td>
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</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 13

<table>
<thead>
<tr>
<th>Type of Microaggression</th>
<th>Invalidation</th>
<th>Criminality</th>
<th>Low Status</th>
<th>Sexualization</th>
<th>Foreignness</th>
<th>Environmental</th>
</tr>
</thead>
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<td>.10</td>
<td>.19</td>
<td>-.17</td>
<td>.09</td>
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<td>83</td>
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<td>79</td>
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<tr>
<td>Trust</td>
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<td>-.16</td>
<td>.05</td>
<td>.01</td>
<td>-.13</td>
<td>-.09</td>
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<tr>
<td>Belief in Genuine Investment</td>
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<td>-.14</td>
<td>.05</td>
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<td>-.07</td>
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<td>Disclose Deeper Feelings</td>
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<td>-.01</td>
<td>.04</td>
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<td>73</td>
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</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
Therapy History

Relations between therapy attendance, vignettes, and ratings were explored. Therapy attendance was analyzed by creating a categorical variable for number of sessions attended during the most recent treatment period (0 sessions, 1-2 sessions, 3-6 sessions, 7 or more sessions) to correspond with those who have never attended therapy, those who quickly decided to discontinue therapy, those who experienced the treatment planning stage of therapy, and those who attended therapy on an ongoing basis. Participants reported between 0 and 32 sessions during the most recent period of seeking services, with an average of 1.67 sessions. Four two-way (therapy attendance x vignette; one for each client response variable) repeated measures ANOVAs with a Greenhouse-Geisser correction were conducted to determine if therapy attendance was associated with differential responses to the four therapeutic alliance and outcome factors across the six vignettes.

ANOVA for likelihood to return (F(4.281, 201.22) = 8.71, p < .0005, η² = .17), trust (F(4.20, 197.18) = 6.73, p < .0005 η² = .13), belief in genuine investment (F(4.07, 203.54) = 8.25, p < .0005, η² = .14), and disclosing deeper feelings (F(3.91, 164.31) = 5.72, p < .0005, η² = .12) indicated main effects of vignette when taking experience in therapy into account. ANOVAs for all four client response variables suggested no main effect of therapy and no significant interaction between therapy attendance and vignette (p > .05) (See Table 14 below).

Results from LSD post-hoc tests indicated again that these effects were largely driven by differences between Vignette C (WHAM), Vignette E (WHAM), and Vignette A.
(Culturally Sensitive) when each is compared to the other vignettes but in a pattern that differs slightly from the results of Hypothesis 3b. Vignette C (WHAM) was rated significantly lower than the Culturally Sensitive and Counterstereotypical vignettes for all four client response variables \((p < .01)\). Vignette A (Culturally Sensitive) was significantly lower than Vignette F (Culturally Sensitive) for trust, belief in genuine investment, and disclosure \((p < .05)\) and lower than Vignette D (Counterstereotypical) for disclosure \((p = .04)\). This may suggest qualities in Vignette A (Culturally Sensitive) that, while being found to be at least as favorable as the WHAM vignettes, are significantly less helpful to the therapeutic alliance and retention than the remaining Culturally Sensitive and Counterstereotypical vignettes.

<table>
<thead>
<tr>
<th>Table 14</th>
<th>Main Effects and Interactions for Vignette and Previous Therapy</th>
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</thead>
<tbody>
<tr>
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<td>Likelihood to Return</td>
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<tr>
<td>Vignette x therapy interaction</td>
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<td>Vignette main effect</td>
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<tr>
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<td>Vignette main effect</td>
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<tr>
<td>Therapy main effect</td>
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<td>Vignette x therapy interaction</td>
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<td>Disclose Deeper Feelings</td>
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<td>Vignette main effect</td>
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<td>Therapy main effect</td>
<td>1.82</td>
</tr>
<tr>
<td>Vignette x therapy interaction</td>
<td>.58</td>
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</table>
The possibility that those who attend therapy even once may have different perspectives than those who have never gone was also explored. ANOVAs for therapy as a dichotomous variable (0 previous sessions vs. 1 or more previous sessions) also indicated a main effect of vignette and no main effect of dichotomous therapy sessions nor interaction of therapy sessions with vignette (See Table 15 below). Results from LSD post-hoc tests indicated patterns similar to those from the ANOVAs involving therapy sessions as a categorical variable. Vignette C (WHAM) was rated significantly lower than the Culturally Sensitive and Counterstereotypical vignettes for all four client response variables \((p \leq .02)\) with the exception of disclosure for which Vignette C (WHAM) ratings were not statistically distinct from Vignette A (Culturally Sensitive) when controlling for dichotomous therapy session history. Vignette E (WHAM) was rated consistently lower than Vignettes D (Counterstereotypical) and F (Culturally Sensitive) \((p < .02)\). Vignette A (Culturally Sensitive) was rated significantly lower than Vignettes D (Counterstereotypical) and F (Culturally Sensitive) for trust and disclosure \((p < .05)\).
Table 15

