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# Perception of Therapists Characteristics by Black and White Clients

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**PERCEPTIONS OF THERAPISTS CHARACTERISTICS BY BLACK AND WHITE  
CLIENTS**

**BY**

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**Submitted in partial fulfillment of the  
requirements for the Degree of Doctor of Philosophy  
Seton Hall University**

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SETON HALL UNIVERSITY  
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## ABSTRACT

This study will examine how White clients perceive Black therapists' based on the ethnic status of the client, as well as the stability of this perception over time. The present study will rectify methodological limitations of prior research, which was limited to one session analogue situations. Parameters studied include White client perceptions of Black counselor attractiveness, expertness, and trustworthiness, which have been proposed as facilitating therapeutic change in the counseling process. The White Racial Attitude Identity Scale-Short (WRAIS-S) will be used to measure White Racial Identity. The Counselor Rating Form-short Version (CRF-S) and the Counselor Effectiveness Rating Scale (CERS) will be used to measure perceived counselor characteristics.

All participants will be asked to sign an informed consent form. All facilities participating in the study will service a diverse population. Prior to intake, prospective subjects will be asked if they would voluntarily participate in a research project. If yes, just prior to the first session they will be given the WRAIS-S. At the end of the initial counseling session, all subjects will receive two additional forms: CRF-S and CERS. Following the fourth counseling session, the CRF-S and CERS will be administered for a second time to the same clients in a like manner.

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## Chapter I

### Introduction

In order to progress, we must acknowledge the role of ethnicity in the psychological intervention and treatment of ethnic minority families in this country. To begin this process, Wilkinson (1996) stressed that there must be a fundamental understanding of the “specific political, social, economic, and legal histories that ethnic minorities have had in the United States” (p. 92). According to Billingsley (1968) Blacks have been “conspicuously shaped by [the] social forces in the American government” (p. 4). He proceeds:

It is these forces that [has] boundaries, which enable us to distinguish the internal from the external environment, and it is typically imbedded in a network of social units both larger and smaller than itself. (p. 4)

In effect, Wilson and Stith (1998) believe it is these very forces that have “played a major role in the developmental etiology of certain mental-health disturbances and in the way mental-health professionals have responded” (p. 116). Overall, the mental-health system seemed unable to recognize the importance of ethnicity within the psychotherapeutic process.

However, over the last few decades, there has been growing interest in research on racial identity in psychotherapy (Aponte & Crouch, 1995). The trend stems from several changes in the mental-health field. Specifically, minority groups are utilizing mental-health services more often than in the past, they are more likely to encounter a White mental-health professional, and they verbalize greater disappointment with clinical services (Aponte & Aponte, 2000). Moreover, Aponte & Wohl (2000)

observed that more minority clinicians are entering the field, and they are engaging a larger number of racially similar and dissimilar clients. The latter trend raises specific questions about the significance of the racial variable in psychotherapy. Thomas and Sillan (1972) suggested that racism in our society significantly defines the character of Black-White relations. Racism not only affects us all, but it also determines to a great extent our relations with those who are like us and those who are dissimilar. Fanon (1963) stated, "The white man is sealed in his whiteness. The black man in his blackness" (p.8). By and large, it appears racism tends to be mediated by color. Erikson (1965) noted that "man meets man always in categories (be they adult and child, man and woman, employer and employee, leader and follower, majority and minority)" (p. 248), and there appears to be little evidence that such perceptions are set-aside in psychotherapeutic relationships.

Although previous literature has dealt with the nature and attitudes of Black clients, there are relatively few studies that have investigated the racial-identity attitudes of those in the majority culture (Whites in the United States) or the possible impact of such attitudes on the process of psychotherapy (Carter, 1995). In particular, research has not focused much attention on the perceptions of White clients in relation to Black counselors. The purpose of this study is to investigate individually and collectively racial-attitudes as they relate to clients' perceptions of counselor effectiveness. Specifically, it was predicted that within marital therapy dyads, individuals' racial-identity attitudes would be related to the ways in which they perceive counselors of similar or different racial backgrounds.

### **Background of the Problem**

According to Carter (1997), racial barriers have limited mental- health professionals' capacities to help racial/ethnic group members and some white individuals on their terms and from their perspectives. Subsequently, Carter estimated that approximately one-third of this nation's population is inadequately served by mental-health providers' efforts to help them grow and to cope with their intrapsychic and interpersonal lives. Smedley (1993) described the role of racial differences as a barrier to the delivery of adequate and effective mental-health treatment as follows:

Where race is the more powerful divider, it does not matter what ones sociocultural background may be or how similar ethnically two so-called racial groups are. In fact, the reality of ethnic, or social class, similarities and differences is irrelevant in situations in which race is the prime and irreducible factor for social differentiation. The best examples of this are blacks and whites in the United States whose cultural similarities are so obvious to outsiders but internally are obfuscated by the racial world-view. When the racial world-view is operant, there can never be an alteration of an individual's or group's status, as both status and behavior are presumed to be biologically fixed. (p. 32)

It has been argued that racial barriers exist in psychotherapy because traditional treatment models have not considered the ramifications of race and racism in human personality development (Aponte & Johnson, 2000; Carter, 1995). Nor have the personal meanings of racial-identity and

the significance of race been extended to White persons (Helms & Parham, 1985). Also, the literature offers little data on how racial influences guide our understanding of psychotherapy interactions. The emphasis in the literature on the racial-identity of visible racial/ethnic people suggested that relatively little effort has been made to define the racial- identities of Whites and the possible impact of aspects of White racial-identity on the process of psychotherapy (Helms, 1984). The implicit assumption is that “white Americans do not belong to a racial group and do not have a culture” (Carter, 1995, p.99). However, White Americans do belong to a racial group with ethnic subgroups (e.g., Italian-American, Irish-American, and German-American), and it would be beneficial if their racial backgrounds were examined (Helms, 1993). Recently, theorists have begun to “speculate about the harmful consequences of racism on the perpetrators of racism, which include the absence of a positive white racial identity” (Helms, 1993, p. 50). Typically, Whites have not been included in racial-identity research, save for providing baseline data. This has led many to assume that White racial experiences are equivalent to the racial experiences of visible racial ethnic group people (Carter & Goodwin, 1994). As a result, research on cross-racial therapy has all but excluded the minority counselor and White client dyad.

Before White racial-identity theory was introduced, researchers (e.g., Campbell, 1971; Dovidio, Evans & Tyler, 1986; Dovidio & Gaertner, 1981, 1983; Gaertner & McLaughlin, 1983; Hamilton, 1981; Ickes, 1984; Karp,

1981) focused on explaining prejudice or individual racism (e.g., personal ideas, attitudes, and behaviors). Helms (1984) observed that the investigation of prejudice provides “no information about how whites feel about themselves as racial beings” (p. 155). Studies examining the attitudes of Whites towards minority group members are generally based on the premise that racism was and continues to be harmful only to the oppressed groups, and that the concept of race is relevant only with respect to Blacks or other people of color (Carter, 1995). Rarely studied are the harmful effects racism may have on Whites.

Helms (1990) argued that most Whites have no concept of what it means to have a White identity that is not supremacist. Furthermore, she observed, “in spite of the pervasive socialization toward racism, some white people do appear not only to develop a white identity, but a white identity that is not predominated by racial distortions” (p. 53).

Much racial-identity research (e.g., Atkinson, 1983; Gardner, 1971; Harrison, 1975; Jones & Seagull, 1978; Pine, 1972; Sattler, 1977; Sundberg, 1981) reported in the last few decades has focused almost exclusively on the perceptions and attitudes of Black clients. The findings of these studies have been inconsistent. The few studies that have examined the impact of White-racial-identity attitudes (Claney & Parker, 1989; Helms & Carter, 1990; Katz, 1978) have been similarly inconclusive.

### **Problem Statement**

The major focus of research on the impact of racial identity on the process of psychotherapy has been on the question of whether Black clients or client

surrogates prefer counselors of the same race/ethnicity. Factors associated with White individuals' racial-identities have appeared less frequently in the research literature, conveying the implicit assumption that White-racial-identity attitudes are non-existent or at least unimportant.

The literature, theoretical assumptions, and some counselors' personal views suggest that clients perceived counselors differently based on the clients' racial-identity attitudes rather than on, as Smedley (1993) suggested, "visible physical traits or phenotype and behavioral differences" (p. 39). For example, White clients who rate high or low on a racial-identity attitude scale may perceive Black and White counselors differently.

Theoretically, this perception would be expected to change over the course of counseling. For example, an initially low client rating of the effectiveness of a therapist from a different racial group might be expected to increase over time as the client becomes more familiar with the counseling process and the individual therapist. That is, over time the client's perceptions would be based less on the racial-identity of the client and more on the actual effectiveness of the therapist.

Therefore, the primary purposes of this study were (a) to determine empirically the relationship between racial-identity development and the initial perceptions of Black and White marital therapy clients of the effectiveness of therapists of the same or different racial group and (b) to determine the stability of these perceptions as treatment progresses.

### **Research Questions**

1. What is the degree of association between the independent variables: Black/White racial-identity attitudes, self-esteem, therapist race, client race and the dependent variables: counselor rating and counselor effectiveness?

2. When racial-identity attitudes are accounted for, what is the variance explained by self-esteem?

### **Theoretical Rationale of the Study**

As stated previously, the majority of research about cross-cultural counseling (e.g., Axelson, 1993; Locke, 1994; Pedersen, 1987; Sue, 1981; Sue & Sue, 1990; Sue & Carter, 1998) has discussed the influence of cultural differences with respect to visible racial/ethnic group members. According to Carter and Thompson (1997), a great deal has been written about the therapeutic needs of minority group members, but less is known about how race influences the therapeutic process for White people. Researchers have studied racial issues from the counselors' perspectives, and clinicians are taught what they should know and understand about cross-racial interactions. Seldom have researchers studied behavioral and cognitive issues in the development of White-racial-identity attitudes (Carter, 1995). To date, only a few theories of racial-identity have been presented, and only one outlines the intrapsychic and interactional process dynamics relevant to racial-identity development (Helms, 1984, 1990, 1995). The same is true of the few empirical studies that have attempted to explore cross-racial therapy process issues (Carkhuff & Pierce, 1967; Carter & Helms, 1992).

In order to understand the experiences of Whites and Blacks with psychotherapy in general and specifically with psychotherapists of different races, a review of the concepts of White and Black racial-identity attitudes is required, as is a review of the literature on interpersonal influence in psychotherapy. Under the heading, Black and White Racial Identity Development, theoretical conceptualizations of Black and White racial-identity attitudes will be described. Within the section, Social Influence, the concepts of social

influence and cognitive dissonance will be discussed in relation to clients' perceptions of counselors.

### **Black-and White-Racial-Identity Development**

Several researchers [(Atkinson, Morten & Sue, 1979, 1998; Cross, 1971, 1995; Hardiman, 1982; Helms, 1984, 1995; Jackson, 1975; Thomas, 1971)] have developed theoretical models to explain racial and identity development. These models imply that "certain attitudes and behaviors may be categorized as stages of development by the degree of adherence to cultural values exhibited" (Bennett & BigFoot-Sipes, 1991, p. 441). More specifically, the researchers above postulated that a client's development in the area of racial-identity would predict the client's preference for an ethnically similar or dissimilar counselor. In support of these theoretical predictions, the results of several empirical studies have indicated that racial commitment does affect preferences for counselors of different racial or cultural groups (e.g., Atkinson, Furlong, & Poston, 1986; Johnson & Lashley, 1989, Sanchez & Atkinson, 1983).

Until recently, however, no theoretical models have been presented to describe the ways in which majority group members develop racial-identities. Thus, there has been no model to use to predict the ways in which White clients might be expected to respond to Black counselors (Helms & Carter, 1990). In 1980, Hardiman (1982, as cited in Sue & Sue, 1990) described the first White Identity development model. Her model described a "developmental sequence of beliefs, values, feelings, and behaviors that white people pass through in developing a nonracist, new white identity" (p. 113). The stages of racial-identity development described by Hardiman include lack of social awareness, acceptance, resistance, redefinition, and internalization. This model appears

to parallel Jackson's (1975) four-stage model for the racial-identity development of Black Americans, which identified stages referred to as acceptance, resistance, redefinition, and internalization.

Jackson's model was in turn derived from Cross's (1971) minority-identity development model. In fact, all extant racial-identity development models stem from Cross's paradigm. Cross and others argued that a Black person's identity is strongly influenced by that person's experiences of racism and oppression (Sue & Carter, 1998 & Sue and Sue, 1990). He delineated a four-stage (originally five stages) developmental model that described Blacks as moving from a "white frame of reference to a black frame of reference," (p. 94). The developmental stages described by Cross (1971, 1995) included: (a) the preencounter stage, which is characterized by a tendency on the part of Blacks to devalue their own ethnic identities and to depend on white society for definitions; (b) the encounter stage, which is marked by confusion about the meaning of race and by an increased desire to explore one's own ethnic identity; (c) the immersion-emersion stage, during which the individual idealizes Black culture and denigrates White culture; and (d) the internalization stage, during which the individual comes to recognize both strengths and weaknesses in both Black and White cultures.

Several theories have addressed the question of the impact of racial-identity development on the experiences of Black and White clients participating in counseling and psychotherapy with Black and White therapists. Atkinson, Morten, & Sue (1979) proposed a five-stage model for minority-identity development, which was later refined by Sue and Sue (1981). This model, now referred to as the

Racial/Cultural-Identity Development (R/CID) model, is based on positing the existence of five levels of racial-identity: conformity, dissonance, resistance and immersion, introspection, and integrative awareness. However, this model does not represent a comprehensive theory of personality development. Rather, it is a typology that is used by counselors to understand the attitudes and behaviors of clients of differing ethnic and cultural backgrounds (Sue, 2003; Sue & Carter, 1998; Sue & Sue, 1990).

The most sophisticated model for explaining the racial dynamics between White clients and Black counselors is Helms' (1984, 1995) White-racial-identity development model. In her model, Helms' suggested that a "white person's reaction to black persons may depend on the way in which the white person has resolved her or his own issues of racial (rather than ethnic) identity" (Helms & Carter, 1991, p. 447). Helms described a six-stage process through which Whites evolve. The six developmental stages are: (a) Contact, which is characterized by naiveté about race and racism and of self as a racial being. The person in this stage is totally oblivious to cultural and racial issues. Such an individual is likely to express the belief that "people are people" (p. 447). (b) Confusion and anxiety characterize the second stage, Disintegration. The person is forced to acknowledge his or her whiteness. Individuals caught between the moral dilemmas of White and Black culture, and between guilt and oppression. (c) The Reintegration stage is marked by pro-White, anti-Black attitudes. Individuals at this stage of development tend to view Whites as superior and all others as inferior. Such individuals are usually angry and fearful. (d) The Pseudo-Independence stage is marked by intellectual acceptance of one's

whiteness along with an acceptance of Blacks. Individuals in this stage often attempt to engage other Whites in understanding racial minorities. (e) The fifth stage, Immersion/Emersion, was added to this model (in 1990) to reflect Hardiman's (1979) contention (as cited in Helms, 1993) "that it is possible for whites to seek out accurate information about their historical, political, and cultural contributions to the world, and that the process of self-examination within this context is an important component of the process of defining a positive white identity" (p.55). This stage reflects deliberate efforts to redefine a positive White identity. Instead of emphasis on changing Blacks, the focus shifts to changing White people. A person at this stage has begun to abandon racism and to acknowledge his/her White-racial-identity. (f) Autonomy, the final stage, is characterized by an internalized positive White identity (Carter, 1990). This final stage is marked by the successful "emotional and intellectual integration of racial differences and similarities" (p. 69). Individuals at this stage of development will seek out cross-racial interactions. Helms' model goes further in suggesting that the first three stages relate to the abandonment of racism and the last three concerns the definition of a nonracist White identity.

Accordingly, Helms' (1990, 1995) stages appear to suggest the ways in which Whites might be expected to react to Black, as well as White, counselors. However, Carter's (1990, 1997) research on white-racial-identity attitudes and the counseling process has been the only effort to date to examine this relationship.

### **Social Influence**

Client perceptions of counselor race may be understood in the context of social-influence theory. Social influence occurs when an individual's relationships with

others (individual, group, institution, or society) have an impact on his or her intellectual activities, emotions, or behaviors (Moscovici & Personnaz, 1980).

Usually such influence is unconscious.

Strong (1968) was the first to recognize counseling as an interpersonal-influence process. He postulated that counselors who are perceived by their clients as attractive, expert, and trustworthy are better able to facilitate psychological change than counselors who are not perceived in this way. McNeil and Stoltenberg (1989) argued that changes in clients' perceptions of counselors are to be expected over the course of treatment. In fact, following the initial contact, the degree to which clients change their perceptions of their counselors varies during the first phase of counseling (Strong, 1968). This variability could be related, at least in part, to changes in a client's racial-identity attitude development.

McNeil and Stoltenberg (1989) expanded Strong's theory to include an attitude-change model termed the Elaboration Likelihood Model (ELM). The two basic concepts proposed in the ELM are *peripheral route processing* and *central route processing* (occurring under low and high client motivation, respectively). Peripheral route processing appears to pertain to clients who are just beginning counseling. Initially, a White client might have limited information regarding the counseling process in general and his or her individual counselor in particular. Accordingly, such a client could be characterized as relatively low in motivation. Such a client is likely to rely primarily on environmental cues in forming his or her perception of a counselor. Under these circumstances, clients' attitudes regarding their counselors are likely to be influenced heavily by racial-identity.

However, as the client gains experience with the counseling process and the counseling relationship develops, client motivation increases, and central route processing appears to pertain. At this point, there tend to be less dependence on external racial attitudes and greater reliance on internal cognitive considerations. At this point, their attitudes are likely to be affected by a client's cognitive evaluations of the specific counselor.

Festinger (1957) suggested that, when two or more of a person's cognitions (e.g., beliefs, attitudes, ideas, and perceptions) are in conflict, the client experiences an uncomfortable psychological state known as "cognitive dissonance." He observed that, when cognitive dissonance is present, the discrepancy motivates the client to attempt to reduce it, perhaps taking steps to avoid situations that are likely to increase or highlight this dissonance (Helms, 1993). Thus, if feelings of discomfort are the result of White moral ambivalence previously described as dissonance, "then it seems likely that the same strategies used to reduce dissonance in general may also be used to reduce race-related dissonance" (Helms, 1993, p. 59).

Helms (1993) proposed three means of reducing race-related cognitive dissonance: (a) changing a behavior (i.e., avoiding further contact with Blacks); (b) changing an environmental belief (i.e., "attempting to convince significant others in her or his environment that blacks are not so inferior"; and (c) developing new beliefs (i.e., getting information from Blacks or Whites to corroborate that racism is not the White person's fault or even that racism fails to exist). The extent to which the White person chooses to reduce dissonance depends on whether or not his or her cross-racial interactions are voluntary (Helms, 1993, 1995). For example, if the person can

extricate him or herself from interracial environments or can remove Blacks from White environments, he or she may choose to do so. The way in which the person reduces dissonance also depends on the person's stage of racial-identity.

### **Definitions of Terms**

*Racial-identity* is defined as "a sense of group or collective identity based on one's perception that he or she shares a common racial heritage with a particular racial group" (Helms, 1993, p. 3). Additionally, racial-identity refers to a Black or White person's identification (or lack of identification) with the racial group with which he or she is generally assumed to share a racial heritage.

*Black-racial-identity* development was identified by Cross (1971, 1995) and Carter (1995) as proceeding through four distinct phases, referred to as preencounter, encounter, immersion-emersion, and internalization. Operationally, scores on the Black Racial-Identity Attitude Scale (BRIAS) as adapted by Parham and Helms (1981) define Black racial-identity.

*White-racial-identity* was defined by Helms (1984, 1990) and as proceeding through five stages, referred to as contact, disintegration, reintegration, pseudo-independence, and autonomy. Operationally, White racial-identity is defined by scores on the White Racial-Identity Attitude Scale (WRIAS) developed by Helms and Carter (1986).

*Perceived counselor attractiveness* is defined as the client's perception of the counselor as friendly, experienced, honest, likeable, expert, reliable, sociable, prepared, sincere, warm, skillful, and trustworthy. Operationally, perceived counselor attractiveness is measured by the client's total score on the Counselor

Rating Form-Short (Barak & LaCrosse, 1975).

*Perceived counselor effectiveness* is defined as the client's perception of the counselor as expert, sincere, competent, skillful, reliable, approachable, trustworthy, friendly, likeable, and someone you would see for counseling. Operationally, perceived counselor effectiveness is measured by the client's total score on the Counselor Effectiveness Rating Scale (Osgood, Suci, & Tannenbaum, 1957).

*Self-esteem* was defined by Rosenberg (1965) the extent to which an individual likes and approves of the self. Operationally, a client's self-esteem is measured by scores on the Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965).

### **Hypotheses**

1.0 It was hypothesized that following the initial counseling session, White clients who are racially less developmentally advanced and have low self-esteem will perceive Black therapists as less credible and White therapists as more credible.

2.0 It was hypothesized that following the initial counseling session, Black clients who are less racially developmentally advanced and have low self-esteem will perceive White therapists as less credible and Black therapists as more credible.

3.0 It was hypothesized that following the fourth counseling session White clients will not perceive Black and White therapists differently.

4.0 It was hypothesized that following the fourth counseling session Black clients will not perceive Black and White therapists

differently.

5.0 It was hypothesized that female clients in general will perceive their therapists in more favorable terms than male clients.

### **Significance of the Study**

Research on within-group differences among Whites has focused on demographic factors such as age, social class, and gender (Gruen, 1966). To date, no study has been reported that has considered White clients' perceptions of Black and White counselors and the relationships of these perceptions to White-racial-identity attitudes. Carter (1990) has suggested that cognitions derived from one's racial worldview "may influence how counseling participants perceive and interact with each other" (p. 46). The results of the study described here speak to the accuracy of this assertion. Thus, experience with a counselor initially based on worldview perceptions could enable clients to appraise their experience in new ways and to develop alternative ways of thinking and behaving. This in turn could foster more psychologically beneficial treatment.

### **Summary**

This chapter has delineated the lack of existing research on the relationship between racial-identity attitudes and the perceptions of White and Black clients of counselors of similar and dissimilar racial backgrounds. The research that does exist has been focused primarily on Black clients and their preferences for counselors of the same race. This chapter identified the reasons that racial-identity attitudes might be expected to be related to clients' perceptions of counselors. Finally, it is suggested in this chapter that the clients' perceptions of their counselors may have an impact on

the treatment process.

## Chapter II

### REVIEW OF RELATED LITERATURE

#### Introduction

In his text, *The Influence of Race and Racial Identity in Psychotherapy*, Robert Carter (1995) commented upon "how little has been written about the counseling process involving Black therapists and White clients" (p.54). Carter offered a two-part explanation for this gap in the counseling literature: (a) Black therapist/White client treatment dyads remain rare in practice when compared to their White therapist/Black client counterparts; and (b) scholars do not view this dyad to be "problematic or interesting" (p. 54).

It is conceivable that Carter is using irony in advancing the second of his reasons for the dearth of attention that has been paid to this topic: As the literature on cross-cultural counseling plainly reveals, mixed-race therapeutic dyads are both problematic and interesting as subjects for empirical investigation.

Regarding Carter's first point, it is evident that the relative rarity of Black therapist/White client dyads presents methodological problems (e.g., sample construction and selection, and a reduction in the significance of study findings, and the relative number and frequency of "real world" cases to which study results might apply) that may well inhibit researchers or otherwise limit their activities.

Yet, as Carter delineated the evolution of race as a psychiatric treatment variable, it became apparent that progress in our understanding of the intra-psychic and interpersonal dynamics that take place when Black therapists counsel White clients has been effectively impeded by deeper barriers. Indeed, Carter (1995) documented the existence of at least four interlocking impediments to the study of this topic: (a) the general neglect of race as a factor in the literature on psychological counseling; (b) the commonplace definition of race according to visible attributes; (c) the

erroneous cultural presumption held by many Whites (including White scholars, researchers, and therapists) that they do not, in fact, possess a racial identity; and, (d) the embedded assumption that the therapist in a mixed-race counseling dyad is necessarily White.

At the very outset of *The Influence of Race and Racial Identity in Psychotherapy*, Carter (1995) underscored a paradox in the investigation of race as a variable in mental health counseling.

Despite the central and enduring significance of race in North American society, psychology, psychiatry, and mental health disciplines relegate race to, at best, a marginal status in models of human development and in treatment approaches.... More often than not, race is thought of by mental health professionals to be an unimportant aspect of personality development and interpersonal relationships. Consequently, how race influences the therapeutic process is not well understood by psychological theorists, clinicians, and clinical scholars. Race as a personality and treatment factor has, at best, been treated as marginal. (pp. 1-2)

While race appears as a prominent factor in virtually all of the other social sciences, its importance as a psychological variable in general, and as a force in the therapeutic process, has never been recognized. Granted, non-Whites did not have widespread access to mental-health services in the United States until after World War II, and this may account for part of the lacuna in the study of race in therapeutic settings. At the same time, even as cross-cultural counseling literature suggests, the predominantly White therapeutic community has been content with the notion that by being sensitive

to people of color, White mental-health professionals can deal with race effectively and with minor alterations in their usual clinical stances.

To be sure, since the early 1950s a considerable body of research has been devoted to race as a treatment variable. Nonetheless, the overwhelming bulk of these empirical studies have defined race in terms of visible racial group characteristics, that is, skin color. Indeed, Cook and Helms (1988) have coined the term "visible racial/ethnic group members" (p. 268.) to designate study populations in those investigations that use skin color to classify their subjects, that is, most of the available research in this area. The demarcation of race, by the criteria of visible appearance, limits comprehension of its meaning as a psychotherapeutic variable in two ways. First, by taking race as a uniform set of physiological characteristics, it blinds us to the potential existence of important psychological differences among individuals who share these characteristics, most notably to variations in their racial-identities as they conceive them. Second, as Smedley (1993) has noted "Unlike other terms for classifying people...the term "race" places emphasis on innateness, on the inbred nature of whatever is being judged. Whatever is inheritable is also permanent and unalterable" (p.93). Visible race definitions, then, are also blind to the possibility that an individual in any racial grouping may undergo development of or alteration in his or her racial-identity and racial attitudes. An additional impediment to our understanding of the dynamics of the Black therapist/White client dyad lies in the widespread belief that Whites (or at least North American Whites) do not have racial identities. Whereas research on Black-racial-identity development began to appear in the early 1970s (Cross, 1971, 1978), research on the development of White racial-

identity did not appear until more than a decade later (Helms, 1984). Thus, Sabnani, Ponterotto, and Borodovsky (1991) observed that "empirical research on minority-identity models, particularly for African Americans, is much more advanced than parallel research on White-identity development" (p. 96). As a result, in the main and congruent with their culture's bias, White therapists serving non-White clients have fixed their attention on minority racial-identity models and have assumed that any racial issues that might arise in treatment are those of transference and counter-transference rather than a product of their own racial-identities or even biases (Ponterotto 1988). By doing so, they participate in the cultural myth that whiteness is a kind of "baseline" norm from which any departures constitute the only source of racial issues or interactions.

Comas-Diaz and Jacobsen (1995) argued, "most of the published information on cross-cultural and interracial psychotherapy has focused on people of color as recipients of professional services, not as the ones providing the services" (p. 94). To date, not only has the literature on Black therapists been sparse, but also the handful of research studies that have been conducted have conceptualized and/or operationalized race as a reflection of skin color.

Helms (1993, 1995) and Carter (1995) have developed the requisite theoretical constructs and measuring instruments to overcome the obstacles that have impaired our knowledge about the process and outcomes of mixed-race treatment dyads in which the therapist is Black and the client is White. While their collective work furnishes us with the means to conceptualize and to explore the intrapsychic and interactional dimensions of this type of treatment dyad, only a handful of empirical

investigations have, in fact, utilized racial-identity theories and study designs. Hence, we will initiate our review of the relevant literature by first surveying studies in which race is defined in terms of visible (skin-color) attributes, recognizing the inherent shortcomings of this approach, especially in application to the therapeutic dynamics of racially-mixed therapeutic dyads. I will then turn to a set of intervening themes in the literature that led, albeit indirectly, to the emergence of the first Black racial-identity theories in the early 1970s, with a discussion of Cross-'s (1971, 1995) model and related Black-racial-identity models to follow. I will then delineate Helms's (1984, 1999) White racial-identity model (and its immediate successors) and Helms's (1995) Black and White model with regard to the influence of race on psychological counseling. The review will conclude with a chronological genealogy of scholarly interest in Black therapists, covering the few published studies that focused on the topic.

### **Studies of Visible Race as a Variable in Psychiatric and Mental- Health Counseling**

Griffith (1977) reviewed the literature on race as a factor in psychotherapeutic relationships and concluded that "most of this literature consists of anecdotal accounts, uncontrolled observations, limited research findings, and a rather one-sided emphasis upon the white therapist-Black client relationship to the neglect of other racial combinations" (p. 27). While some of these early studies do adhere to scientific convention, most of the work published before the late 1970s displayed one or more of these defects, the norm being impressionistic discussions grounded upon the author's experience with a small set of racial cases unblemished by quantitative

methods.

It was in the aftermath of World War II that the increased access of Black Americans to mental health treatment stimulated the earliest investigations into race as a factor in the therapeutic process. Among others, Adams (1950), Heine (1950), St. Clair (1951), and Kennedy (1952) all conceptualized race as a visible, physiological feature, and all these investigations essentially aimed to provide White therapists with guidance for their treatment interactions with Black patients. More often than not, the purpose of these pieces was to alert White therapists to characteristically dysfunctional personalities of their Black patients and to specific transference and counter-transference behaviors associated with Black patient pathologies. For example, Adams (1950) counseled his readers that Black clients often use the deprivations and denigrations of their social experiences as shields against disclosure of their underlying inner conflicts, noting, for instance, that "a therapist may have a patient who rationalizes that death is more desirable than life as a Negro, but this excessive feeling has its origin in other sources" (p. 308).

The early literature also assumed that Black clients had psychological problems for which there were no analogous problems among Whites. Thus, Kennedy (1952) stated, "the Negro patient reflects in a unique way the fate he shares with every member of his in-group. Hence his specific life experiences are only secondarily elaborated and the development of the individualized ego is blurred by the phenomenon of color" (p. 313). In Kennedy's view, while racial-identity is a factor in therapy with Blacks, it is not an influence in the treatment of whites because the latter have "more room for elaboration" than the former (p. 315).

As the number of Blacks entering the mental-health field increased in the 1960s, a host of studies investigated the counselor-race preferences of Black clients and the treatment outcomes of same-race versus mixed-race therapeutic dyads (Banks, Berenson & Carkhuff, 1967; Gardiner, 1972; Hefferon & Bruehl, 1971). On the whole, this research indicated that Black clients preferred to work with therapists of their own race and that Black clients reported higher degrees of understanding, more opportunity for self-exploration, and a stronger disposition to continue with treatment when they were served by Black counselors than when they were served by White counselors. Indeed, based on these results, several researchers (Banks, 1972; Kincaid, 1969; Vontress, 1970, 1971) argued that there was a low probability of successful psychotherapeutic outcomes in racially heterogeneous treatment dyads.

Yet even during the 1950s, some scholars were beginning to challenge the pillars supporting the view that race is a problem confined to Black patients that can best be addressed by directing or assigning them to therapists of the same (visible) race. Bernard (1953) cautioned that White mental-health professionals must be aware of their own unconscious racial biases in dealing with Black clients. Indeed, Bernard was the first scholar to observe that while White therapists may deny existence of racial issues in the treatment of Black clients, they tend to either over sympathize with the effects of being Black or, second, to fulfill "an apparent need to deny and sidestep any such effects altogether" (p. 262). Moreover, in an insight that would anticipate the Black-racial-identity theories of the 1970s, Bernard suggested that the significance of race for Black clients may vary depending on their consciousness of its role in their lives and that this variance might exert an influence on the cross-racial treatment process. Similarly, by 1968, Schachter and Butts were writing that differences in racial stereotypes held by Black clients and White therapists can have a determinative influence on the psychotherapeutic process and treatment outcomes.

Continuing to focus almost exclusively on Black patient/White therapist treatment

dyads, research conducted in the 1970's demonstrated that, in these cross-race couplings at least, racial factors have an impact on the therapeutic process for the therapist, for the patient, and for their interactions. By 1980 or so, as indicated by reviews of the empirical literature by Orlinsky and Howard (1978), Parloff, Wasknow and Wolfe (1978) and Highlen and Hill (1984), a growing number of research studies indicated that race does indeed have demonstrable and complex effects on psychiatric therapy.

Many of these investigations continued to concentrate upon the therapist-race preference of Black patients and their attitudes toward psychotherapy. For instance, Wolkon, Moriawaki and Williams (1973) reported that within a racially mixed patient population as a whole, race in itself was not a factor in attitudes toward psychotherapy. They also reported that the Black patients in their study expressed a higher preference for Black therapists than their White counterparts and were generally more dissatisfied with the results of therapy than were the Whites in their sample. Both Harrison (1975) and Sattler (1977) found that "all things being equal" Black clients tended to prefer Black counselors. Likewise, Sattler (1977), summarized the results of 20 counselor attitude preference studies, and he concluded that therapist race appears to be of minimal importance to white subjects. White subjects may feel free not to state a racial preference because they believe that it would be rare for them to encounter a black therapist or because of the operation of a social desirability factor---the white subjects desire to appear benevolent (p. 263). Once again, restricting their understanding of race to a unifying, physiological distinction, that is, skin color, these studies continued to treat Black clients as special while White patients remained outside of the racial-issue domain.

During this time, some attention was turned to examinations that encompassed therapist race variables. Bryson and Cody (1973) found that White clients reportedly understood Black counselors as well as they understood White counselors and

obtained a similarly neutral finding for Black clients. However, Bryson and Cody stated that both Black and White counselors felt that they understood clients of the same race better than they did clients of a different race.

Eight years later, Turner and Armstrong (1981) came to decidedly different conclusions in their survey of two groups of psychotherapists, 41 White and 38 Black. Turner and Armstrong reported that both groups reported being able to empathize with a client of a different race to the same extent as a client of their own race, and they stated that Black counselors experienced greater reported comfort in mixed-race counseling dyads than did White counselors.

Proctor and Rosen (1981) investigated the expectations and preferences of 34 clients for the race of their counselors and their degrees of satisfaction with counseling outcomes. Among their results, Proctor and Rosen stated that both White and Black clients expected their counselors to be White; while about half of both the White client and Black client groups indicated that, they had no preference for a counselor of a particular race. Their results indicated to Proctor and Rosen that neither dropout rates nor reported client satisfaction with counseling outcomes showed any statistically significant correlations with the racial makeup of actual treatment dyads.

During the 1970s, Jackson (1973), Samuels (1972), and Sattler (1977) all undertook analogue studies of the black patient/white therapist treatment process. Samuels (1972) reported that White therapists characteristically sought to elicit information from their Black clients during initial treatment sessions rather than building a personal relationship or therapeutic alliance. Sattler (1977) concluded that both White and Black therapists "working with Black clients need special awareness of their own and their client's feelings about blackness and whiteness (including an understanding of potential transference and counter-transference reactions)" (p. 252). Sattler (1977) observed that "White therapists in their work with Black clients

occasionally were better at facilitating self-exploration than Black therapists, and Black therapists occasionally perceived themselves to be more empathic with White clients than with Black clients" (p. 273).

As the aforementioned studies indicate, during the 1970s and the 1980s, the thrust of research into race as a counseling variable underwent some modest revision, with much greater emphasis being placed on therapists' racial attitudes as factors in treatment processes. Among others, Gardner (1971), Jones and Seagull (1977), Green (1985), and Mays (1985) all found from personal observation and empirical investigation that, like their clients, therapists in racially mixed treatment dyads often have personal biases that influence interactions, many of which remain unrecognized by a clinically objective therapist. Gardner (1971) noted that, in racially mixed treatment dyads, both patient and therapist will approach each other cautiously at first, attempting to discern the other's racial attitudes. Somewhat later, Green (1985) and Mays (1985) reported that White therapists treating Black patients might find themselves inhibited by a subconscious effort to reduce their Black clients' perceptions that they were being bossy.