Main Effects and Interactions for Vignette and Previous Therapy (Dichotomous)

<table>
<thead>
<tr>
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<th>df</th>
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<td>205.44</td>
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<td>Vignette x therapy</td>
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<td>3.90</td>
<td>171.70</td>
<td>.89</td>
<td>.01</td>
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</table>
CHAPTER 5

DISCUSSION

Many researchers seek to ameliorate the negative impacts of dealing with systemic oppression and improve mental health outcomes for Black people through research on experiences of discrimination, access to mental health resources, institutional distrust, satisfaction with therapy, the impact of stereotyping, microaggressions in therapy, and culturally sensitive therapeutic approaches. In addition to leveraging the knowledge from these often-unconnected corners of research, this study examined Black participants’ assessments of therapist behaviors as a first step in identifying ways therapists can be trained to serve their African descended clients more effectively.

In summary, several patterns emerged in Black participants’ ratings of hypothetical therapists. First, therapist behavior categories were not psychometrically distinct. Instead, many similar correlations in ratings of vignettes could be seen across multiple therapist categories and for each of the client response variables (likelihood to return, trust, disclosing deeper feelings, and belief in genuine investment); suggesting similarities in how vignettes from different therapist behavior categories were received by participants. Consequently, remaining analyses examined differences between individual vignettes. Secondly, alliance-
related variables (trust, disclosing deeper feelings, and belief in genuine investment) were correlated with the retention variable (likelihood to return for all six vignettes, indicating a connection that a strong alliance – in the form of trust, willingness to disclose deeper feelings, and a belief in the therapist’s genuine investment -- was connected to one’s likelihood to return to therapy for the Black participants in this study.

In terms of how therapist behavior categories were rated in relation to each other, participants reported a greater likelihood to return, greater trust and belief in genuine investment, and greater likelihood of disclosing deeper feelings when hypothetical therapists showed Culturally Sensitive or Counterstereotypical behaviors than when the therapist showed WHAM behaviors. Client responses to hypothetical therapists did not differ by participant demographics, with the exception of ancestry for which differences in average client responses emerged for those of recent African and those of “more complex” ancestry when compared to both those descended from people enslaved and brought to the US during the trans-Atlantic slave trade and those of recent Caribbean ancestry. These differences remained clear when analyzed as two dichotomous groups, indicating that participants of recent African or “more complex” ancestry reported a lower likelihood of returning to see hypothetical therapists across all types of therapist behaviors than participants descended from enslaved people and those of recent Caribbean descent, except for two specific vignettes (one Culturally Sensitive and one Counterstereotypical. There was a significant main effect, qualified by an interaction. Possible explanations related to culture, each group’s
relative influence on research, and the general applicability of each vignette will be elaborated upon in a later in the discussion.

Lastly, given the often-conflicting findings concerning the impact of discrimination, experiences in therapy, and other demographic factors on African-descended people’s perceptions of therapy, relations between client response variable ratings with the number therapy sessions they had previously attended and experiences of microaggressions, respectively, as an exploratory aim. Exploring the potential impact of the number of therapy sessions participants previously attended indicated no association with having gone to therapy nor with the number of sessions on participants’ responses to therapist behavior. Participants who had more previous experiences of microaggressions related to perceptions of criminality and foreignness rated Vignette A (a Culturally Sensitive vignette) lower for belief in genuine investment. Findings related to each aim of the study are summarized and interpreted in greater detail below.

**Aim 2**

*Associations Between Therapist Behavior Categories and Responses to Client Response Variables*

I expected that the three designated therapist behavior categories would be psychometrically distinct; however, results showed many correlations between vignettes of different categories.

This could suggest that there were other meaningful qualitative differences between these vignettes that have not been operationalized nor measured in this study. In particular,
Vignette E (the highest rated WHAM) was only significantly different from Vignette A (the lowest rated Culturally Sensitive vignette) on ratings of likelihood to return. This is worth noting, since these two vignettes describe the same rupture with differences in how the therapist attempts to repair it. WHAM vignettes were developed to represent real behaviors that therapists who mean well may be likely to enact, but simultaneously behaviors that research and client responses indicate are harmful to the therapeutic alliance or the client’s wellness (i.e. having stereotypical or superficial knowledge of client-related cultural factors, being dismissive of client concerns, or invalidating client’s perceptions; Chang et al., 2020; Chang & Berk, 2009; Graham et al., 2013; D. W. Sue et al., 2007).