Jones (1978, 1982) was one of the first researchers to investigate race as a force in the therapeutic process, which unfolds over time. Based on direct observations of actual therapy over multiple sessions, Jones (1978) reported that while race did not have an impact upon therapeutic outcomes, it did have an effect on the quality of the therapeutic process. Jones collected his data over an average of 10 sessions for each matching. He found that within Black therapist/White client dyads there was a statistically significant decline over time in the therapists' efforts to see the clients in terms of their race and a decline in therapists' ease of identifying with patient. For the White therapist/Black client dyads in his study, Jones noted a progressive increase in the Black client's ability to express anger and in the client's acting out of feelings in the presence of the therapist (p. 233). Lastly, Jones echoed an old finding in his

report that, "if the client was white, it mattered little if the therapist was black or white in terms of both therapy process as well as outcome" (1978, p. 234).

Four years later, Jones (1982) undertook an investigation of 64 White and Black patients who had been seen in psychotherapy for a mean of 31 hours, with half the subjects in each group in racially homogenous therapist-patient dyads and the other half in racially heterogeneous therapist-patient dyads. Jones subsequently interviewed the therapists in all four of these groups. He reported that White therapists rated their clients, and most particularly their Black clients, as being more psychologically impaired than did the Black therapists. Jones once again noted, "there were no differences in psychotherapy outcome as a function of the client-therapist racial match" (p.722).

Examining Jones's (1978, 1982) work, Carter (1995) stated several years later that "Jones's studies indicate that race is an important variable in the psychotherapeutic process, but they do not suggest the nature of the influence" (p. 160). Indeed, all of the studies reviewed are limited in their explanatory power by not addressing both inter-personal and intra-psychic variables in the cross-racial treatment dyad.

To provide their findings with conceptual mechanics, scholars and researchers investigating the impact of visible race upon the treatment process and its outcomes frequently drew upon Strong's (1968) theory of psychological counseling as a social influence process. Indeed, Strong's counseling model was employed by many investigators of visible race as a means of explaining why Black clients, for example, prefer Black therapists and achieve more therapeutic benefit from them than they would from White therapists. In time, however, these studies had an indirect part in

the advent of the racial-identity theories of the 1970s and 1980s. Before turning to an examination of Black-racial-identity theory as presented, among others, by Cross (1971, 1995), we shall survey some of the forces in theory and in historical development that effectively paved the way for efforts to conceptualize race as a treatment variable that goes well below the skin of patients and therapists alike.

### **Toward Racial Identity Theories: Counseling as Personal Influence, the Civil-Rights Movement, and the Concept of Racial Identity**

One of the chief theoretical frameworks for the interpretation of results from studies investigating the influence of race upon psychotherapeutic processes was (and remains) social-influence theory (Strong, 1968) and the underlying consequences for mental-health counseling. Guided by social-influence theory, research studies have generally demonstrated that people see as credible and attractive those individuals whom they perceive to be similar to themselves (Goodyear & Robvak, 1981; Short, Moore & Williams, 1991). In 1968, Strong presented a conceptualization of psychiatric counseling as an interpersonal-influence process in which a client's perceptions of a counselor serve as key variables in the determination of change in both a client's attitudes and in his or her behaviors.

A large number of studies, conducted in the decade or so after Strong's (1968) social-influence model of psychiatric counseling was published, showed that a client's perception that a therapist is similar to him or herself has a positive impact upon that client's ratings of the therapist in terms of expertness, trustworthiness, and attractiveness (Strong & Schmidt, 1970; Schmidt & Strong, 1971; Strong & Dixon, 1971; Strong & Matross, 1973; Strong & Claiborn, 1982). That being so, it is logical

to assume that the "matching" of counselors and clients by social characteristics would be supportive of therapeutic efficacy. Indeed, in reviews of the pertinent research by Corrigan, Dell, Lewis and Schmidt (1980) and Heppner and Dixon (1981) concluded that client perceptions of a counselor's being similar to him or herself do indeed have a significant positive impact upon the therapeutic process and upon variable treatment outcomes, through the intervening processes of perceived therapist expertness, attractiveness, and trustworthiness. Thus, for example, LaCrosse (1980) reported that individuals in a substance-abuse program were more likely to benefit from counseling by therapists who were similar to themselves and were more likely to see these therapists as being attractive, trustworthy and well-versed in their professional fields. Similar results were reported by Heppner and Heesacker (1982) who noted that a client's perceptions of counselor expertness, attractiveness, and trustworthiness are subject to change over time, that is, through the duration of multi-session counseling regimens. It should be noted, however, that most of the counselor social-influence research of the 1970s and 1980s came in the form of analogue study designs, many of them based on a single interview or questionnaire (Corrigan, Dell, Lewis & Schmidt, 1980).

Given that cross-racial therapeutic dyads overtly entail significant differences in the visible social attributes of clients and therapists, it is by no means surprising to find that Strong's theoretical construct has been incorporated into the emerging literature on cross-cultural counseling. Thus, in an article entitled "Credibility and Racial/Cultural Similarity in Cross-Cultural Counseling," Sue (1981) wrote that the "credibility and attractiveness of the counselor is very much dependent on the

psychological set or frame of mind of the culturally different client" (pp. 54-55). At bottom, this approach to cross-cultural (or cross-racial) treatment posits that White therapists must be aware a non-White client's perceptions of the social differences which divide them can have a negative impact on the treatment process and its outcome unless the therapist takes measures to boost his or her credibility in the eyes of a client.

In application to cross-racial treatment dyads, the hypothesis that a non-white client's perceptions of being similar to or different from his or her therapist will affect the therapeutic process via association with counselor credibility, attractiveness, and professional competence has been explored at length. Thus, for example, in defining race in terms of visible attributes, that is, skin color, Sladen (1982) asked 12 White and 12 Black college students to rate sets of White and Black counselors in terms of empathy, attractiveness, and client improvement. Consistent with prior research findings, Sladen reported that students gave the highest rating to those therapists who were similar to themselves in visible race and the lowest ratings to those that were dissimilar to themselves in terms of visible race.

Nevertheless, Schmendinghoff (1977) reported from his research that race that is, visible race, is less important as a determinant of social-influence in a counseling process within mixed treatment dyads than is the similarity or dissimilarity of patient/therapist beliefs and attitudes about race. Here, the basis for a client's perception that a therapist is like him or herself is construed as variable racial attitudes rather than superficial physical characteristics.

According to Helms (1989), "more often than not, Black racial identity theories,"

such as Cross's (1971) model, "evolved in response to the investigators' attempts to explain individuals' varied responses to a social movement, the Civil Rights movement of the 1960s" (p. 229). During the 1960's, researchers noted that Blacks did not respond uniformly to the Civil Rights Movement's call for commitment to the cause of racial equality. In terms of both cognitive and behavioral responses, Black Americans varied in their reactions to the Civil Rights Movement. These observations, in turn, stimulated scholars like Vontress (1971) to develop typologies of Black people according to their attitudes and beliefs about race. Vontress suggested that Black Americans can be classified as (a) colored, (b) Negro, or (c) Black. While such taxonomies were a step away from reliance upon visible characteristics to define race, they were nonetheless static and invariant, suggesting that if a Black person has a colored racial attitude/belief cluster, he or she will remain colored across individual development stages.

The last piece of the puzzle leading toward the formulation of racial-identity theory involved the incorporation of individual, intra-psychic identity development theories into the emergent mix. Akin to the findings of Vontress (1971) and Cross (1971), racial-identity theories are based on the premise "that people's racial identities vary---that is, how and to what extent they identify with their respective group(s)---and that a person's race is more than his or her skin color, or physical features" (p. 2). The most widely and highly regarded racial-identity models embrace developmental processes such that an individual might advance (or retreat) over time from being "colored" to being "Black" in Vontress' (1971) terminology.

It was, of course, Erik Erikson (1963) who advanced a model of individual

development that accommodates the influence of culture upon a human being's sense of oneself. Yet, while Erikson (1963) acknowledged that culturally rooted racial beliefs do have effects on the development of a Black person's identity, he did not explore this topic at any length. Indeed, Erikson's (1965) essay on "The Concept of Identity in Race Relations" is a rambling discussion of the social status of Blacks in the United States circa the mid-1960s. As it turns out, scholars and researchers extending or operationalizing Erikson's model of human identity development have tended to avoid race as a variable. As Carter (1995) asserted "the omission of the influence of race in human development theories is quite curious, particularly when studies...consistently show that race and its social meaning are aspects of identity development during the formative years of human development, particularly in the United States" (p.76). In support of this contention, Goodman (1970) noted that American children begin to form a sense of their racial identity at a very early stage of development. Goodman observed that "By the third-year of his life the [Negro] child is asking the kinds of questions that ultimately will include one about skin color" (p. 37).

### **Black Racial-Identity Theory**

With all of this in mind, one can then understand the impetus behind the advent of the racial-identity development theories that first arose in the early 1970s and the significance of these models for the study of race as a variable in the psychological treatment process. It was in 1971 that theories of Black racial- identity development or Nigrescence (that is, the process of `becoming Black), began to portray an individual's racial sense of self as "a changing process, a process that is influenced by

individual characteristics as well as situational or environmental factors" (Helms 1989, p. 227). The first such construct is customarily attributed to Thomas (1971).

Thomas posited that Black Americans move through five stages in a linear progression ranging from the least to the most advanced stage of racial identity. Each of these five stages correlates with certain emotional, psychological, and behavioral clusters. Concurrently, it was Cross (1971) who put forth an alternative five-stage model of Black racial-identity development, consisting of (a) Pre-Encounter, (b) Encounter, (c) Immersion-Emersion, (d) Internalization, and (e) Internalization-Commitment statuses.

Since its initial formulation in 1971, Cross's model has undergone substantial changes. In 1978, Cross folded the Internalization-Commitment stage into the Internalization stage resulting in the four-stage model that remains in current usage. Carter (1991) has supplied an extremely concise synopsis of Cross's (1978) model of Black racial-identity development, as follows:

- (A) Pre-Encounter is a stage in which the individual devalues his or her own race or racial group and attempts to deny membership in that group (i.e., anti-Black and pro-White); Pre-Encounter attitudes are thought to be associated with impaired psychological functioning; (B) in the Encounter stage, the individual has an experience or series of experiences that challenge his or her anti-Black and pro-White attitudes; thus, Encounter attitudes reflect a state of psychological confusion and emotional turmoil; (C)

Immersion-Emersion is the stage in which the individual becomes deeply involved in discovering his or her Black cultural heritage and has idealized images and intense emotions about his or her new Black identity; psychologically, the individual may feel anxious about his or her new identity and hostile and angry toward Whites; and (D) during the Internalization stage, the person internalizes a positive Black identity; the Internalization attitudes have associated with them an awareness and acceptance of a bicultural identity structure. Implicit in the descriptions of Internalized racial identity attitudes is the notion that one may be psychologically healthy. (p.106)

The significance of this construct for the understanding of how race impacts the therapeutic process will become fully evident in the next section of this review when we examine the White racial-identity development models put forth by Helms (1984, 1995). At this juncture, one note's that Cross's model allows researchers to go beneath" visible race in their study of race as a factor in the mental- health treatment process and, at the same time, permits the possibility (indeed, the likelihood) that an individual's racial-identity develops over time.

Since 1971, several scholars have published alternatives to Cross, that is, Jackson's (1975) four-stage model of Black racial-identity unfolding through (a) passive-acceptance, (b) active-resistance, (c) redirection and (d)

internalization stages. Both Helms (1984, 1995) and Helms and Piper (1994) have delineated Black racial-identity development models that are, in essence, modified versions of Cross's (1978) construct.

The chief alternative to Cross, however, stems from the work of Atkinson, Morton and Sue (1979) who put forth a racial-identity development schema that is purportedly valid in application to all non-Whites in predominantly White cultures, for example; to Hispanics, Asians, Native Americans. Their Minority-Identity Development Model consists of five stages: (a) conformity, (b) dissonance, (c) resistance, (d) introspection, and (e) awareness.

(A) Conformity Stage: characterized by a non-White individual's preference for the dominant (White) cultural values over those of the individual's own racial/ethnic culture.

(B) Dissonance Stage: featuring confusion and conflict, as the individual challenges his or her prior assumptions about conformity and questions the authority of dominant culture.

(C) Resistance and Immersion Stage: distinguished by an active rejection of dominant (White) culture and the embracement of minority-views, a desire to combat racism, and an urge to learn more about the individual's own culture.

(D) Introspection Stage: characterized by a resumption of internal conflict, a "break out" against restrictions of prior stages, and an effort to reconcile the individual's new-found cul-

tural values with his or her personal experiences.

(E) Articulation and Awareness Stage: characterized by "a sense of self-fulfillment with regard to cultural identity," an "objective assessment of both the mainstream, dominant culture assumptions and those of the individual's minority group culture, and a desire to limit all forms of racial/ethnic oppression.

(Sue, 1981, p. 66)

Clearly, the Atkinson et al. model, as described by Sue (1995), closely resembles the developmental sequence found in Cross's (1971, 1995) Black racial-identity model, but it differs markedly in its assumption that this stage progression is relevant to members of all minority groups.

More recently, in *Multicultural Counseling Competencies*, Sue and Carter (1998) outlined what they referred to as a Racial/Cultural Identity Model that they purported to be valid and reliable for Whites and non-Whites. The stages of the RCIM model are, in fact, identical to Atkinson et al.'s (1998) Racial-Identity Development model. Sue and Carter (1998) believed it was

anchored in the belief that all minority groups experience the common force of oppression, and as a result, all will generate attitudes and behaviors consistent with a natural internal struggle to develop a strong sense of self-and group-identity in spite of oppressive conditions. (p. 75)

Still, Sue and Sue's (1990) and Sue and Carter's (1998) models are fundamentally

different from those of Cross (1978, 1995) and from Helms' (1984, 1995) White racial-identity models in that they assume that minority and majority group members transit the same course in the development of their racial-identities. Given the racially associated differences that divide the White majority in the United States from the non-White minority, this assumption is questionable, as is the contention in Atkinson et al. that all non-White minority group members are subject to the same racial identity development process.

Returning to Cross' (1971, 1978) model, a number of researchers (Helms, 1981, 1990; Helms & Parham, 1985; Parham, 1982; Parham & Helms, 1985; Ponterotto & Wise, 1987) have tested its validity and reliability. Parham (1982) reported that Blacks in the Pre-Encounter and Immersion-Emersion stages characteristically harbor feelings of inferiority, inadequacy, and hypersensitivity. Subsequently, Parham and Helms (1985) confirmed that the Pre-Encounter and Immersion-Emersion stages of Black racial-identity development correlate with low self-actualization tendencies, low self-regard, and high anxiety; that Blacks in the Immersion-Emersion status report feelings of hostility; and that the Encounter stage among Blacks is characterized by low levels of anxiety, high self-actualization, and high self-regard (Parham & Helms 1985).

More recently, Carter (1995) used Helms and Parham's Racial-Identity Attitude Scale for Blacks exemplifying Cross's (1978) four-stage model in a study of 95 Black college students, ranging in age from 17 to 33-years-old. Carter reported several meaningful correlations that are generally supportive of the power of Cross's (1978) model to discriminate aspects of psychological functioning among African-

Americans. Among Carter's results, Pre-Encounter status was associated with paranoia, anxiety, memory impairment, hallucinations, and global psychological dysfunction; Immersion-Emersion status, on the other hand, displayed negative correlations with memory impairment. Carter concluded that his findings "seemed to suggest that African Americans at various levels of racial-identity may function psychologically differently" (p. 112).

To the present, however, only a handful of empirical studies (e.g., Carter and Helms 1992; Carter, 1995, and Helms, 1999) have examined cross-racial therapy process issues that define race in developmental identity terms as opposed to visible characteristics. Pomales, Claiborn and LaFromboise (1986), for instance, tested the hypothesis that Black racial-identity development would affect perceptions of White counselor's behaviors. Pomales et al. classified 54 Black college undergraduates under two headings, Encounter and Internalization. They reported that the Encounter sample rated White counselors as less culturally sensitive, but more competent, than did the subjects whom they had classified as being in the Internalization stage. On the whole, however, the potential importance of Cross's work has not enjoyed a commensurate degree of empirical research. Indeed, until 1984, the vast majority of the studies within the voluminous literature on cross-cultural counseling continued to omit a crucial dimension of race in counseling, that is, the extension of racial-identity theory in relation to Whiteness.

### **White Racial-Identity**

In seeking to answer the question of whether racial-identity impacts psychotherapy, Carter (1995) initiated a reply by noting that "advocates of the race

per se assumption who also use transference and counter-transference assert that racial stereotypes affect the psychotherapeutic process only in cross-race dyads" (p. 157). Carter's assertion pointed to both a shortcoming in the research and to a topic that must be taken into account if we are to answer the question that Carter posed for himself.

This is particularly so given that the lion's share of relevant studies in the counseling literature define race in terms of visible characteristics and that most studies have been conducted under the premise that a White therapist either does not have a racial-identity at all or that it exerts no influence on the treatment process with either non-White or White clients.

Moving toward both an answer to this question and a discussion of White racial-identity development (WRID) models, Carter (1995) observed that, until recently, the vast majority of White Americans did not consider themselves to possess a racial-identity. As Carter (1995) explained, "typically, Whites have not included themselves in the dialogue about race, because they have been taught to explore ethnicity rather than racial group membership," and, as a consequence, "many discussions of cross-racial therapy have excluded Whites and their White racial identity" (p.100). Nevertheless, it is patently evident that White Americans do have a distinct racial reference group and that this reference group exerts an influence on the development of their identities.

Katz (1985) has argued that, contrary to prevailing mainstream (i.e. White) beliefs, Whites in North America have a cultural pattern that is distinct from non-White groups in United States. Among other dimensions that characterize this White

culture, according to Katz (1985) are a stress on individualism with a self-centered worldview, an orientation toward action and toward external accomplishments, and a strong need to comply with social rules and conventions. Katz further noted that White U.S. cultural values comprise the foundation for ideas about psychotherapeutic theory and practice that predominate within the mental health community. To this day, most U.S. Whites (including scholars, researchers, and working therapists) are not aware that they have racial-identities and many are apparently threatened by expressions of Black racial-identity (Helms 1990, p. 52). On the other hand, as Helms has written, "in spite of the pervasive socialization toward racism, some White people do appear not only to develop a White identity, but one that is not predominated by racial distortions" (p.53).

Thus, despite the ubiquity of the notion that White people do not have a racial-identity, we would concur with White-racial-identity development theorists in asserting that the contrary is the case that White people vary in racial-identity statuses along lines similar to those that discriminate amongst non-Whites, and that these statuses or stages are subject to change over time. In this context, we note Jones's (1972, 1981) assertion that racism is, in fact, a multi-dimensional phenomenon, having individual, cultural, and institutional sources and manifestations. According to Carter (1995), "all three forms of racism (i.e., individual, institutional, and cultural) can be aspects of a White person's racial identity, because each type of racism is ingrained in American cultural patterns and institutional practices" (p. 101). Thus, to become truly healthy, a White individual in US society must advance to a higher level WRID stage. Absent such progress, the White individual will unwittingly suffer not

only the distortionary effects of racism, but his or her development will also manifest non-racial or generalized developmental pathologies.

By the time that Janet Helms published her White racial-identity development model in 1984, alternative frameworks for viewing variation in the racial identities of Whites in the US were available. Helms (1993) herself has reviewed five early models of White racial-identity other than her own. Two of these-- Kovel (1970) and Terry (1977)--are static typologies in which a developmental dimension is absent. Thus, Kovel (1970) divided Whites into five racial-identity types: dominative racist, aversive dominative racist, aversive liberal racist, ambivalent, and non-racist. Terry (1977) categorized White racial-identity under three rubrics, (a) Color Blind; (b) White Blacks; and (c) New Whites. In addition to her own 1984 model, Helms (1993) referred to three other paradigms of White racial-identity development, those of Ganter (1977), Carney and Kahn (1984), and Hardiman (1979).

Hardiman (1982) proposed a White racial-identity development model consisting of four stages: (a) Acceptance (of White superiority), (b) Resistance to White superiority assumptions, (c) Redefinition, and (d) Internalization. This final status is marked by a White individual's internalization of positive, non-racist White identity attitudes and beliefs. Based heavily upon Jackson's (1975) model of Black racial-identity, Hardiman's (1982) conceptualization was quite similar to that which would be set forth by Helms in 1984. Of these resemblances, Helms (1993) has written:

Both models are similar in that they propose a linear process of attitudinal development in which the White person [sic] potentially progresses through a series of stages differing in the

extent to which they [sic] involve acknowledgment of racism and consciousness of Whiteness. They [sic] differ in the particulars of some of the stages, though both agree that the highest stage involves an awareness of personal responsibility for racism, consistent acknowledgment of one's Whiteness, and abandonment of racism in any of its forms as a defining aspect of one's personality. (pp. 53-54)

Shortly after Hardiman's initial publication of her model, she expanded the model to include a fifth stage Immersion/Emersion on the premise that White Americans can seek out accurate information about racial-identity. Indeed, Helms freely allows that she modified her own White racial-identity development model to include an Immersion-Emersion component. Since that time, however, problems with efforts to develop scales for the measurement of Immersion-Emersion in Whites have led some researchers to essentially drop this stage from Helms' model. Still, Helms' (1984, 1995) model remains the most widely utilized model of White racial-identity development. Helms' (1984, 1995) model enjoys substantial empirical support while Hardiman's has not been used extensively by researchers. Given all this, Helms' 1984 model, and its successive refinements (Carter, 1995; Helms, 1990, 1995; Helms & Piper, 1994) have become the salient framework for the conceptualization and study of White racial-identity development. Indeed, owing to Helms' publication of a second model in 1984, in which Black and White racial-identity development stages were used as concepts for the study of the impact of race on psychotherapeutic processes, we are led to accept Carter's (1995) contention that Helms (1984, 1995) is

the only author who has outlined a model that captures both the intrapsychic and interactional process dimensions of racial-identity development in counseling.

In contrast to Sue and Carter (1998), Helms maintains that the racial-identity development among U.S. Whites differs significantly from that of U.S. Blacks and other non-White inhabitants of U.S. society. Indeed, two core assumptions underlie Helms' theory of White racial-identity development. First, according to Helms, Whites are socialized to believe that they are superior to visibly non-White people. Second, in addition to this assumption of superiority, since Whiteness is the norm in our society, Whites can avoid, deny, or ignore dealing with their White racial-identities. However, as Helms (1990) noted, when a White person is in a position in which he or she cannot ignore Whiteness, for example, assignment to a Black psychotherapist, this individual must deal with White identity issues in some way. To this, I would add a third premise, implicit in Helms' model and its subsequent refinements. That is, whether they are aware of it or not, "because racism causes White people to deny, distort, and repress the realities of race relations in their environments, it has negative impacts on White people as well as having benefits" (Helms 1993, p. 241).

Embodied in Helms' model of White racial-identity development is the premise that "the evolution of a positive White racial-identity consists of two processes, the abandonment of racism and the development of a nonracist White identity" (Helms 1990 p.49). In one formulation of Helms' model, White racial-identity development is marked by a "succession" of six stages: (a) Contact, (b) Disintegration, (c) Reintegration, (d) Pseudo-Independence, (e) Immersion-Emersion, and (f) Autonomy.

With an overlap in the middle, the earliest of these stages (i.e., Contact through Pseudo-Independence) features an abandonment of White racism, while the latter stages (i.e., Reintegration through Autonomy) are marked by the development of a distinct White racial-identity. What Helms refers to as a Contact stage in White racial-identity development is basically a state of naiveté in the sense that the individual White person lacks a conscious racial-identity. As Carter (1995) asserted, "generally a person at this level of development will unconsciously judge people of color by using White society's standards" (p. 104). As Helms put it, the Contact stage in White racial-identity development is characterized by minimal contacts with people of color, and so the individual "is unlikely to be forced to rethink his or her racial perspective" (Helms 1990, p. 57).

At the next level, Disintegration, a White individual becomes consciously aware of racial differences. According to Carter (1995), this second stage is "associated with emotional conflicts, psychological confusion, and moral dilemmas that arise as a person confronts his or her sense of human decency and racial norms" (p. 105). The Disintegration stage, then, is marked by a high degree of internal polarization, which Whites tend to resolve through three strategies: the avoidance of non-Whites altogether, attempts to convince others that non-Whites are not inferior, or the adoption of the view that racism really does not exist or that, if it does, Whites have no part in it.

A third phase, Reintegration, arises when an individual White person acknowledges that he or she is White and consciously embraces a belief in White superiority. "People at this status level," Carter noted, "selectively attend and

reinterpret information to conform to societal stereotypes" (1995, p. 106). Whites in the Reintegration stage tend toward either passive strategies to deal with race (e.g., deliberate avoidance of non-Whites) or active strategies (e.g., participation in collective efforts to protect white privileges). Hence, the most overt racists in American society (e.g., members of the Ku Klux Klan) are likely to be high in the Reintegration stage.

It is in the fourth stage, termed pseudo-independence by Helms that a White individual moves toward a positive White racial-identity. In this stage, the individual becomes aware not only of his or her Whiteness, but of the ways in which he or she has intentionally or inadvertently supported or participated in white racism. Whites in this stage often become uncomfortable with themselves as White people and begin to alter their attitudes. However, such change is primarily intellectual in nature. In the Pseudo-Independence stage, Whites tend to identify more closely with Blacks than with racial peers when racial issues are brought up. "In Pseudo-Independence," Carter writes, "a person's interaction with blacks may take the form of helping them to meet the prevailing white societal standards" (1995, p. 107). At this juncture, a transition has been initiated from externally imposed definitions of race toward internal development of racial-identity. However, Whites at this stage are hampered by the absence of positive models of Whiteness in society. According to Helms (1990),

The person at this level of awareness (Pseudo-Independence) begins to feel marginal regarding race and racial issues.

However, if whites in this stage have incentives to persevere,

these people will begin their quest for positive aspects of being White that are unrelated to racism and a better understanding of one's Whiteness. These activities lead into Immersion-Emersion, the fifth (level) of White racial identity development. (p. 62)

Many self-professed White liberals display the characteristics of the Pseudo-Independence stage.

The Immersion-Emersion stage in White racial-identity development, as construed by Helms, is distinct from the corresponding Immersion-Emersion status in Black racial-identity development. In this phase, Whites do not reject Blacks (as Immersion-Emersion stage Blacks reject Whites), but instead, embrace their Whiteness. "In this level of racial-identity development," Carter (1995) writes, "Whites revise myths about blacks and whites by incorporating accurate information about the present with the historical significance and meaning of racial group membership" (p. 107).

According to Helms (1990), Whites in Immersion-Emersion stage enter into a process of self-exploration during which race is a salient variable, and this involves both emotional and cognitive restructuring. As Helms reported, Whites in the Immersion-Emersion stage often experience an emotional catharsis or rebirth. "These positive feelings," she asserted, "not only help buttress the newly developing White racial-identity, but provide the fuel by which the person can truly begin to tackle racism and oppression in its various forms" (Helms 1990, p. 62).

The sixth and final stage of Helms's White racial-identity development model (as

cited in Carter, 1995), Autonomy, "occurs when an individual internalizes, nurtures, and applies the new meaning of Whiteness to his or her interactions and does not oppress, idealize, or denigrate people of color based on racial group membership" ( p. 108). Such enlightened and self-assured Whites are open to new information about their own racial-identities and the racial-identities of non-Whites, can operate in mixed-race interactional settings, and, in fact, actively seek out cross-racial experiences, viewing them as inherently beneficial (Helms, 1990, p. 63).

At this juncture, a word of caution is in order. Helms (1990, 1993), Parham (1989) Helms and Carter (1990), Sabnani, Ponterotto, and Borodovsky (1991), and Gushue (1993) have all noted that the term "*stages*" and their arrangement in a sequential order may be misleading. As Sabnani et al. (1991) wrote, racial-identity development models (for Blacks, for Whites, and for multi-racial/ethnic group members) do not follow a neat, linear path, for "in reality the movement may be more complex, marked by loops into previous stages at various choice points" (p.82). Similarly, Gushue (1993) has stated that, "development in these models is not age-related or even inevitable. In fact...the process can be arrested for some individuals (and)...for some there may be a certain amount of recycling" (p.492). In a "Reaction" comment appearing in the April, 1993 issue of *The Counseling Psychologist*, Helms wrote that she

has recommended that stages of racial identity be viewed as levels of racial complexity, with higher or more advanced stages greater sophistication in one's conceptualization skills with regard to one's own racial characteristics as well as those of other racial groups.

According to this perspective, each stage of racial identity is potentially present in the person, but whether they are equally available to govern the person's attitudes, feelings, and behaviors is determined by the level of maturation within the individual. Whether a stage matures within the individual is determined by a combination of the unique cognitive processes (personal identity) as well as the quality of the (racial) environments in which he or she interacts. (p. 241)

What causes an individual to transit from one stage to the next in racial-identity development is uncertain. According to Jones and Carter (1996), "it is currently unclear what specific events move a (White) person from one status to another in racial-identity development. It seems to be related to personal values, experiences, and individual resolve" (p. 5). Thus, rather than a strictly unidirectional, linear sequence that unfolds predictably and can be explained by intervening experiential phenomena, the stages in all models of racial-identity, including those of Cross (1978, 1995) and Helms (1984, 1995) display overlap, iteration, and problematical movement.

During the past decade, empirical studies have been conducted aimed at the investigation of one or more of each of the White racial-identity stages contained in the Helms model. Thus, for example, McCaine (1986) reported that Whites in the Contact-stage "have a weak sense of self and do not exhibit independent ideas and behavior" (p. 29). Indeed, Contact stage Whites display an inability to form close, meaningful relationships independent of racial issues. According to Carter and Parks

(1992), White men with high Contact status are prone to obsessive/compulsive behavior and memory impairment. Based upon his own research and that of his colleagues, Carter (1995) noted that, "the Contact stage is psychologically characterized by low self-actualization, dependency, psychological symptoms for men and a basic denial of race" (p.151).

Helms and Carter (1991) have reported that Whites with a high Disintegration status tend to prefer counselors with social characteristics similar to their own. Those in the Reintegration stage, according to Tokar and Swanson (1991) are given to immature interpersonal relationships, high degrees of anxiety, and psychological distress. According to Carter and Parks (1992), Reintegration-status Whites "have significantly higher levels of paranoia, concerns about drugs, and they wonder if some things they see and hear are real" (p.18).

On the upside of the spectrum, Taub and McEwen (1992) have reported that Pseudo-Independence status in Whites is associated with mature interpersonal relationships. However, neither McCaine (1986) nor Carter (1987) found an association between a Pseudo-Independence racial-identity status and any type of affect, although they did find Pseudo-Independence to be predictive of a preference on the part of White clients for same-race counselors, most especially for White female counselors. Lastly, Bernstein, Wade, and Hofmann's (1987) reading of Helms (1984) indicated to them that "White clients might ultimately express no preferences for the race of their counselors as a result of having achieved the final stage of development in which members of any racial group are accepted as individuals" (p. 60). Tokar and Swanson (1991) have characterized Whites in the Autonomy stage by

stating that "a secure appreciation and acceptance of oneself and others (autonomy) appears to be associated with a liberation from rigid adherence to social pressures and with a strong inner reliance (inner directedness" (p. 299). As predicted by Bernstein et al., Whites in the Autonomy stage reported no preferences for counselor race.

Turning to a closer examination of Tokar and Swanson's (1991) investigation into the validity of Helms's model of White racial-identity development, we find a close correspondence between maturation in the racial- identity of White people and in their capacities for self-actualization. Tokar and Swanson (1991) mainly found that "negative predictors of self-actualization were lower-level White racial identity attitudes (e.g., Contact), whereas white racial- identity attitudes that emerged as positive predictors of self-actualization variables were more developmentally advanced (i.e., Autonomy)" (p. 299).

Claney and Parker (1989) applied the five-stage variant of Helms's model to study the correlation between levels of White racial consciousness and the perceived comfort of Whites in situations in which they must interact with Blacks. Their survey of 339 White undergraduates led Claney and Parker to report that whites in the first and last stages of the model (Contact/Autonomy) reported being more comfortable in situations involving Blacks than those in the three "middle" stages (Disintegration, Re-integration, and Pseudo-Independence, with "Immersion/Emersion" dropped from consideration). They concluded that "the results of this research show a clear curvilinear relationship between White racial consciousness and perceived comfort with Black individuals, with the research indicating that being completely foreclosed (stage one) or well-acquainted (stage five) is more indicative of perceived comfort

with Black individuals than other stages of development" (Claney & Parker 1989, p. 449).

The results reported by both Tokar and Swanson (1991) and Claney and Parker (1989) are suggestive of a high degree of explanatory power and construct validity for the Helms (1984) model and its instrumentation (the "five stage" White Racial-identity Attitude Scale as published by Helms & Carter in 1990). However, in specific application to race as a counseling variable, findings have not been conclusive. Indeed, the only published empirical studies of Helms' White racial-identity development model published between 1984 and 1994 are two studies by Carter (1987, 1990), an investigation of counselor race preferences among Black and White clients conducted by Helms and Carter (1991), and an analytical review by Helms and Piper (1994). Since that time, Carter (1995) has operationalized an interactional model of Black and White racial-identity for use in the study of the therapeutic process (see Helms' Interaction Model and Elaborations of Helms by Carter). Nevertheless, the confirmation and implementation of Helms' White racial-identity Attitude model is confined to, at best, six or seven empirical investigations.

The earliest effort to implement the Helms' White racial-identity development model was Carter's (1987) exploration of correlations between the racial statuses described in Helms's model and the therapist race preferences of White and Black students. Helms and Carter (1991) supplied a concise synopsis of this study's methods and chief findings.

Carter (1987) used counseling situations in mental health professionals and graduate students role-played counselors and clients discussing racial

issues in either heteroracial dyads (e.g., Black counselor/White client) or homoracial dyads (e.g., White counselor/White client). In Carter's study predictor variables were White racial identity attitudes (Helms & Carter, 1990) and dependent variables were client reactions as measured with Hill, Helms, Spiegel and Tichenor's (1988) client reactions system. Carter found that in heteroracial dyads, White client surrogates' Reintegration and Disintegration attitudes were related to their perceptions that the simulated counseling that they received lacked direction and was ineffective (Helms & Carter, 1991, p. 447). In this analogue study design, then, Carter (1987) used an earlier version of Helms and Carter's White Racial-Identity Attitude Scale (WRIAS), that is, a White Racial-Identity Inventory (Carter & Helms, 1987), to generate significant findings as to the influence of racial-identities in therapeutic dyad interactions.

In his second study of Helms' model, Carter (1990) directed 100 White undergraduate students to complete the White Racial-Identity Inventory and his own New Racism Scale, in a search for correlations between measures of racial attitudes and measures of White racial-identity development stages. His results were supportive of a strong parallel between the status categories described by Helms and levels of racial bias.

In 1991, Carter and Helms tested the correlation between stages of White racial-identity development as posited in Helms and Carter (1991) (with "Immersion-Emersion" excised) and the counselor racial preferences of 183 White and 76 Black clients. They reported that stages in White racial-identity development were

predictive of White clients' preference for White counselors and Black clients' preferences for White counselors. Helms and Carter concluded that "It appears that participants' levels of preference for White counselors were influenced by their own racial-identity attitudes" (1991, p. 452).