However, the content of Vignette E (WHAM- in which the therapist expresses interest in the client educating them about the general experience of Black people) may have been so subtle of a negative manipulation that it was interpreted in a microaggressive way by some and in a genuine way by others. It could have been interpreted as an active desire for awareness that has been encouraged by multicultural psychologists and found to be associated with positive therapy outcomes (Chang & Yoon, 2011; Graham et al., 2013). The lack of distinction between therapist behavior categories may be explained by the similarities in content and ratings of these two vignettes (Vignette A – Culturally Sensitive and Vignette E -WHAM). While the goal of this study was to test subtle differences in therapist behavior, studying a wider range of behaviors with more specificity of the behaviors in each vignette may allow for more extreme differences in responses from participants and, thereby, an
increased ability to distinguish which specific therapist behaviors lead to specific impact on clients.

These results may also provide evidence that well-meaning behaviors are typically seen as helpful by Black clients. However, in combination with the high frequency of negative experiences and microaggressions in therapy for Black clients (Burris, 2012; Hook et al., 2013), that would suggest that there is a high number of therapist-client interactions happening in which the therapist does not actually have positive intentions towards their Black clients. More intervention is likely needed that identifies and addresses explicit prejudices that therapists have towards Black clients, even when social desirability may lead therapists to represent themselves as having positive explicit attitudes towards Black people.

**Relation of Client Response Variables**

Based on previous research suggesting a) the importance of disclosure, belief in genuine investment, and trust to the therapeutic alliance (Abdullah & Brown, 2011; Chang & Yoon, 2011; Gómez, 2015; Tillman et al., 2010), b) the positive relation between therapeutic alliance and retention (Earl et al., 2011; Wintersteen et al., 2005), and c) the positive impact of all of the aforementioned variables on mental health outcomes (Chang & Yoon, 2011; Earl et al., 2011), I hypothesized that ratings of the three alliance-related variables (trust, disclosure, belief in genuine investment) would correlate with ratings of the retention-related variable (likelihood to return) within each vignette. As expected, there was a very strong correlation between alliance-related variables and the retention-related variable within all six vignettes. In addition, there was a moderate to strong correlation of the three alliance-related
variables (trust, disclosing deeper feelings, and belief in genuine investment) to each other within all vignettes. This suggests that trust, disclosure, and belief in the therapist’s genuine investment often co-occur and have some connection to clients’ likelihood to continue attending therapy. Furthermore, likelihood to return was one of the highest rated variables for all vignettes except Vignette E (WHAM). This may be due to the hypothetical therapist’s suggestion that the only way they can learn about Black people’s experiences (and avoid further ruptures) is if the client puts in the emotional work to explain a presumed monolithic Black culture to them. This may have led to lower ratings of likelihood to return, despite positive ratings of variables related to alliance. While people may believe the therapist means well and cares about them, it may not seem worth returning for interactions that could be emotionally draining in the long run.

Aim 3

Impact of Demographic Variables

The potential effect of several demographic variables were explored prior to conducting primary analyses, including age, gender, sexual orientation, racial identification (Black or Multiracial), race perceived by others, household income, level of education, religious or spiritual practices, ancestry, country of birth, and generational status. Those who felt their ancestry was best described as recently African or “Not listed/More complex ancestry” made significantly lower ratings for likelihood to return, trust, belief in genuine investment, and disclosing deeper feelings than those who were best described as recently Caribbean or descended from those enslaved and brought to the United States. These
differences were taken into account in the primary analyses. Other demographic categories showed no significant relation with the client response variables.

Some possible explanations for demographic differences by ancestry may include differences in institutional knowledge, cultural influence on therapy, and cultural differences between these ancestral groups, as well as potential differences in how helpful each vignette may be in general. It is possible that those of recent African or “more complex” ancestry have less institutional knowledge of how to navigate US healthcare and mental health systems than those who have had more generations of family members living in the US, leading to less certainty about what can be considered better or worse in a mental health interaction. This could result in less positive ratings of trust, disclosing deeper feelings, belief in genuine investment of the therapist, or likelihood to return when considering a variety of therapist behaviors than a participant who feels confident about which behaviors from therapists will prove helpful to them in the US context. Furthermore, evidence suggests that many African immigrants, have encountered a great deal of cultural insensitivity and lack of understanding of African values from providers, have concerns about providers being impatient and dismissive of linguistic differences, or have suspicions that Western health interventions would cause adverse effects for Africans due to 1) lack of knowledge about African-specific needs or 2) active negligence or intended harm due to discrimination from Western providers (Omenka et al., 2020). These suspicions of harm may result from many historical and continued attempts by Western doctors and scientists to test potentially or definitively harmful interventions in African countries (Busari & Wojazer, 2020).
It could also be that those descended from enslaved peoples or of recent Caribbean ancestry have been more involved in testing of psychological interventions or had more opportunities to give input in mental health systems in the US, resulting in the therapist methods tested in this study more closely aligning with their needs than they do for those of recent African or “more complex” ancestry. Omenka, Watson, and Hendrie (2020) conducted a review of literature on the healthcare experiences and needs of Africans and recent African immigrants in the US. They remarked that they experienced great difficulty in finding any research on African values as they relate to healthcare and that their study is likely the first review of this understudied population in healthcare. This lack of study may result in currently used Culturally sensitive and general counseling techniques feeling more applicable, relevant, or reassuring to those descended from enslaved peoples or of recent Caribbean ancestry on whom a greater amount of research and counseling techniques are based. While a mismatch of cultural expectations and values is well-documented for Black people in general with the mental healthcare system (Abdullah & Brown, 2011; Gómez, 2015; Tillman et al., 2010), it is possible that there is even greater cultural mismatch for those with recent ancestry from another continent.

It is also plausible that some combination of cultural stigma about mental health in addition to lack of institutional knowledge results in the lower willingness to disclose deeper feelings observed in this study for those of recent African or “more complex ancestry.” People with more recent African or “more complex” ancestry may have different cultural beliefs about disclosure than those with ancestry more recently tied to the Americas. Omenka
and colleagues (2020) also note a great deal of stigma about mental health care and interventions from people of recent African origin. In particular, they note a high level of stigma about healthcare services in general (even preventative ones) and being labeled as depressed. Stigma about depression was related to cultural emphasis on having a good reputation, associations with mental health issues with stigmatized conceptions of "madness" in home countries associated with low economic status, and viewing depression as a conception and issue specific to White people. The difference in willingness to disclose in this study could also result from cultural differences unrelated to mental health (i.e., how one is supposed to give or frame feedback) that lead some ancestral groups to give higher or lower ratings respectively on questionnaires like this.

In addition, the interaction between ancestry and vignette ratings shown in Figure 6 may indicate that Vignettes D (Counterstereotypical) and F (Culturally Sensitive) involved an approach that more consistently inspires people to return to see a therapist across ancestry differences for Black people than any of the other vignettes. Vignette D includes a high and clear level of validation of the client in which the therapist states the client is “valuable, of worth, and intelligent,” while Vignette F includes clear validation of the client’s stated cultural values. In comparison, other vignettes have more references to stereotypes to which people with more recent African or “more complex” ancestry may not be as generationally exposed, involve a rupture, or validate the presence of negative emotions (which may be more stigmatized for those of recent African or “more complex” ancestry). Vignettes D and F focus more heavily on the value and strengths of the client and of their heritage. This
provides additional support for the value of strengths-based approaches with Black people of varying ethnic and ancestral backgrounds (Alegría, Polo, et al., 2008; Babatunde-Sowole et al., 2020; Jones et al., 2007; Jones & Ford, 2008).

**Vignette Comparisons**

Hypotheses about how client response variable ratings would compare by therapist behavior category were partially supported. While the therapist behavior categories were not statistically distinct as mentioned in Aim 2, it was hypothesized that Culturally Sensitive vignettes would be rated above average (>5.00) and statistically higher than WHAM vignettes, while WHAM vignettes would be rated below average (<5.00). In support of this hypothesis that Black-identifying people would respond positively to Counterstereotypical and Culturally Sensitive behaviors, all average ratings for those four vignettes were above 5.00 and statistically higher than ratings for both of the WHAM vignettes. However, average ratings for one of the WHAM vignettes (Vignette E – Toby) were also higher than neutral. Additionally, Vignette E (Toby) was rated statistically higher than the other WHAM vignette (Vignette C – Alex) for all client response variables, except disclosing deeper feelings. Although these results did not indicate the clear distinctions originally predicted between therapist behavior categories, they suggest that the Counterstereotypical vignettes hold important strategies that result in positive ratings similar to those of Culturally Sensitive vignettes, even without acknowledgment of culture. In addition, Vignettes C and E (WHAM) had the most participants who chose not to respond at all to the prompts after reading the scenario (an average of 24 missing responses for Vignette C and 21 missing for Vignette E
compared to 7-11 missing for the remaining vignettes). These were not participants who dropped out of the study as they answered most prompts for vignettes other than C and E. It is possible that not answering was also a representation of dislike of these types of behaviors. Research suggests that African Americans are more likely to use avoidance as a coping mechanism in situations that are racially stressful. Avoidance coping includes ignoring the stressor or continuing as if it didn’t happen, avoiding places/people involved, and doing things to get it off one’s mind (Hoggard et al., 2012). However, there is not enough information with which to interpret participants skipping these questions. This could also be a result of uncertainty about how to interpret the interaction in the vignette or a variety of different specific issues for specific participants.