Since that time, considerably more sophisticated studies of White racial-identity development has been published. In addition, Helms' (1984, 1995) Black and White racial-identity development model, as designed for implementation in therapeutic counseling, has been published by Carter (see below). By 1994, Helms and Piper were able to present an internally cohesive model of plausible explanatory power prospectively capable as a valid theoretical construct to guide field investigation and move us toward race as an intra-psychic and interactional force in both racially heterogeneous and racially homogeneous treatment dyads. Based upon the available research, Helms and Piper were able to state three incisive conclusions about race as a psychological variable:

- (1) That racial identity development is a process in all racial groups, including Whites, even though separate models may be necessary;
  - (2) that racial identity encompasses both perceptions about self and about one's racial/ethnic group; and, (3) that racial identity "represents ego differentiations that are more or less mature, with less mature ego statuses being derived primarily from external sources and more mature ego statuses (or levels) stemming from a process of exploration, discovery, integration, and maturation."
- (Helms & Piper 1994, p. 127)

Having concluded their review of the research concerning Helms's White Racial-Identity Development (WRID) model, as did McCaine (1986), Tokar and Swanson, (1991), Taub and McEwen (1992) and Carter and Parks (1994), Helms and Piper (1994) stated that "Healthy [racial] identity development occurs by a maturation process in which the person learns to substitute internal definitions and standards of racial-group identity for externally or societally imposed definitions" (p. 128). Thus, despite the comparative paucity of research studies using WRID concepts and methods, Helms's construct, in conjunction with its Black racial-identity development counterparts (e.g., Cross, 1978; Helms, 1994; Helms & Piper, 1994), provides the necessary theory and methodology to study race as an intra-psychic/interactional variable in the counseling process and, more pointedly, for the study of the Black therapist/White client dyads.

### **Helms' Interaction Model and Elaborations of Helms by Carter**

In 1984 Helms also published a heuristic Black and White Model of racial identity in a study titled "Toward a Theoretical Explanation of the Effects of Race on Counseling." She would later describe the reasoning behind her effort to combine White and Black racial-identity models into a basis for understanding therapeutic action. Thus in 1986 Helms hypothesized that interactions involving four racial dyads-- White therapist/White patient, Black therapist/Black patient, White therapist/Black patient, and Black therapist/White patient--would yield variations in the racial-identity development statuses of therapists and patients that would, in turn, have a demonstrable influence on therapeutic processes and outcomes.

In what must be considered an exploration of the theoretical possibilities and

implications of these hypothesized correlations, Helms (1984) began her discussion of a Black and White model for use in the study of counseling processes by stating that prior cross-racial models had assumed that therapists are White and that their racial attitudes, levels of awareness, and identities are invariably (or ideally) those of professional (or clinical) "neutrality" (Helms 1984, p. 128). Drawing upon emergent WRID theory, Helms asserted that White therapists do indeed have White racial-identities, that race is inherent in their cultural development, and that these identities can be classified according to the WRID for the purpose of observing variance in racial-identity development stages among both White and Black therapists (i.e., through a BRID counterpart) (Helms 1984, p. 127).

Moreover, Helms stated that combinations in the variable racial-identity development statuses in different therapist/client racial dyads would have powerful effects. Helms cited interpersonal influence theory principles to suggest that a counselor with a more advanced racial-identity status can potentially interact with a client having a less advanced racial-identity in furthering therapeutic progress on racial and non-racial issues. In addition to such progressive relations, as designated above, Helms posited the potential for parallel, crossed, and regressive relationships.

In a parallel relationship, Helms (1984) proposed that client and therapist will be at the same level within their respective racial-identity development stages. For example, if a White therapist was in a Contact stage of development with a Black client in a Pre-Contact stage their (low) levels of racial-identity would be in parallel, as would be the case if a Black therapist were to be in an Internalization stage and treated a White patient in an Autonomy stage. In a crossed relationship, Black and

White participants in counseling dyads have racial-identity statuses that are essentially in opposition to each other. Thus, for example, in a therapeutic dyad comprised of a Black client with a Reintegration status rejecting White culture and a White therapist harboring a (white supremacist) Disintegration status, as Carter (1995) understated it, "neither the client nor the counselor empathizes with the other's racial attitudes" (p. 131). He added that both may engage in "educative strategies," which "frequently hamper the formation of a therapeutic relationship, causing either the patient or the counselor to become frustrated and to terminate treatment" (p. 131).

A progressive relationship, in Helms' (1984) terminology, exists when a counselor has a racial-identity status that is at least one level above that of his or her client. Thus, a Black counselor in a mature Internalization status could form a progressive relationship with a White client in a Contact or Disintegrative stage of racial-identity development. According to Carter (1995), such relationships can be productive "if the counselor can focus the client on the treatment" (p. 131).

Conversely, a regressive relationship (Helms, 1984) exists when a counselor has a racial identity stage that is at least one level below that of his or her client. A White therapist in a Contact stage combined with a Black patient in an Internalization stage would illustrate a regressive relationship in the extreme. According to Carter (1995), regressive relationships often devolve into a power struggle between the patient and the counselor since "both participants have strong affective reactions to each other, and conflict may characterize the relationship's dynamics" (p. 132).

Helms (1984) concluded her speculative theoretical work by indicating the potential significance of this Black and White model for the study of and the

improvement of therapeutic processes and outcomes.

Ideally, in a progressive relationship, the counselor will be able to gradually move the client toward a healthier stage. Yet if a counselor remains at the same stage, then the relationship becomes parallel, a condition that is likely to result in a counseling impasse. The counselor cannot move the client further than the counselor has come. To the extent that racial issues are an important concern in the counseling process, regressive relationships are likely to end in termination because the counselor is unable to enter the client's frame of reference. The specific implications of parallel and crossed relationships will probably differ depending on whether the counselor and/or clients are Black or White and whether the counseling is intra- or cross-racial; but by identifying the counselor and client's race consciousness stages, it should be possible to make predictions about the quality of the counseling relationship as well as possible counseling outcomes. (Helms, 1984, p. 159)

This approach to the study of race as a variable in therapeutic interactions is completely congruent with implications that can be drawn from BRID and WRID theory and supporting research. It hints at a means of deriving therapeutic benefits, underscores the need for racial-identity development in therapists of all races/ethnicities, and provides guidance for working in cross-cultural dyads as well as

same-race dyads.

The problem here is that the operationalization of this model is complex, yielding a multiplicity of dyad/RID stage combinations, a need to measure these accurately, and a need to observe therapeutic processes in interaction. Thus far, while Carter (1997) has modified this approach, only Helms and Piper (1999) has ever utilized it in conjunction with her BRID/WRID model(s) and instrumentation(s). Helms (1999) reported that in the parallel dyads she studied, stable and placid counselor/client relationships were most often observed in those pairs in which both counselors and therapists reported feeling understood. Nevertheless, parallel dyads were not likely to generate change in the racial attitudes of either participant. Progressive dyads were characterized by tension, but exhibited the greatest degree of client growth. In regressive dyads, Helms (1999) reported high degrees of both covert and overt interpersonal conflict, and that these dyads are "characterized by disharmony and conflict" (p. 182). The highest degree of conflict between the counselor and the client was observed by Helms to occur in crossed relationships, this combination being the least likely to generate client growth (p. 170).

Lastly, Carter published two studies in 1995 in which he used modifications of Helms and Carter's (1991) WRIDS and of Helms' (1994) BRIDS under the umbrella of what he referred to as an emerging Racially Inclusive Model of Psychotherapy (RIMP). In the first of these studies, Carter operationalized an updated version of Helms's Black and White theoretical construct among a set of four racial dyads-- White/White, White/Black, Black/Black, and Black/White--including 12 mixed dyads, of which four were comprised of a Black counselor and a White client.

Results indicated that, when a Black counselor within the Pre-Encounter stage of Black racial-identity was coupled with a White client, there was a complete avoidance of racial issues. Black counselors with an Encounter stage of racial-identity development, Carter observed displayed marked intentions to deepen their White client's emotional awareness when racial issues were discussed. Carter (1995) highlighted his most significant results for Black counselor/White client dyads in his sample:

In summary Black counselor/White client dyads were strongly influenced by each participant's racial identity attitude development. A Black counselor who has high Pre-encounter attitudes when working with a White client believes that racial discussions are a worthwhile endeavor. Furthermore, if the counselor's Encounter attitudes are high, attempts to focus on a client's emotional experiences may lead the client to increased self-knowledge. If the counselor has internalized his or her Black identity, the White client may respond neutrally. On the other hand, a Black counselor, when working with a white client who has high Pseudo-Independence attitudes, may enhance expectations that change is possible. However, if the White client's Disintegration and Reintegration attitudes are high, the Black counselor is seen negatively, and the client receives little benefit from working on racial issues with the counselor. Perhaps this level of racial identity development, with its strong defenses,

limits a positive therapeutic exchange. (p. 170)

From his results, Carter sought to reinforce three broad theoretical points contained in racial-identity development theory as applied to the counseling process: (a) that racial-identity is more significant as a determinant of psychotherapeutic process than is visible race; (b) that racial-identity statuses do vary and do exert an influence on the behaviors of both therapists and clients and; (c) that racial-identity status does have an impact on dyadic interactions between counselors and therapists.

In a second study, appearing in 1995, Carter utilized three of the categories in Helms's four-part relationship classification scheme--Parallel, Progressive, and Regressive--to study interactions in racially heterogeneous and racially homogeneous treatment dyads. Among the findings reported was that in parallel relationships counselors tended to give a higher assessment of the treatment process than did their client (regardless of dyad composition), while progressive relationships were characterized by considerable uneasiness on the part of the client which, nonetheless "seems to be beneficial to the counseling process" (Carter, 1995, p.180). In regressive relationships, Carter noted, clients tended to give more favorable evaluations of treatment session than did their counselors. From the results of this second study (which are far too lengthy to permit detailed analysis), Carter (1995) stated:

In summary, these three relationship types---parallel, progressive and regressive---are associated with different qualitative experiences in terms of the clients and counselor's perceptions of and affective reactions to a session. It seems that these relationship types, which are based on the combination of the counselor's and

client's highest racial identity attitude, have different counseling processes and outcomes. (p. 194)

On the whole, this study generated meaningful results in support of Helms's parallel-crossed-progressive-regressive construct of racial-identity stages in counseling dyads, including the Black therapist/White client dyad, to which we now turn our attention.

### **Studies of the Black Counselor/White Client Dyad**

As the broad contours of the study of race as a counseling variable delineated connote, the Black counselor/White client treatment dyad has received scant attention by scholars. In 1971, in an introduction to a review of the topic, Gardner stated that "Very little has been reported in the literature on the parameters and dynamics of psychotherapeutic interaction when the therapist is black and the client white" (p.82). Gardner considered this lacuna to be odd in light of the intriguing findings from studies of visible cross-race dyads featuring Black counselors. More than a decade later, Helms (1999) would again remark upon the dearth of research devoted to therapeutic interactions between Black therapists and White clients (p. 9). More than a decade thereafter, as was noted at the outset of this review, Carter (1995) observed that "the characteristics and effectiveness of Black counselor/White client dyads have received minimal attention in the therapy literature," and then added that, "in general, the literature has focused on White clients' negative reactions toward Black counselors therapeutically (p.130)

The most widely-cited early study of Black counselors working with White clients is, in fact, Curry's (1964) study, that consisted of a series of personal

observations from which Curry deduced that the Black therapists' skin color evoked symbolic clusters associated with increased fear and anxiety and an impediment to any therapeutic alliance. By contrast, in his early discussion of Black therapists, as it appeared in a 1967 issue of the *American Journal of Psychiatry*, Grier stated that "When the Therapist Is a Negro," unique problems may arise, but that a "skillful" Black therapist can frame such transference and countertransference issues in a manner that actually facilitates the therapeutic process. Grier's observations, it may be noted, were based on only three case studies.

Perhaps the most dominant strand in studies of Black therapists working with White clients that appeared in the 1960s and early 1970s revolved around the concept of the potential for this type of dyad to generate client dissonance. A number of researchers, including Curry (1964), Gardner (1971), and Griffith (1977), reported that White clients assigned to Black counselors often attempt to resolve the cognitive dissonance of being treated by a Black professional through the use of denial and rationalization, "that is, the white client may deny the color difference and thereby treat the black therapist as if such differences did not exist" (Griffith 1977, p. 37).

This approach to the study of Black counselor/White client dyads is salient in Jackson's (1973) investigation of mixed-race counseling dyads. Of the Black-therapist/White patient dyads she observed, Jackson wrote: "The initial reactions that ensue when a white patient is assigned to a black therapist range from surprise and anger to relief and increased optimism with reference to receiving help" (p. 275). Jackson explained that White clients were often surprised that a Black person had attained the level of education and training necessary to work as a professional

counselor. Jackson also noted more positive responses from White clients who had previous friendships with Blacks. She continued:

Treatment expectation corresponds closely with initial reaction. With the surprised reaction, there is an attempt to reconcile being seen for treatment by a black person. This may be negated by making the person an exceptional black. This process essentially removes the therapist's 'blackness' as it were or makes it more acceptable to be seen by someone other than a member of one's own race. (p. 275)

Jackson avoided any summary conclusions about the therapeutic efficacy of mixed-race dyads, but she did indicate that, for at least some White clients, racial bias could act as a barrier to successful treatment outcomes, noting, for instance, that when a White patient displayed anger at being assigned to Black therapist, he or she "has a harder time accepting treatment" and may well engage in overt displays of anger during therapy sessions (Jackson, 1973, p. 276).

Griffith (1977) also underscored the potential defects of the Black therapist/White patient dyad. She reiterated the dissonance hypothesis noted earlier by Jackson:

If the issue in the white-therapist-black-client relationship is one of trust, and that in the black therapist-black client relationship is one of identity, then the issue in the black therapist-white client relationship is one of status contradiction. In the eyes of the white client, the black therapist may simultaneously have low status because of his membership in the black group, and high

status because of his professional role. (p.36)

Griffith (1977) added her own reason for seeing treatment in a Black counselor/White client dyad as vulnerable to confounding racial influences, that is, the "mark of oppression."

Another potential difficulty for the black therapist-white client relationship is the white client's 'mark of oppression' perception of his [sic]-black therapist. In such cases, the client may be reluctant to discuss his relatively insignificant complaints in the light of the socioeconomic deprivations his black therapist has undoubtedly suffered. As such, he may be over solicitous toward his therapist and thereby create insurmountable obstacles in treatment. (p. 37)

In conjunction with studies based on a social- or interpersonal- influence model of counseling, results from Gardner (1971), Jackson (1973), and Griffith (1977) all stressed the potential for transference and countertransference issues arising in the Black therapist/White client dyad to complicate, retard, or undermine treatment progress. This, in turn, reinforced the notion of racial matching in counseling dyads. Studies offering similar observations about the Black counselor/White client dyad continue to be conducted, and, like their predecessors, they persisted in using visible definitions of race. Thus, for example, Pinderhughes (1989) has observed that white clients may respond to Black therapists by viewing them as supercompetent while Comas-Diaz and Jacobsen (1991) have noted that White clients may experience a sense of guilt or shame when interacting with a non-white therapist. This negative

affect stems from the client's guilt about the privileges he or she enjoys as member of a dominant racial culture.

All of these studies are inherently flawed in their approaches to race as a variable and as such, are severely limited and badly distorted in their possibilities to yield valid, reliable, and, in the end, useful results. What is required, then, is an approach to the study of the Black therapist/White client counseling dyad that combines BRID and WRID theoretical concepts and investigational instruments with an interactional framework similar to that advanced by Helms in her Black and White model (1984) as later operationalized by Carter (1995) in his study of both same-race and mixed-race treatment dyads.

### **Conclusion**

What we have seen, then, is that, while the emergence of racial-identity theory in the 1970s and its extension to whites in the 1980s has yielded a theoretical construct for studying the impact of race on intra-psychic and interpersonal dimensions of the counseling process, very few empirical investigations have followed this approach. Most studies of cross-racial treatment dyads, including the Black therapist/White client dyad, have relied upon visible definitions of race, overlooked whiteness, and sorely neglected the study of dyads in which Blacks are the treatment professionals. Yet, at the same time, the theories advanced by Cross, Helms, and Carter, among others, appear to have significance for our understanding of race as a variable in the counseling process and as a basis for the enhancement of treatment outcomes. Thus, the literature on the Black therapist/White client counseling dyad requires additional research using study designs that are governed by racial-identity development theory.

It is toward fulfilling that need that the original fieldwork described in Chapter III of this study is addressed.

## Chapter III

### METHODOLOGY

#### **Introduction**

The purpose of this chapter is to describe the methods and procedure, which were used in this research study. Topics include the research sample, the procedures, and the instruments, along with specifications of the reliability, validity, and the methods of data analysis.

#### **Sample**

The sample of this study consisted of a non-randomly selected clinical population of 108 married couples. The couples sought marital therapy at outpatient community mental-health clinics or with private psychotherapists or marital therapists in the New York metropolitan area. Four groups of 27 couples each were recruited, with the four groups representing the combination of client race and therapist race (Black clients with Black therapist, Black clients with White therapist, White clients with Black therapist, and White clients with White therapist). Assuming a moderate effect size of 0.5, the sample size of 27 clients per cell yields a statistical power of .80 for any comparison of cell means. This translates into an 80% chance of obtaining a significant mean difference.

Criteria for participation in this study were the following: (a) participants had to have been married for at least 2 years before counseling. This condition is administered to control for the honeymoon effect, which is commonly associated with first-year marriages. (b) The marriage had to be the first for both participants. (c) This experience with marital therapy had to be the first for the couple. The last two criteria were established to control for the effect that experiences in marriage and therapy may have had on a participants perceptions (Katz, 1993). (d) Both members of the marital dyad had to be from the same racial group. (e) No two marital dyads were in treatment with the same therapist.

This eligibility criterion was required to maintain independence of observations within the research sample.

### **Procedures**

Mental-health professionals at several outpatient mental-health facilities, as well as psychotherapists and marital therapists in private practices in the New York metropolitan area, were contacted by telephone or in person to solicit their help in circulating information about this study to participants who were seeking marital therapy services for the first time. Professionals who agreed to inform potential participants about the nature of this study were sent or brought a Letter of Recruitment (see Appendix A) describing the purpose of the study and the criteria for participation. They were also provided with a sample packet containing the research measures (see Appendices D, E, F, G, and H). Participants also received a Letter of Introduction (see Appendix B) and a Consent Form (see Appendix C).

The mental-health professionals who agreed to participate asked their administrative staff members or receptionists to serve as project administrators of the research at their particular sites. Any follow-up contacts by the investigator were directed to these individuals. To clarify the inclusionary criteria for subjects participating in the study and to answer questions about the study, a brief meeting between the investigator and each project administrator was arranged.