Vignettes A, B, D, and F (Counterstereotypical and Culturally Sensitive) showed a complex pattern of relation to each other with one of the Culturally Sensitive vignettes (Vignette A – Drew) being rated significantly lower for disclosing deeper feelings than Vignettes B, D, and F. This difference may be related to the nature of the vignette as it is about a disclosure-related rupture. It may not have felt possible to participants for the rupture to be repaired enough to give a high disclosure rating within such a short amount of time. For instance, multiple models for repairing therapeutic ruptures involve multiple stages of reflection and discussion (Chang et al., 2020; Owen et al., 2011).

The WHAM vignette (E – Toby) with a similar scenario but different resolution from the therapist received similar average ratings for disclosure (Vignette E – Vignette A = .14, \( p = .08 \)); while Vignette A was rated significantly higher than Vignette E for likelihood to
return (Vignette E – Vignette A = 1.52, \( p = .002 \)). This may suggest that the behaviors in Vignette A (Culturally Sensitive) maintain clients’ willingness to return to therapy even though there is more hesitation to disclose, allowing the therapist the opportunity to continue reestablishing the alliance in future sessions. Text for Vignettes A and E are listed below, while text for all six vignettes can be found in Appendix A. Future studies may benefit from examination of what types of ruptures are most and least distressing to participants in order to reduce the possibility that the distress of the rupture itself confounds ratings of the therapists attempts to reestablish the therapeutic alliance.

**Figure 7**

*Text for Vignettes A and E*

<table>
<thead>
<tr>
<th>Vignette A – Drew (Culturally Sensitive)</th>
<th>Vignette E – Toby (WHAM)</th>
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<tbody>
<tr>
<td>There was an awkward moment in your therapy session. Your therapist, Drew, said, “I can imagine how painful that must have been”. Feeling somewhat angry, you explain that Drew could never fully understand how it felt because of the differences between you. Drew apologized immediately, “You’re right. I wanted to acknowledge your pain, but I’m sorry I did it badly. Although it is my goal to be as helpful to you as I possibly can, I also know that there may be times when I can’t fully appreciate your experiences. I want you to know that I’m always open to talking about these topics and that I’ll be more careful in the future. It’s important to me to understand what you’re going through better.”</td>
<td>There was an awkward moment in your therapy session. Your therapist, Toby, said, “I can imagine how painful that must have been”. Feeling somewhat angry, you explain that Toby could never fully understand how it felt because of the differences between you. Toby apologizes immediately, “You’re right. I don’t understand at all, especially because our cultures are so different. Can you tell me more about the experiences of Black people? I want to be able to help and I know I can’t do that without you helping me to understand your culture better.”</td>
</tr>
</tbody>
</table>
Aim 4

Experiences of Microaggressions

Correlational associations were explored between experiences of racial microaggressions (RMAS) and client response variable ratings for each vignette. While nearly all of the vignettes exhibited no significant correlation with the frequency nor appraisal of microaggressions, associations were found for belief in genuine investment for Vignette A (Drew - Culturally Sensitive). For this vignette, belief in genuine investment was negatively associated with the frequency of microaggressions related to stereotypes of criminality and foreignness, as well as stressful appraisals of foreign-related microaggressions. Since microaggressions are often subtle indications of disrespect (D. W. Sue et al., 2007), it is possible that these experiences of microaggressions create a level of sensitivity in those who have experienced them; however, it is more likely that something in this particular vignette subtly communicates a type of disrespect that people frequently encounter with microaggressions related to criminality and foreignness.

Previous Therapy History

There was no significant impact of therapy history on the pattern of response to the hypothetical therapists in this sample when examined categorically nor when examined as a dichotomous categorization of therapy sessions into no therapy and 1 or more therapy sessions. One limitation for this analysis was that there were very few participants who had any past therapy experience, with only 14 out of the 54 participants who responded to the question about therapy having any past therapy experience; this is too low a cell size to draw
any conclusions about the impact of therapy history from this data. The high missingness of this personal mental health data in comparison to hypothetical information related to mental health interactions may be explained by the generally high level of mental health stigma amongst Black people as noted by previous studies (Alvidrez et al., 2008; Carpenter-Song et al., 2010; Conner et al., 2009; Omenka et al., 2020). While it is possible that therapy or specific interactions in therapy impact clients’ perceptions of therapists, this study did not yield results that could elucidate the nature of these possibilities nor directly examine the importance of experiences in previous therapy to Black clients’ appraisals of therapists supported by previous research (Diala et al., 2000; Earl et al., 2011).