Mental-health professionals requested the project administrators to explain to clients the purpose of the study, the nature of the questionnaires to be completed by potential participants, the confidentiality of the participants' responses, and the anonymity of the participants' identities. The mental-health professionals explained to potential participants that (a) a decision to participate or not to participate in the research study would have no effect on continued treatment by the therapist and (b) if they did decide to participate, they would be

free to withdraw from participation at any point.

Procedures for distributing the research packets to potential participants were reviewed in the meetings between project administrators and the investigator. All the research materials were distributed to participants either by this investigator directly or by the project administrator. Therapists did not distribute research packets to participants directly.

This procedure was followed, so potential research participants would not feel obligated to participate because their therapists would know whether or not they had elected to participate.

On their own, participants read the Letter of Introduction (see Appendix B), and they read and signed a Consent Form (see Appendix C). The investigator requested in the Consent Form that, prior to the initial session, participants would complete three paper-and pencil questionnaires in the following order: (a) the Personal Data Form (see Appendix D); (b) the Rosenberg Self-Esteem Scale (see Appendix E) and (c) one of the two Racial Identity Attitude Scales, (either the Black or the White racial-identity Attitude Scales, depending on the respondent's race, see Appendix F).

After the first and the fourth counseling sessions, each participating client completed the Counselor Rating Form Short (CRF-S) and the Counselor Effectiveness Rating Scale (see Appendices G & H). Participants did not complete the research measures in front of the mental-health professionals who provided treatment, nor did they return the packets to these professionals. This procedure was employed to minimize the possibility that clients would rate counselors favorably because they thought that the counselors might become aware of their evaluations.

Each questionnaire included instructions on how participants should complete the measures.

Participants were informed through the Letter of Introduction and the Consent Form about how to contact the investigator with questions they might have about the study. They were also told that they could request a summary of the findings of the study from the investigator when these findings became available. Finally, the Letter of Introduction directed the participants to send the completed questionnaires immediately to the investigator. Self-addressed envelopes were provided to participants for this purpose.

### **Research Instruments**

The following instruments were employed to measure the research variables: (a) a personal data form, (b) the Rosenberg Self-Esteem Scale, (c) the Black Racial-Identity Attitude Scale (Parham & Helms, 1981), (d) the White Racial-Identity Attitude Scale (Helms & Carter, 1987), (e) the Counselor Rating-Form-Short (Barak & LaCrosse, 1975), and (f) the Counselor Effectiveness Rating Scale (Osgood, Suci, & Tannenbaum, 1957). These instruments are described in the sections that follow.

The Personal Data Form (PDF) was designed specifically for this study. The investigator employed this form to elicit information about each participant's age, sex, socioeconomic status, race/ethnicity, educational level, number of times married, length of marriage, previous experience with marital therapy, and country of origin. Responses to the PDF were used to insure that respondents met study eligibility requirements. Those married more than once, those married less than 2 years, those with prior exposure to marital therapy, and those in mixed-race marital dyads were not included in the final sample.

The PDF was submitted to three experts (research psychologists). They were asked to review the questions for clarity and ease of understanding. They were to make recommendations for change and return the questionnaire to the investigator. Based on recommendations, a revised PDF was formulated. The

revised form was resubmitted to each expert to ensure agreement and clarity of each item. This provided the information needed to establish face validity (Thorndike & Hagen, 1961).

The Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965) is a 10-item measure of global self-esteem, which employs a 5-point Likert-type response format, with response options ranging from *strongly agree* to *strongly disagree*. Rosenberg (1965) defined self-esteem as the extent to which an individual likes and approves of the self. Rosenberg (1965) and Antonucci and Jackson (1983) stated that an individual's self-esteem tends to be a relatively stable attribute, which is commonly viewed as a component of mental-health or subjective well-being.

Using the Guttman (1950) and Menzel (1953) scaling procedures, Rosenberg (1965) reported the reproducibility coefficient of this scale to be .92, and its scalability to be .72. These coefficients indicate that the RSE is a unidimensional measure of self-esteem. From Stouffer et al. (1952), one may infer that a scale whose coefficient of reproducibility is .90 or more is taken as an arbitrary minimum for satisfactorily and unidimensional reliability. Wylie (1974) reported that the reliability of the RSE was impressive, particularly for a ten-item scale

Although reliability coefficients originally reported for the RSE were based on a norming sample of 5,024 adolescents attending New York high schools (Rosenberg, 1965), subsequent research (Berry & Sipps, 1991; Garber, 1991; Goldsmith & Matherly, 1987; Hanley & Wilhelm, 1992), using adult subjects, showed the usefulness of this scale to measure self-esteem in young adult and older populations. Silber and Tippett (1965) obtained a test-retest reliability coefficient of .85 for 28 college students. Westway and Wolmarans (1992) reported a reliability coefficient of .78 in a sample of adult Black

tuberculosis patients with a low literacy rate.

With respect to the validity of the RSE, Silber and Tipett (1965) reported significant positive correlations between scores on the RSE and scores on three other measures of self-esteem (the Kelley Repertory Test, the Health Self-Image Questionnaire, and interviewer ratings of self-esteem).

To control for possible response set bias, half of the items of the RSE are positively worded, such that agreement reflects high self-esteem, and the other half are negatively worded, so that agreement reflects low self-esteem. In the study reported here, items were recoded and summed, so that higher total RSE scores represented higher self-esteem.

The Black Racial-Identity Attitude Scale (BRIAS) (Parham & Helms, 1981) was designed to convert a Q-sort measure of Black racial-identity developed by Hall, Cross, and Freedles (1972) into a transportable paper-and-pencil measure. The BRIAS was designed to measure the general themes of four of the five stages of racial identity proposed by Cross (1971): Preencounter, Encounter, Immersion/Emersion, and Internalization.

A minimum criterion for using the scale is that the subscales assess different types of attitudes consistently (Helms, 1993). To establish reliability, the current BRIAS scale was developed using a diverse sample of 250 college students. Diversity was reflected in terms of gender, age, geographic location, type of educational institution (public versus private), and the racial composition of the respondents' educational environments (predominantly White versus predominantly Black). Test-retest reliability coefficients reported by the authors for the several stage subscales of the BRIAS were generally acceptable, ranging from .51 to .80 for the four subscales (Helms & Parham, 1986).

As an indication of construct validity, Helms (1993) reported that the BRIAS items tapped four orthogonal factors, which corresponded closely to the

four stages. Moreover, scores on the racial-identity stage scores explained a significant proportion of the variability in Black students' preferences for a counselor of the same race.

The BRIAS is comprised of 50 items to which participants respond using a 5-point Likert-type response format (1 = *strongly disagree*, 5 = *strongly agree*). Scores were obtained for each subscale by summing the valid responses to items, which pertain to that subscale, and dividing by the number of items in the subscale for which valid responses were obtained. Respondents with valid responses to fewer than 90 percent of the items in the subscale were assigned missing values for the subscale score. High scores reflect an awareness or consciousness of race and racism while low scores reflect least sensitive to race and racism. In this study, scores on the Internalization subscale were taken to represent the degree to which respondents were developmentally advanced in terms of racial-identity.

The White Racial-Identity Attitude Scale\_(WRIAS) (Helms & Carter, 1986) was constructed to assess the five stages of White racial-identity attitudes in their model of White racial-identity development (i.e. Contact, Disintegration, Reintegration, Pseudo-Independence, and Autonomy). According to this model, Contact attitudes are characterized by neglectful attention to racial/cultural differences; Disintegration attitudes are represented by an awareness of race and its social implications, and an awareness of one's own identity as a White American; Reintegration attitudes involve the vilification of everything that is associated with Black culture and the exaggeration of the virtues of everything that is associated with White culture; Pseudo-Independence symbolizes intellectual involvement and growing understanding of Black culture; and Autonomy attitudes embody the emotional and intellectual acceptance of racial differences and similarities.

Based on a sample of 506 White college students, Carter (1987) reported internal reliability coefficients for the five subscales of the WRIAS as follows: Contact (.55), Disintegration (.77), Reintegration, (.80), Pseudo-Independence (.71), and Autonomy (.67).

Like the BRIAS, the WRIAS contains 50 items, which have a 5-point Likert-type response format. On the WRIAS, each of the five subscales is comprised of 10 items. Scores for each subscale were obtained by summing the valid responses on the items comprising the subscale, then dividing by the number of valid responses. Subjects with fewer than nine valid responses for any subscale were assigned a missing value for the subscale score. In this study, scores on the Autonomy subscale were taken as indicating the extent to which a respondent was characterized by developmentally advanced racial-identity attitudes.

The Counselor Rating Form-Short (CRF-S) is an abbreviated version of the original Counselor Rating Form (CRF; Barak & LaCrosse, 1975). The original CRF had 36 items and was designed to measure the extent to which the client perceived the counselor as characterized by the three social influence dimensions of attractiveness, expertness, and trustworthiness (Morran, Kurpius, Barak, & Rozecki, 1994). The CRF was validated on a norming sample of 202 undergraduate psychology students, who used the scale to rate the counseling behavior of three well-known psychologists after viewing their work in a film. Factor analysis of ratings confirmed the three-factor structure of the instrument for each of the three therapists rated. LaCrosse (1980) provided evidence of the predictive validity of the CRF by demonstrating significant correlations between client ratings of counselors following an initial counseling session and subsequent client ratings of goal attainment over the course of counseling. Barak and Dell (1977) reported that client ratings of counselors on all three dimensions of the CRF were correlated significantly with client willingness to make referrals to the

counselor.

The CRF-S contains 12 items. Four of the items are drawn from each of the three areas assessed in the original CRF. Ponterotto and Furlong (1985) reviewed the available research on the psychometric characteristics of the CRF-S and concluded that the scale is reliable and has good construct validity.

The Counselor Effectiveness Rating Scale (CERS) (Atkinson & Carskaddon, 1975) is a 10-item scale employing a 7-point semantic differential type response format. Like the CRS, the CERS yields scores reflecting a client's perception of the therapist as attractive, expert, and trustworthy. The CERS was validated on a sample of 206 undergraduate students. The CERS was found to have acceptable reliability and to be correlated strongly with scores on the CRF.

#### **Data Analysis**

All the data were entered into the SPSS-PC (version 11.0) statistical-analysis system. Scale scores were obtained for each of the subscales of the BRIAS and WRIAS by averaging valid responses to the items comprising each subscale. Descriptive statistics were obtained to facilitate mean comparisons of subscales. This allowed the investigator to make judgments regarding the predominant stage of racial-identity awareness between both the Black and White client samples.

Individuals representing each developmental stage of racial-identity were formed for both Black and White respondents. High and low, self-esteem groups were formed for all respondents by a median split on the Rosenberg Self-Esteem Scale.

The first four research hypotheses were tested by means of multivariate analyses of variance (MANOVA's). One MANOVA was carried out for ratings made following session 1 and for ratings made following session 4 for each of the following subject groups: White (male and female) clients and Black (male and

female) clients. In each MANOVA, the independent variables were racial-identity group, self-esteem (relatively low vs. relatively high), client race, and race of therapist. The six dependent variables in each analysis were the CRS-S subscale scores and the CERS subscale scores for therapist attractiveness, expertise, and trustworthiness.

The fifth research hypothesis, pertaining to expected differences in ratings of therapists due to the gender of the client, was tested by means of discriminant analysis comparing the males and females on session 1 and session 4 ratings on the CRS and CERS subscales assessing attractiveness, expertise and trustworthiness.

## Chapter IV

### RESULTS

#### Introduction

The study reported here was designed to examine the effect of racial-identity on the perceptions of Black and White marital-therapy clients of the attractiveness, expertise, and trustworthiness of their therapists. It was expected that clients with relatively more advanced racial-identity attitudes would express more favorable attitudes toward their therapists.

The study was also designed to examine the effects of client self-esteem and therapist race, as well as the interactive effect of racial-identity and self-esteem. It was expected that with respect to clients' initial reactions to their therapists, both Black and White clients would manifest a significant interaction between racial-identity development and self-esteem. It was anticipated further that White clients who are relatively less advanced in terms of racial-identity and relatively low in self-esteem would initially perceive Black therapists as less attractive, expert, and trustworthy than White therapists. Similarly, it was expected that Black clients who are relatively less advanced in terms of racial-identity and relatively low in self-esteem would initially perceive White therapists as less attractive, expert, and trustworthy than Black therapists.

It was anticipated further that by the fourth counseling session, Black and White clients who are less advanced in terms of racial-identity and low in self-esteem would no longer manifest significant differences in their perceptions of Black and White therapists.

It was further hypothesized that following the first counseling session, female respondents would generally perceive their therapists in more favorable terms than male respondents. By the conclusion of session four, it was anticipated that this effect attributable to gender would no longer be significant.

In this chapter the results of the study will be reported. The first section of the chapter contains the demographic variables. The second section concerns the mean ratings for the first and fourth sessions of the CRF and the CERS. It also includes the scoring of the Black-Racial-Identity Attitude Scale (BRIAS) and the White-Racial-Identity Attitude Scale (WRIAS) including the classification of clients into racial-identity groups, and the differences in therapist evaluations among clients in the different racial-identity groups.

The third section records analyses of the five principal research hypotheses. Based on the initial findings obtained with respect to racial-identity groups, Black and White respondents were subsequently classified into groups representing relatively less and relatively more advanced racial-identity. The final section of the chapter contains additional analyses including tests for the significance of session one to session four client ratings of therapists.

### **Demographic Variables**

One hundred and eight married couples participated in this study, which included 54 White couples (50%) and 54 Black couples (50%). The participants' ages ranged from 24 years to 45 years. For females, the mean age was 34.57 years with a standard deviation of 5.7 years. For males, the mean age was 33.65 years with a standard deviation of 5.4 years. These data are presented in a

frequency distribution in Table 1. Table 2 displays the mean ratings and standard deviations for the first and fourth sessions of the CRF and the CERS.

### **Black-and White-Racial-Identity Attitude Scales**

The BRIAS and WRIAS are distinct instruments that assess differing aspects of racial-identity. Accordingly, the scores of Black clients on the BRIAS are calculated separately from the scores of White clients on the WRIAS, and the scores of Black clients on the BRIAS are not comparable to the scores of White clients on the WRIAS. The BRIAS yields scores on five dimensions of racial-identity: Preencounter, Encounter, Immersion, Emersion, and Internalization. The scales have differing numbers of items, and scale scores are calculated for each scale by summing the items and dividing the sum by the number of items in the scale. This preserves the scale metric, guaranteeing that scores on all the scales have a theoretical range of 1 to 5, reflecting the 5-point Likert type response format.

Similarly, the WRIAS yields scores on five dimensions of racial-identity: Contact, Disintegration, Reintegration, Pseudo-Independence, and Autonomy. Calculations for the WRIAS are computed likewise.

Although Helms and Carter (1992) recommend against using the BRIAS or WRIAS to assign individuals to a single racial-identity category, they note that some researchers do so. This is typically done by placing each respondent in the category corresponding to the racial-identity attitude scale on which he or she had the highest score. A preliminary analysis was carried out to assess the viability of this approach to the use of the racial-identity attitude scales in the present study. Table 3 presents frequency distributions of racial-identity categories for Black and White females and males. Among Black females and males, the great majority of respondents had their highest BRIAS score on either the Emersion or

Table 1

*Frequency Distribution of Participants' Ages*

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<u>Age</u>	<u><i>n</i></u>	<u>%</u>
24	10	4.6
25	6	2.7
26	12	5.6
27	6	2.8
28	8	3.7
29	10	4.6
30	8	3.7
31	10	4.6
32	6	2.8
33	12	5.6
34	14	6.5
35	18	8.3
36	14	6.5
37	20	9.3
38	14	6.5
39	16	7.4
40	10	4.6
41	10	4.6
42	2	0.9

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Table 1 (continued)

Age	<i>n</i>	%
43	4	1.9
45	6	2.8
Total	216	100.0

Table 2

*Descriptive Statistics on CRF-S and CERS (first and fourth sessions)*

Group	Scale	<i>n</i>	mean	SD
Session 1				
CRF-S	attractiveness	216	18.77	4.21
	expertise	216	20.08	4.67
	trustworthy	216	19.29	4.41
CERS	attractiveness	216	14.07	3.26
	expertise	216	14.65	3.70
	trustworthy	216	14.66	3.34
Session 4				
CRF-S	attractiveness	216	21.75	4.40
	expertise	216	22.91	4.16
	trustworthy	216	22.30	4.29
CERS	attractiveness	216	16.46	3.15
	expertise	216	16.80	3.61
	trustworthy	216	16.88	3.00

Table 3

*Frequency Distributions on BRIAS and WRIAS Racial Identity Categories*

Race	Racial Identity Category	<i>n</i>	%
Black	Preencounter	2	1.9
	Encounter	7	6.5
	Immersion	1	0.9
	Emersion	69	63.9
	Internalization	29	26.9
White	Contact	8	7.4
	Disintegration	2	1.9
	Reintegration	1	0.9
	Pseudo Independence	48	44.4
	Autonomy	49	45.4

the Internalization Scale, with the modal racial-identity category being Emersion for both females and males. Among White females and males, the great majority of respondents had their highest WRIAS score on either the Pseudo Independence or the Autonomy Scale, with the modal racial-identity category being Autonomy for both females and males.

### **Hypotheses Testing**

The research hypotheses implied a relationship between racial-identity development and clients' perceptions of their therapists. All scales of the BRIAS were selected for use in differentiating distinct stages of racial-identity among the Black clients. All scales of the WRIAS were selected to differentiate distinct stages of racial-identity among the White clients. All subscales of the BRIAS and WRIAS were used as the research suggested that the scales may interact with each other in significant ways.

All respondents completed the Rosenberg Self-Esteem (RSE) Scale. The median RSE scale score happened to be 29 among both female clients and male clients. Scores up to 29 were classified as low self-esteem, and scores of 30 or greater were considered to represent relatively high self-esteem.

#### **Hypothesis 1.0**

The first research hypothesis stated that following the initial counseling session, White clients (male and female) who are racially less developmentally advanced and have low self-esteem would perceive Black therapists as less credible and White therapists as more credible. This hypothesis implies significant multivariate analyses of variance (MANOVA) between racial-identity development, self-esteem, and race of the therapist and client. It further implies significant interactions for one or more of the CRF-S or CERS subscales at session one.