**Summary of Interpretations**

These results suggest that therapist behaviors that demonstrate knowledge, awareness, and skill in addressing the complexity of stereotypes have similarly positive effects to behaviors currently emphasized by cultural sensitivity training on Black people’s perception of elements important to therapeutic alliance and retention. This indicates the importance of further research on addressing stereotypes, specifically, in addition to cultural sensitivity. Perhaps the current lack of emphasis on countering stereotypes stems from a desire to avoid drawing unnecessary attention to marginalization and potentially negatively impacting clients’ mental health in the process. However, there may be benefits to bringing awareness to stereotypes; namely demonstrating understanding of the client’s context and appropriately externalizing the causes of negative interactions and systemic impacts of situations in which stereotyping is at play, thereby creating a stronger bond with the client instead of solely
increasing distress. In addition to the ideas of knowledge, awareness, and skill drawn from research and theory on cultural sensitivity and competency (D. W. Sue et al., 1992), results support existing evidence for the positive impact of strengths-based therapeutic approaches for Black clients (Alegría, Polo, et al., 2008; Babatunde-Sowole et al., 2020). While participants responded positively to Culturally Sensitive and Counterstereotypical vignettes, people of all ancestries responded most consistently well to the vignettes in those categories that focused on strengths more than deficits and negative emotion.

Participants presented a complicated pattern of responses to the six vignettes. This may be due to the diversity of the types of situations and responses within the vignettes or may reflect meaningful and externally valid differences in how Black people would respond to therapists exhibiting these behaviors. Testing a larger number of vignettes on a sample as ethnically diverse as the current sample of Black people would help to elucidate the degree to which these results apply consistently across groups of people of African descent (who are often ethnically diverse).

Further research is needed to understand the impact of microaggressions and experiences in therapy on the usefulness of these different therapist behaviors for Black people. In particular, it is unclear what the relation between assessment of genuine investment and past experiences of microaggressions for Vignette A may mean. This could be an indication that the type of rupture described in the vignette is particularly meaningful for people in our society who face frequent microaggressions related to assumptions of criminality or foreignness, that there is a contradiction presented by the dilemma and its
resolution, or that something in the resolution indicates conflicting messages that are more likely to be interpreted negatively by those with more experiences of those microaggressions. Torres-Harding et al. (2012) indicate that experiencing criminality-related microaggressions is common for African-Americans, while microaggressions related to being perceived as foreign are less frequent than for other racial minority groups. However, because their study does not disambiguate the terms “African-American” and “Black,” it is unclear how ethnically representative their Black sample was of people in the US broadly. It may be that while African-Americans experience fewer microaggressions related to foreignness, people of recent Caribbean, African, or “more complex” ancestry may still experience them to a large degree. Consequently, there may be many Black people experiencing criminality or foreignness-related microaggressions for whom Vignette A (Culturally Sensitive) poses difficulties, making further study of these dynamics important to understanding how to best serve Black people.

Vignette A (Drew – Culturally Sensitive) presented a pattern of findings quite different from most of the other vignettes in three ways. 1) While it was consistently rated above neutral, ratings for disclosure were significantly lower for this vignette than for the remaining Culturally Sensitive and Counterstereotypical vignettes. 2) Belief in genuine investment for “Drew” was negatively correlated with experiences of microaggressions, while other vignettes showed no association. 3) It is the only Culturally Sensitive or Counterstereotypical vignette that does not differ significantly from the WHAM vignettes for every client response variable. This may point to a level of ambiguity this vignette presents
about how safe it is to disclose, despite the fact that the ratings were frequently higher for this
vignette than for the two WHAM vignettes. This is particularly important to note as this
vignette contains several messages therapists are encouraged by trainings on cultural
sensitivity to communicate (i.e., acknowledgment of having made a mistake, non-defensive
openness to negative feedback, consideration of how one’s differences in privilege can
impact therapeutic experiences, etc.; Chang et al., 2020; Hays, 2008; D. W. Sue et al., 1992).

Vignette E (Toby) was predicted to be rated below neutral but received ratings above
or not significantly different from neutral. This WHAM vignette may not have sufficiently
represented microaggressive behavior to fully test this study’s hypothesis. While this vignette
was intended to demonstrate expectations that Black people educate a White therapist about a
monolithic “Black” culture, some participants may have interpreted the therapist’s behavior
as a genuine interest in understanding the client’s cultural background. It is also possible that
the initial scenario presented by Vignettes A and E requires longer term repair and
interpretation than could be accomplished within the frame of this study.

In contrast, Vignette C (WHAM) was rated much lower than Vignette E (WHAM)
and involved the therapist suggesting the client had been incorrect in their appraisal of racism
and needed to change how they think. Although this behavior was microaggressive in and of
itself (specifically, a microinvalidation as defined in D. W. Sue et al., 1992), it showed no
associations based on respondents’ previous experiences of microaggressions. Suggesting
that Black people’s thinking is the source of problems related to racism may be more
consistently interpreted as problematic than behaviors that include a desire to be educated
about race, leaving it unimpacted by participants’ history of microaggressions. Future studies may benefit from making behaviors that have possible positive interpretations about the therapists’ beliefs about the value of Black people’s thinking, beliefs, abilities, emotions, or cultural values distinct from those that actively devalue aspects of their worth.

**Limitations**

**Measure Development**

A large limitation of this study is the lack of qualitative verification of how Black people interpret the intention behind the therapist behaviors presented in the vignettes, an issue with quantitative research on these topics acknowledged by multiple scholars (Chang et al., 2020; Thompson & Alexander, 2006). For instance, as mentioned above, does “Can you tell me more about the experiences of Black people?” indicate a genuine interest in the specific client’s experiences or a belief that Black people are defined by their race? Information about these distinctions would aid in the interpretation of statistical results and is also an important next step for this line of research. The ability of the vignettes to validly depict the concepts espoused by the therapeutic behavior categories, as well as the measure’s relevance to real life experiences with therapists, would be elucidated by qualitative data from Black people without clinical psychology backgrounds.

**Demographic Questions**

There are several areas in which demographic questions could be improved to better capture the diversity of the sample and present identities in a more inclusive way to improve participants’ experience of taking the survey. This study was part of a larger project
exploring Black people’s experiences. Consequently, some demographic questions were more suited to capturing other research interests.

Use of a single selection racial identification question forces participants to choose between identifying with a single race and identifying as “Multiracial” when there are some people who prefer to identify with two races without identifying as “Multiracial.” Similarly, a single selection ancestry measure may artificially limit the measurement of Black people’s complex ancestry. Participants may have parents with differing ancestry but be required to choose one. Given the differences found in this study related to those with “Not listed/More complex ancestry,” having more information about the diversity of participants’ ancestry may help to clarify these effects. Lastly, some participants who were omitted from this study for other reasons indicated “non-binary” as their gender. The measure for gender included the options “male,” “female,” “transgender,” and “not listed.” The omission of an option for non-binary, gender fluid, or gender neutral who are not transgender may feel othering, and this option could be included in future studies.

In addition, some participants were automatically excluded from later measures because they did not respond to the single selection racial identification question. This was done to prevent people who do not identify as “Black” and are ineligible for the study from participating; however, some participants who responded to an open-ended racial identification with responses like “African-American” were still omitted from the study. This may limit representation of people who do not identify with the racial label of “Black” but still identify as being of African descent. Lastly, participants were not asked about the
method by which they were recruited, so it was not possible to examine variability due to recruitment method in this sample. This may limit considerations of demographic differences between different populations of Black people who participated and, consequently, interpretations of the external validity of these results to specific groups of Black people.

**Internal and External Validity**

The variability in the vignettes likely increases the external validity of this study while decreasing its internal validity. Interactions in therapeutic dyads differ widely for people of color and Black people in particular (Cabral & Smith, 2011; Chang & Berk, 2009; Gómez, 2015; Omenka et al., 2020), and this study provides important information about the particular types of interactions included here. However, using more similar scenarios between vignettes may have made the effects of vignettes on the client response variables easier to interpret while making the study easier to replicate in the future. Simultaneously, the vignettes resulted in relatively similar and high ratings from participants. While this may indicate success in depicting therapeutic interactions intended to help, it may be an inaccurate representation of therapeutic interactions for Black people out in the world, which research indicates are varied and sometimes extremely negative (Burris, 2012; Chang & Berk, 2009; Constantine, 2007; Hook et al., 2016; Lagomasino et al., 2011), especially since evidence suggests that approximately 81% of clients of color experience microaggressions in therapy with Black clients experiencing them as being more impactful (Hook et al., 2016). The measure developed in this study would benefit as mentioned above from additional qualitative exploration of the interpretations of Black participants. This would serve two
purposes: 1) increasing variability in the positive and negative valence of vignettes, representative of the range of behaviors that therapists tend to exhibit with therapists out in the world and 2) increasing the specificity of the degree to which each vignette accurately depicts the therapist behavior category intended.

**Conclusion**

The field of psychology tends to situate therapists as the authority in assessing clients’ experiences, which creates many opportunities for providers’ biases and systemic cultural marginalization of Black people’s experiences to negatively impact their mental health outcomes (Chang & Berk, 2009; Gómez, 2015; Hook et al., 2016; D. W. Sue et al., 2007). This makes commencing this line of research from the perspectives of those who are oppressed important in order to reduce confirmatory bias toward existing therapeutic methods and institutionalized conceptions of Black people’s experiences. While there is extensive research on the many physical and mental health disparities experienced by people of African descent in the US (Diala et al., 2000; Gómez, 2015; Hamilton et al., 2015; Paradies et al., 2015), knowledge and acknowledgement of these disparities is not sufficient. It is necessary to move towards action and wellness intervention tailored to Black people’s lived experiences and preferences, as well as to situate responsibility for change with those inside institutions and whose actions account significantly for the maintenance of mental health disparities, even in situations designed to improve mental health (e.g., therapists; Begeer et al., 2009; Larrison & Schoppelrey, 2011; Owen et al., 2012). Consequently, this study examined Black participants’ responses to therapist behaviors assessed using variables
associated with positive mental health outcomes through their improvement of the therapeutic alliance (trust, disclosing deeper feelings, and belief in genuine investment) and likelihood to return, variables also previously found to be important to Black clients in their assessment of therapists (Earl et al., 2011).