A series of MANOVA's were run to identify any differences in therapist and client race, racial-identity, and self-esteem that might be attributable to therapist

ratings. In each analysis, the independent variable was therapist and client race, self-esteem, and racial-identity; the dependent variables were the ratings assigned to therapists on the CRF-S and the CERS. Table 4 presents the results of the multivariate tests in the MANOVA used to test these hypotheses among the White (male and female) client sample. The data in Table 4 indicate that there was a significant multivariate interaction for self-esteem and therapist race ( $F = 2.23$ ,  $df = 6$  and  $89$ ,  $p = .047$ ). Therefore, White females and males show significant differences based on the race of the therapist. The results presented in Table 5 indicated significance on the CRF-S for attractiveness ( $F = 4.28$ ,  $df = 1$  and  $94$ ,  $p = .041$ ) and the CERS for trustworthiness ( $F = 5.91$ ,  $df = 1$  and  $94$ ,  $p = .017$ ) and attractiveness ( $F = 4.58$ ,  $df = 1$  and  $94$ ,  $p = .035$ ). Thus, following the first counseling session, White clients perceived a difference in ratings assigned to Black and white therapists. The means in Table 6 indicate that White clients who rated high on self-esteem, tended to rate White therapists higher than Black therapists. The mean CRF-S attractiveness rating assigned to White therapists was 20.58 ( $SD = 1.36$ ), and that assigned to Black therapists was 17.35 ( $SD = 1.47$ ). The means in Table 7 represent the CERS trustworthiness rating assigned to White therapists was 14.64 ( $SD = 1.18$ ), and that assigned to Black therapists was 13.72 ( $SD = 1.16$ ). Finally, Table 8 indicates that the mean CERS attractiveness rating assigned to White therapists was 13.54 ( $SD = 1.2$ ), and that assigned to Black therapists was 13.02 ( $SD = 1.07$ ).

### **Hypothesis 2.0**

It was hypothesized that following the initial counseling session, Black clients (male and female) who are less racially developmentally advanced and have low self-esteem will perceive White therapists as less credible and Black therapists as more credible.

As in the case of the White clients, this hypothesis was tested by MANOVA for a Black (male and female) client sample. The results of the

Table 4

Multivariate Analysis of Variance of Racial-Identity and Self-Esteem Ratings for Therapist Attractiveness, Expertise, and Trustworthiness Following the Initial Session (White client sample,  $n = 108$ )

Effect	Wilks' Lambda	$F$ (6, 89)	$p$
Racial Identity Group (A)	.820	.762	.783
Self-Esteem Group (B)	.962	.593	.735
Therapist Race (C)	.953	.726	.630
A x B	.956	.340	.981
A x C	.799	1.15	.301
B x C	.869	2.23	.047*
A x B x C	.886	1.91	.087

\* $p < .05$ .

Table 5

Multivariate Analysis of Variance of CRF-S and CERS Ratings for Therapist  
 Attractiveness, Expertise, and Trustworthiness Following the Initial Session

(White client sample,  $n = 108$ )

Source of Variance	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
CRF-S					
Attractiveness	83.469	1, 94	83.469	4.28*	.041
Expertness	10.679	1, 94	10.679	0.490	.486
Trust	1.979	1, 94	1.979	0.111	.740
CERS					
Attractiveness	57.921	1, 94	57.921	4.581*	.035
Expertness	36.222	1, 94	36.222	2.721	.102
Trust	72.533	1, 94	72.533	5.913**	.017

\*  $p < .05$ . \*\*  $p < .01$ .

Table 6

Mean Differences of CRF-S Attractiveness Rating Following Initial Session Broken Down by Self-Esteem Ranking and Therapist Race (White client sample,  $n = 108$ )

Self-Esteem	Black			White		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Low	17	19.18 <sub>a</sub>	1.23	19	16.61 <sub>b</sub>	1.18
High	37	17.35 <sub>c</sub>	1.47	35	20.58 <sub>d</sub>	1.36

*Note.* Means in a row with different subscripts differ significantly at  $p < .05$ . For the CRF-S measure for attractiveness, higher means indicate higher ratings of White therapists.

Table 7

Mean Differences of CERS Trustworthiness Rating Following Initial Session Broken Down by Self-Esteem Ranking and Therapist Race (White client sample,  $n = 108$ )

Self-Esteem	Black			White		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Low	17	16.13 <sub>a</sub>	.997	19	13.45 <sub>b</sub>	.783
High	37	13.72 <sub>c</sub>	1.16	35	14.64 <sub>d</sub>	1.18

*Note.* Means in a row with different subscripts differ significantly at  $p < .01$ . For the CERS measure for trustworthiness, higher means indicate higher ratings of White therapists.

Table 8

Mean Differences of CERS Attractiveness Rating Following Initial Session Broken Down by Self-Esteem Ranking and Therapist Race (White client sample,  $n = 108$ )

Self-Esteem	<i>n</i>	Black		White		
		<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Low	17	15.74 <sub>a</sub>	1.12	19	13.12 <sub>b</sub>	.880
High	37	13.02 <sub>c</sub>	1.07	35	13.54 <sub>d</sub>	1.20

*Note.* Means in a row with different subscripts differ significantly at  $p < .05$ . For the CERS measure for attractiveness, higher means indicate higher ratings of white therapists.

MANOVA of Black clients' ratings of their therapists after session 1 are presented in Table 9. The tests presented in Table 9 indicated a significant main effect for racial identity ( $F = 1.93$ ,  $df = 6$  and  $95$ ,  $p = .006$ ). The data in table 9 also indicated significant multivariate interactions for racial-identity and self-esteem ( $F = 1.93$ ,  $df = 6$  and  $95$ ,  $p = .033$ ), and therapist race and racial-identity ( $F = 2.65$ ,  $df = 6$  and  $95$ ,  $p = .003$ ). There was also a significant multivariate interaction for racial-identity, self-esteem and therapist race ( $F = 2.18$ ,  $df = 6$  and  $95$ ,  $p = .051$ ). These findings support the second research hypothesis. Thus, Black clients show a significant difference based on racial-identity, self-esteem and the race of the therapist. The results presented in table 10 indicates significance on the CRF-S for trustworthiness ( $F = 4.12$ ,  $df = 6$  and  $95$ ,  $p = .004$ ) and the CERS for expertness ( $F = 2.37$ ,  $df = 6$  and  $95$ ,  $p = .058$ ), trustworthiness ( $F = 3.08$ ,  $df = 6$  and  $95$ ,  $p = .02$ ) and attractiveness ( $F = 2.80$ ,  $df = 6$  and  $95$ ,  $p = .03$ ). Following the first session, these results are indicative of Black clients perceiving a difference in ratings assigned to Black and White therapists. The means in table 11 and 12 indicated that Black clients who rated high on racial-identity, tended to rate Black therapists higher than White therapists. Table 11 indicates the mean CRF trustworthiness rating assigned to Black therapists was 18.73 ( $SD = 4.65$ ) and 20.20 ( $SD = 6.10$ ) and that assigned to White therapists was 17.84 ( $SD = 3.98$ ) and 19.05 ( $SD = 2.87$ ). The means in Table 12 signify the CERS trustworthiness rating assigned to Black therapists was 15.05 ( $SD = 3.56$ ), and that assigned to White therapists was 14.21 ( $SD = 3.13$ ). Table 12 illustrates that the mean CERS attractiveness rating assigned to Black therapists was 14.57 ( $SD = 3.57$ ), and that assigned to White therapists was 13.28 ( $SD = 2.26$ ). Table 12 indicates that the mean CERS expertness rating assigned to Black therapists was 14.78 ( $SD = 3.39$ ), and that assigned to White therapists was 14.87 ( $SD = 3.70$ ). Table 12 also indicates that the mean CERS trustworthiness rating assigned to Black therapists was 15.05 ( $SD = 3.56$ ), and that assigned to Whites was 14.21 ( $SD = 3.13$ ). The means in Table

Table 9

Multivariate Analysis of Variance of Racial-Identity and Self-Esteem Ratings for Therapist Attractiveness, Expertise, and Trustworthiness Following the Initial Session (Black client sample,  $n = 108$ )

Effect	Wilks' Lambda	<i>F</i> (6, 95)	<i>p</i>
Racial Identity Group (A)	.620	1.92**	.006
Self-Esteem Group (B)	.934	1.06	.391
Therapist Race (C)	.938	.986	.440
A x B	.785	1.93*	.033
A x C	.722	2.65**	.003
B x C	.901	1.65	.142
A x B x C	.873	2.18*	.051

\*  $p < .05$ . \*\*  $p < .01$

Table 10

Multivariate Analysis of Variance of CRF-S and CERS Ratings for Therapist  
 Attractiveness, Expertise, and Trustworthiness Following the Initial Session  
 (Black client sample,  $n = 108$ )

Source of Variance	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
<b>CRF-S</b>					
Attractiveness	94.009	4, 95	23.502	1.66	.165
Expertness	172.766	4, 95	43.192	2.12	.084
Trust	296.046	4, 95	74.151	4.12**	.004
<b>CERS</b>					
Attractiveness	91.366	4, 95	22.842	2.80*	.030
Expertness	128.899	4, 95	32.225	2.37*	.058
Trust	120.509	4, 95	30.127	3.08*	.020

\*  $p < .05$ . \*\*  $p < .01$ .

Table 11

Mean Differences of CRF-S Trustworthiness Rating Following Initial Session Broken Down by Racial-Identity and Therapist Race (Black client sample,  $n = 108$ )

Racial-Identity	Black			White		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Preencounter	2	28.50	.707	0	----	----
Encounter	5	20.20 <sub>a</sub>	1.64	2	23.50 <sub>b</sub>	2.12
Immersion	0	----	----	1	11.00	----
Emersion	37	18.73 <sub>c</sub>	4.65	32	17.84 <sub>d</sub>	3.98
Internalization	10	20.20 <sub>e</sub>	6.10	19	19.05 <sub>f</sub>	2.87

*Note.* Means in a row with different subscripts differ significantly at  $p < .01$ . For the CRF-S measure for trustworthiness, higher means indicate higher ratings of Black therapists.

Table 12

Mean Differences of CERS Trustworthiness, Attractiveness, and Expertness Ratings Following Initial Session Broken Down by Racial-Identity and Therapist Race (Black client sample,  $n = 108$ )

Racial-Identity	Black			White		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Preencounter	2	10.00	.000	0	----	----
	2	12.00	.000	0	----	----
	2	6.50	.707	0	----	----
Encounter	5	14.60	2.88	2	15.50	.707
	5	12.80	4.15	2	17.00	2.82
	5	15.20	3.70	2	15.00	1.41
Immersion	0	----	----	1	8.00	----
	0	----	----	1	10.00	----
	0	----	----	1	13.00	----
Emersion	37	15.05 <sub>a</sub>	3.56	32	14.21 <sub>b</sub>	3.13
	37	14.57 <sub>c</sub>	3.57	32	13.28 <sub>d</sub>	2.26
	37	14.78	3.39	32	14.87	3.70
Internalization	10	16.40 <sub>e</sub>	3.09	19	14.37 <sub>f</sub>	2.03
	10	16.50 <sub>g</sub>	2.91	19	14.42 <sub>h</sub>	2.09
	10	15.30	5.25	19	15.63	3.15

*Note.* Means in a row sharing subscripts are significantly different. For the CERS measure for trust and attractiveness, higher means indicate higher ratings of Black therapists.

13 and 14 indicate that Black clients who rated high on racial-identity and self-esteem, tended to rate Black therapists higher than White therapists. The means for CRF trustworthiness rating (see Table 13) assigned to Black therapists was 18.73 ( $SD = 4.65$ ), and that assigned to White therapists was 17.84 ( $SD = 3.98$ ). The means in Table 14 show the CERS trustworthiness rating assigned to Black therapists was 15.05 ( $SD = 3.56$ ), and 16.40 ( $SD = 3.90$ ) and that assigned to White therapists was 14.22 ( $SD = 3.13$ ) and 14.38 ( $SD = 2.03$ ). Table 14 further shows that the mean CERS attractiveness rating assigned to Black therapists was 14.57 ( $SD = 3.57$ ) and 16.50 ( $SD = 2.91$ ), and that assigned to White therapists was 13.28 ( $SD = 2.26$ ) and 14.42 ( $SD = 2.09$ ). Table 14 also shows that the mean CERS expertness rating assigned to Black therapists was 15.00 ( $SD = 3.40$ ) and 15.30 ( $SD = 5.25$ ) and that assigned to White therapists was 14.87 ( $SD = 3.70$ ) and 15.63 ( $SD = 3.15$ ).

### **Hypotheses 3.0**

Hypothesis 3 stated that following the fourth counseling session, White clients (male and female) would not perceive Black and White therapists differently.

Multivariate analyses of variances (MANOVAs) were run to identify any differences attributable to therapist race that might exist after the fourth counseling session. In each analysis, the independent variable was therapist race, the dependent variables were the ratings assigned on the CRF-S and the CERS. The results of the MANOVA of white clients' ratings of their therapists after session 4 are presented in Table 15. The results indicated significance on the CRF for attractiveness ( $F = 7.78$ ,  $df = 1$  and 101,  $p = .006$ ), expertness ( $F = 12.83$ ,  $df = 1$  and 101,  $p = .001$ ), and trustworthiness ( $F = 3.80$ ,  $df = 1$  and 101,  $p = .054$ ) and on the CERS for attractiveness ( $F = 5.63$ ,  $df = 1$  and 101,  $p = .019$ ) and expertness ( $F = 5.18$ ,  $df = 1$  and 101,  $p = .025$ ). The means for attractiveness, expertness, and

Table 13

Mean Differences of CRF Trustworthiness Rating Following Initial Session Broken Down by Self-Esteem, Racial-Identity and Therapist Race (Black client sample,  $n = 108$ )

Self-Esteem	Racial-Identity	Black			White		
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
low							
	Preencounter	2	8.50	.707	0	----	----
	Encounter	5	20.20	1.64	2	23.50	2.12
	Immersion	0	----	----	1	11.00	----
high							
	Emersion	37	18.73 <sub>a</sub>	4.65	32	17.84 <sub>b</sub>	3.98
	Internalization	10	20.20 <sub>c</sub>	6.10	19	19.05 <sub>d</sub>	2.87

*Note.* Means in a row sharing subscripts are significantly different. For the CRF measure for trustworthiness, higher means indicate higher ratings of Black therapists.

Table 14

Mean Differences of CERS Trustworthiness, Attractiveness, and Expertness Rating  
Following Initial Session Broken Down by Self-Esteem, Racial-Identity and  
Therapist Race (Black client sample,  $n = 108$ )

		Black			White		
Self-Esteem	Racial-Identity	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
low	Preencounter	2	10.0	.000	0	----	----
		2	12.00	.000	0	----	----
		2	6.50	.707	0	----	----
	Encounter	5	14.60	2.88	2	15.50	.707
		5	12.80	4.15	2	17.00	2.83
		5	15.20	3.70	2	15.00	1.41
	Immersion	0	----	----	1	8.00	----
		0	----	----	1	10.00	----
		0	----	----	1	13.00	3.61
high	Emersion	37	15.05 <sub>a</sub>	3.56	32	14.22 <sub>b</sub>	3.13
		37	14.57 <sub>c</sub>	3.57	32	13.28 <sub>d</sub>	2.26
		37	15.00 <sub>e</sub>	3.40	32	14.87 <sub>f</sub>	3.70
	Internalization	10	16.40 <sub>g</sub>	3.90	19	14.38 <sub>h</sub>	2.03
		10	16.50 <sub>i</sub>	2.91	19	14.42 <sub>j</sub>	2.09
		10	15.30	5.25	19	15.63	3.15

*Note.* Means in a row sharing subscripts are significantly different. For the CERS measure for trustworthiness and attractiveness, higher means indicate higher ratings of Black therapists.

Table 15

Multivariate Analysis of Variance of CRF-S and CERS Ratings for Therapist Attractiveness, Expertise, and Trustworthiness Following the Fourth Session (White client sample,  $n = 108$ )

Source of Variance	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
CRF-S					
Attractiveness	170.837	1, 101	170.837	7.781**	.006
Expertness	233.677	1, 101	233.677	12.837***	.001
Trust	75.689	1, 101	75.689	3.806*	.054
CERS					
Attractiveness	66.154	1, 101	66.154	5.636*	.019
Expertness	83.009	1, 101	83.009	5.185*	.025
Trust	24.376	1, 101	24.376	2.137	.147

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$

Table 16

Mean Differences of CRF-S Attractiveness, Expertness, and Trustworthiness Ratings Following Initial Session Broken Down by Racial-Identity and Therapist Race (White client sample,  $n = 108$ )

Racial-Identity	<i>n</i>	Black		<i>n</i>	White	
		<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>
Contact	4	24.50	4.51	4	23.00	1.40
	4	24.25	2.98	4	23.25	3.77
	4	23.00	4.96	4	23.25	3.30
Disintegration	1	26.00	----	1	24.00	----
	1	25.00	----	1	27.00	----
	1	26.00	----	1	26.00	----
Reintegration	1	19.00	----	0	----	----
	1	18.00	----	0	----	----
	1	18.00	----	0	----	----
Pseudo-Independence	19	21.79	5.34	29	22.52	4.70
	19	24.63	3.25	29	23.14	4.47
	19	22.47	4.95	29	23.03	4.25
Autonomy	29	21.03 <sub>a</sub>	4.77	20	20.00 <sub>b</sub>	4.80
	29	22.31 <sub>c</sub>	4.26	20	20.50 <sub>d</sub>	5.40
	29	22.14 <sub>e</sub>	4.26	20	20.90 <sub>f</sub>	4.93

*Note.* Means in a row sharing subscripts are significantly different. For the CRF measure for attractiveness, expertness and trustworthiness, higher means indicate higher ratings of Black therapists.

trustworthiness on the CRF-S rating assigned to Black therapists (see Table 16) was 21.03 ( $SD = 4.77$ ); 22.31 ( $SD = 4.26$ ), and 22.14 ( $SD = 4.26$ ) and that assigned to White therapists was 20.00 ( $SD = 4.80$ ); 20.50 ( $SD = 5.40$ ), and 20.90 ( $SD = 4.93$ ). The means for attractiveness and expertness (see Table 17) on the CERS rating assigned to Black therapists was 16.79 ( $SD = 3.41$ ) and 16.03 ( $SD = 4.58$ ) and that assigned to White therapists was 13.85 ( $SD = 3.63$ ); 14.05 ( $SD = 4.17$ ). The CRF-S and CERS means in Tables 16 and 17 show that White clients who rated high on racial-identity, tended to rate Black therapists higher than White therapists. Thus, following the fourth counseling session, White male and female clients perceived a difference in ratings assigned to Black and White therapists.