This preliminary study indicates the importance and validity of therapeutic behaviors that specifically address stereotypes and suggests those behaviors demonstrating beliefs, knowledge, and skills related to stereotypes (mirroring D. W. Sue et al.'s 1992 three-domain conceptualization of cultural competence) may be as capable of contributing to trust, demonstrating genuine investment, disclosure, and retention as therapist behaviors that are emphasized and centered in culturally sensitive therapist training; such as attending to and acknowledging cultural differences, willingness to learn about the client’s culture, and recognizing the client strengths stemming from cultural differences (American Psychological Association, 2003; D. W. Sue, 2001; D. W. Sue et al., 1992). However, more research is needed to explore the specific relations between the types of behaviors incorporated into the vignettes, what interpretations from participants led to this pattern of results, and how to adapt an understanding of Black people’s preferences into therapist action.
### APPENDIX A.

### VIGNETTES

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Order</th>
<th>Text</th>
</tr>
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<tbody>
<tr>
<td>Vignette A (Drew) Culturally Sensitive</td>
<td>1</td>
<td>There was an awkward moment in your therapy session. Your therapist, Drew, said, “I can imagine how painful that must have been”. Feeling somewhat angry, you explain that Drew could never fully understand how it felt because of the differences between you. Drew apologized immediately, “You’re right. I wanted to acknowledge your pain, but I’m sorry I did it badly. Although it is my goal to be as helpful to you as I possibly can, I also know that there may be times when I can’t fully appreciate your experiences. I want you to know that I’m always open to talking about these topics and that I’ll be more careful in the future. It’s important to me to understand what you’re going through better.”</td>
</tr>
<tr>
<td>Vignette F (Francis) Culturally Sensitive</td>
<td>6</td>
<td>You tell your therapist, Francis, about how, lately, demands at work, home, and other parts of your life have been so high that they are overwhelming. You explain that to people who share your culture, being committed to family and your duties to them (like your job) is really important and you don’t want to let them down. Francis says, “You’ve told me a bit about your cultural identity. It would be helpful for me to hear more about how you see your cultural</td>
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</tbody>
</table>
background contributing to this situation.” Then Francis suggests that you look for solutions together that can be supportive enough of your family and keep your cultural values without completely overwhelming you.

| Vignette B (Kerry) | Counterstereotypical | 2 | You tell your therapist, Kerry, about how, lately, demands at work, home, and other parts of your life have been so high that it’s overwhelming. You’ve been able to handle things in the past and feel like you should be able to handle everything this time, too. Kerry says, “It’s wonderful that it’s so important to you to be reliable and that you want to be there for other people as much as you do. At the same time, you don’t have to be invincible. It may even be that the messages everyone gets so often about the ‘strong Black woman/invincible Black man’ - this unrealistic idea that Black people should be able to take on endless burdens without complaining, having help, or getting tired - make it hard to feel like it’s ok to be anything else. You need compassion and room to be human, too.” |

<p>| Vignette D (Devon) | Counterstereotypical | 4 | You've been dealing with discrimination from one of your bosses. They often question your credentials or intelligence. In addition, they are constantly micro-managing projects you are assigned. You describe to your therapist, Devon, that you are starting to feel anxious, stressed out, and uncertain at work more and more every day. Devon acknowledges the stress associated with dealing with discrimination at work. Devon also talks with you about the many ways that people can be affected by negative stereotypes that others push on them and how important it is to pay attention to and take pride in the ways in which you are valuable, of worth, and intelligent. |</p>
<table>
<thead>
<tr>
<th>Vignette C (Alex)</th>
<th>3</th>
<th>Recently, you had an experience where you felt you were treated badly because of your race. You describe this situation to your therapist, how upset you felt, and how you keep thinking about it. Your therapist, Alex, suggests exploring other possible explanations for the way you were treated. Alex states that interpreting the causes of the situation differently can make the situation less distressing and offers techniques to shift your focus to help you feel less upset after situations like this.</th>
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<tbody>
<tr>
<td>Vignette E (Toby)</td>
<td>5</td>
<td>There was an awkward moment in your therapy session. Your therapist, Toby, said, “I can imagine how painful that must have been”. Feeling somewhat angry, you explain that Toby could never fully understand how it felt because of the differences between you. Toby apologizes immediately, “You’re right. I don’t understand at all, especially because our cultures are so different. Can you tell me more about the experiences of Black people? I want to be able to help and I know I can’t do that without you helping me to understand your culture better.”</td>
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