#### **Hypothesis 4.0**

Hypothesis 4 stated that following the fourth counseling session Black clients (male and female) would not perceive Black and White therapists differently.

Multivariate analyses of variances (MANOVAs) were also run to identify any differences attributable to therapist race that might exist after the fourth counseling session. In each analysis, the independent variable was therapist race, the dependent variables were the ratings assigned on the CRF and the CERS.

The data presented in Table 18 for the Black clients' ratings after session 4 indicate significance on the CRF for attractiveness ( $F = 2.948$ ,  $df = 4$  and 100,  $p = .024$ ), and expertness ( $F = 3.23$ ,  $df = 4$  and 100,  $p = .015$ ). Significance was also attained on the CERS variables for attractiveness ( $F = 2.65$ ,  $df = 4$  and 100,  $p = .037$ ), expertness ( $F = 3.17$ ,  $df = 4$  and 100,  $p = .017$ ), and trustworthiness ( $F = 2.42$ ,  $df = 4$  and 100,  $p = .053$ ). The means for attractiveness and expertness on the CRF-S rating

assigned to Black therapists (see Table 19) was 22.84 ( $SD = 3.68$ ); 23.16 ( $SD = 4.28$ ); 23.20 ( $SD = 2.10$ ) and 25.20 ( $SD = 2.44$ ) and that assigned to White therapists was 20.72 ( $SD = 3.97$ ); 22.15 ( $SD = 3.90$ ); 22.90 ( $SD = 3.93$ ), and 24.37 ( $SD = 2.65$ ).

Table 20 shows that the means for attractiveness, expertness, and trustworthiness on the CERS rating assigned to Black therapists was 17.80 ( $SD = 1.23$ ); 19.00 ( $SD = 1.94$ ), and 18.80 ( $SD = 1.23$ ) and that assigned to White therapists was 17.16 ( $SD = 2.90$ ); 17.90 ( $SD = 2.68$ ), and 17.52 ( $SD = 2.48$ ). The CRF-S and CERS means in Tables 19 and 20 show that Black clients who rated high on racial-identity, tended to rate Black therapists higher than White therapists. Thus, following the fourth counseling session, Black male and female clients perceived Black and White therapists differently.

### **Hypothesis 5.0**

The fifth hypothesis stated that female clients in general would perceive their therapists in more favorable terms than male clients. This hypothesis was tested by means of discriminant analyses. Discriminant analyses were run for both respondent groups (females and males) comparing respondents in the different gender categories on the CRF-S and CERS ratings they assigned to their therapists after both the first session and the fourth session. The results of these analyses are represented in Tables 21 and 22. The data presented in Table 21 for female clients' ratings after session 1 indicate significance on the CRF for trustworthiness ( $F = 2.924$ ,  $df = 1$  and 100,  $p = .043$ ). Table 22 presents significant data on the CRF for male clients' ratings after session 4 for expertise ( $F = 3.081$ ,  $df = 1$  and 100,  $p = .036$ ). However, the overall  $F$  was not significant. Therefore, it is not valid to look at .03 and .04 because of overlapping variance. Thus, the respondents' gender does not appear to be related to their assessments of their therapists, either after the initial session or

Table 17

Mean Differences of CERS Attractiveness and Expertness Ratings Following the Fourth Session Broken Down by Racial-Identity and Therapist Race (White client sample,  $n = 108$ )

Racial-Identity	Black			White		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Contact	4	16.25	3.77	4	16.25	1.89
	4	15.75	3.86	4	17.25	1.70
Disintegration	1	18.00	----	1	18.00	----
	1	14.00	----	1	17.00	----
Reintegration	1	15.00	----	0	----	----
	1	13.00	----	0	----	----
Pseudo-Independence	19	16.05	3.79	29	16.76	3.06
	19	16.58	4.21	29	17.10	3.18
Autonomy	29	16.79 <sub>a</sub>	3.41	20	13.85 <sub>b</sub>	3.63
	29	16.03 <sub>c</sub>	4.58	20	14.05 <sub>d</sub>	4.17

*Note.* Means in a row sharing subscripts are significantly different. For the CERS measure for attractiveness and expertness, higher means indicate higher ratings of Black therapists.

Table 18

Multivariate Analysis of Variance of CRF-S and CERS Ratings for Therapist Attractiveness, Expertise, and Trustworthiness Following the Fourth Session  
(Black client sample,  $n = 108$ )

Source of Variance	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
<b>CRF-S</b>					
Attractiveness	173.0473	4, 100	43.37	2.94*	.024
Expertness	179.456	4, 100	44.86	3.23*	.015
Trust	121.293	4, 100	30.32	1.85	.126
<b>CERS</b>					
Attractiveness	77.071	4, 100	19.27	2.65*	.037
Expertness	104.988	4, 100	26.25	3.17*	.017
Trust	62.263	4, 100	15.57	2.42*	.030

\*  $p < .05$ .

Table 19

Mean Differences of CRF-S Attractiveness and Expertness Rating Following the Fourth Session Broken Down by Racial-Identity and Therapist Race (Black client sample,  $n = 108$ )

Racial-Identity	<i>n</i>	Black		White		
		<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Preencounter	2	18.50	2.12	0	----	----
	2	19.50	2.12	0	----	----
Encounter	5	20.20	6.61	2	18.50	2.12
	5	23.40	4.04	2	19.50	2.12
Immersion	0	----	----	1	13.00	----
	0	----	----	1	16.00	----
Emersion	37	22.84 <sub>a</sub>	3.68	32	20.72 <sub>b</sub>	3.97
	37	23.16 <sub>c</sub>	4.28	32	22.15 <sub>d</sub>	3.90
Internalization	10	23.20 <sub>e</sub>	2.10	19	22.90 <sub>f</sub>	3.93
	10	25.20 <sub>g</sub>	2.44	19	24.37 <sub>h</sub>	2.65

*Note.* Means in a row sharing subscripts are significantly different. For the CRF measure for attractiveness and expertness, higher means indicate higher ratings of Black therapists.

Table 20

Mean Differences of CERS Attractiveness, Expertness, and Trustworthiness, Ratings Following the Fourth Session Broken Down by Racial-Identity and Therapist Race (Black client sample,  $n = 108$ )

	<i>n</i>	<u>Black</u>		<u>White</u>		
		<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Racial-Identity						
Preencounter	2	12.00	.000	0	----	----
	2	12.00	.000	0	----	----
	2	13.50	.707	0	----	----
Encounter	5	17.40	3.05	2	20.00	.000
	5	19.40	1.52	2	17.50	.707
	5	18.40	3.13	2	18.50	.707
Immersion	0	----	----	1	17.00	.000
	0	----	----	1	20.00	.000
	0	----	----	1	18.00	2.53
Emersion	37	17.06	2.65	32	16.50	3.21
	37	16.73	2.30	32	17.78	2.92
	37	16.97	2.86	32	17.15	2.44
Internalization	10	17.80 <sub>a</sub>	1.23	19	17.16 <sub>b</sub>	2.90
	10	19.00 <sub>c</sub>	1.94	19	17.90 <sub>d</sub>	2.68
	10	18.80 <sub>e</sub>	1.23	19	17.52 <sub>f</sub>	2.48

*Note.* Means in a row sharing subscripts are significantly different. For the CERS measure for attractiveness, expertness and trustworthiness, higher means indicate higher ratings of Black therapists.

Table 21

Discriminant Analyses Comparing Clients' Ratings of Their Therapist by Gender  
on CRF-S and CERS Ratings of Their Therapist after Session 1 and 4 (females)

Group	Variable	Wilks Lambda	<i>F</i> (1,100)	<i>p</i>
		Session 1		
females ( <i>N</i> =108)	CRF-S			
	attractiveness	.899	1.875	.146
	expertise	.896	1.939	.135
	trustworthy	.851	2.924	.043
	CERS			
	attractiveness	.977	0.401	.753
expertise	.881	2.252	.094	
trustworthy	.903	1.795	.160	
		Session 4		
females ( <i>N</i> =108)	CRF-S			
	attractiveness	.973	0.467	.707
	expertise	.916	1.527	.219
	trustworthy	.980	0.344	.794
	CERS			
	attractiveness	.929	1.274	.293
expertise	.927	1.306	.283	
trustworthy	.958	0.723	.543	

Table 22

Discriminant Analyses Comparing Clients' Ratings of Their Therapist by Gender on CRF-S and CERS Ratings of Their Therapist after Session 1 and 4 (males)

Group	Variable	Wilks Lambda	<i>F</i> (1,100)	<i>p</i>
Session 1				
males ( <i>N</i> =108)	CRF-S			
	attractiveness	.937	1.120	.350
	expertise	.844	3.081	.036
	trustworthy	.951	0.865	.466
	CERS			
	attractiveness	.905	1.745	.170
	expertise	.947	0.930	.433
	trustworthy	.932	1.219	.312
Session 4				
males ( <i>N</i> =108)	CRF-S			
	attractiveness	.930	1.253	.301
	expertise	.915	1.541	.215
	trustworthy	.946	0.957	.420
	CERS			
	attractiveness	.971	0.492	.689
	expertise	.939	1.086	.364
	trustworthy	.974	0.447	.720

after the fourth session.

### **Further Analyses**

An additional analysis was performed to determine whether clients' ratings of therapists tended to improve from session one to session four. Paired sample *t* tests were run to determine the significance of these changes. The results of these *t* tests are presented in Table 23. The tests were significant for both female and male participants for all the subscales of both the CRS and the CERS. After four sessions, clients' ratings of the attractiveness, expertise, and trustworthiness of their therapists increased on each of the outcome measures. Thus, respondents clearly held more favorable opinions of their therapists as they got to know them better. This result is not surprising, but it is important, because it indicates that perceptions of therapists were changing, even if these changes were not related to client racial-identity or self-esteem, or to the race of the therapist. Clearly the significant findings presented in Table 23 were influenced by large numbers of cases involved in the session one to session four comparisons. This raised the issue of statistical power; specifically the possibility that the paucity of significant findings obtained in the previously reported MANOVAS might be due in part to the relatively small cell sizes.

### **Summary**

The expectation that clients who were racially less developmentally advanced with relatively low self-esteem would initially tend to rate therapists of the same race more favorably than therapists of a different race were not met. Clients who were racially less developed with relatively low self-esteem tended to rate the opposite race higher. Additionally, more racially developed clients (Black and White) with high self-esteem tended to rate their own race higher. Following the fourth counseling session, the expectation that clients would not perceive therapists differently was not met. After the fourth session, clients tended to rate therapists, in all areas, as much more attractive, expert, and trustworthy rather than simply

Table 23

Paired Sample T-tests for the Significance of Changes in Ratings of Therapists From  
Session One to Session Four

group	variable	session 1		session 4		<i>t</i>
		<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	
females ( <i>N</i> =108)	CRS					
	attractiveness	18.94	4.29	21.59	4.29	5.05***
	expertise	20.24	4.92	22.93	4.34	4.96***
	trustworthy	19.80	4.56	22.40	4.30	5.04***
	CERS					
	attractiveness	14.21	3.52	16.49	3.01	5.60***
	expertise	14.96	3.77	17.28	3.35	5.61***
	trustworthy	14.78	3.54	17.20	3.05	6.14***
males ( <i>N</i> =108)	CRS					
	attractiveness	18.25	4.10	21.76	4.06	6.50***
	expertise	20.44	4.37	22.94	4.18	4.67***
	trustworthy	19.47	4.97	22.00	4.53	4.03***
	CERS					
	attractiveness	14.20	3.34	16.30	3.22	4.86***
	expertise	15.03	3.75	16.88	3.47	4.28***
	trustworthy	14.88	3.46	16.82	2.99	4.65***

\*\*\*  $p < .001$

attractive and trustworthy. Finally, the hypothesis that female clients would generally rate therapists more favorably than male clients was not confirmed. Exploratory analyses showed that both female and male clients tended to rate therapists higher following session 4 than they did following session 1. This suggests that the clients viewed therapists more favorably as they got to know them better.

## Chapter V

### Discussion

In this chapter, the findings of the study will be discussed. The discussion section has been organized under three major headings, as follows: (a) summary of research findings; (b) study contribution to the literature; and (c) limitations and recommendations for further investigation.

#### Summary of Research Findings

The study reported here was designed to determine the effects of racial-identity development and self-esteem on clients' perceptions of the attractiveness, expertise, and trustworthiness of therapists of the same race or a different race. It was anticipated that after the first counseling session, clients with relatively less highly developed racial-identities and relatively low self-esteem would rate therapists of the same race as more attractive, expert, and trustworthy than they would rate therapists of a different race. The expectation of significant differences following the first counseling session was based on social-influence theory (Strong, 1968) and on theories of Black-and White-racial-identity development (Carter, 1995; Cross, 1995; Helms, 1998).

Social-influence theory suggests that people typically tend to view as attractive and competent those individuals whom they perceive to be similar to themselves, and a substantial number of research studies have indicated a positive relationship between the client's perception that the therapist is similar to him or herself and the client's ratings of the therapist in terms of attractiveness, expertness, and trustworthiness (Strong & Schmidt, 1970; Schmidt & Strong, 1971; Strong & Dixon, 1971; Strong & Matross, 1973; Strong & Caliborn, 1982).

It was expected that following the initial counseling session, similarity with respect to race would make a difference in clients' perceptions of the attractiveness and effectiveness of their counselors. It was expected that clients who were not

highly developed with respect to their racial-identity and had relatively low self-esteem would conform most closely to the social influence paradigm. It was anticipated further that individuals with highly developed racial-identities and those with high self-esteem would immediately be able to look beyond superficial similarity based on race and rate their counselors based on other factors.

It was expected that after four counseling sessions, any effects due to social influence would be attenuated as clients got to know their counselors better and they had more concrete data upon which to formulate their opinions. Although the differences observed following the first counseling session were not as anticipated, the changes that occurred over the first four sessions do appear to be as expected.

Following session four, there were no significant differences in the ratings assigned to Black and White therapists. Clients of both races tended to assign their therapists rather high ratings on attractiveness and effectiveness following the first session, regardless of the race of the therapist. These ratings went up significantly from the first to the fourth session, indicating that the clients' impressions of the therapists improved as they got to know the therapists better.

Finally, it was expected that client gender would be a factor in determining therapist assessment. Client gender was not a factor in determining assessments of therapists, either following the first counseling session or following the fourth counseling session. This finding argues against the stereotypical view of couple's treatment that suggests that men tend to be initially less receptive to the idea of couples counseling than women are. If this viewpoint were accurate, one would expect that men might evaluate their therapists less favorably than women, at least initially. The results of the present study suggest that this was not the case.

The results of the study did not support the expected outcomes. Among White clients, the racial-identity development variable was not a significant factor in determining attitudes toward therapists. However, self-esteem was a factor. There

was a tendency for individuals with low self-esteem to assign more favorable ratings to therapists of a different race than to therapists of the same race. These findings do not support the relevance of the racial-identity development theory with respect to White clients, although they are consistent with and perhaps inform social influence theory in a highly logical manner (Strong, 1968). What was seen with the White clients in the study was that if one likes oneself (i.e., Autonomous), then initially one tends to assign more favorable ratings to individuals who are superficially more similar to oneself than one does to individuals who are superficially less similar. If an individual does not like oneself (i.e. Contact), the opposite situation pertains. Then the individual tends to feel more confident about and comfortable with someone who is different. One might conclude that an individual who falls in the Contact stage and is unhappy with oneself might feel some ambivalence about seeking help from a therapist who is perceived to be very much like oneself. Moreover, an individual who falls in the Autonomy stage who is content with his or her worldview feels no ambivalence about seeking help from a therapist who is either similar or dissimilar. Carter (1995) stated:

The sixth and final stage of Helm's White Racial Identity Development model, Autonomy, "occurs when an individual internalizes, nurtures, and applies the new meaning of Whiteness to his or her interactions and does not oppress, idealize, or denigrate people of color based on racial group membership" (p. 108). Such "enlightened" and self-assured whites are open to new information about their own racial identities and the racial identities of non-whites, can operate in mixed-race interactional settings, and, in fact, actively seek out cross-racial experiences, viewing them as inherently beneficial. (Carter, 1995, p. 108)

These findings are consistent with racial-identity development theory (Helms, 1998) and with the observations of Pomales, Claiborn & LaFromboise

(1986), and Smedley (1993) that one's own racial-identity development can have an impact on how one perceives individuals of other racial groups.

These findings obtained with Black clients are also consistent with the early literature indicating that Black clients tend to prefer Black counselors to White counselors (Hefferon & Bruehl, 1971). It may be that around that time three and one-half decades ago when minority clients were beginning to increase their utilization of mental health services, many Black clients were less advanced with respect to racial-identity development and more apprehensive about the possible impact on the therapeutic process of therapist/client racial differences. Such discomfort would have resulted in a preference for a therapist of the same race. Today this would be characteristic only of those individuals who are at the lowest stages of racial-identity development. This interpretation of the findings of the present study may pertain primarily to the evolution of racial attitudes and racial-identity development over time. One wonders whether studies carried out today would indicate the same degree of preference for therapists of the same race among minority clients as was observed in the early studies of client preference.

### **Study Contribution to the Literature**

Despite prior research findings, it should also be noted that the findings of the present study do not necessarily cast doubt on the general validity of social-influence theory. Race is only one dimension along which individuals may be similar or different. Educational level, age, shared cultural values, political viewpoints, and styles of dress are all factors that may contribute to an individual's perception that he or she is either similar to or different from another person. It is quite possible that the

clients and counselors who participated in the research described here were generally similar with respect to these other variables, and that these similarities counted more heavily in the minds of the clients than similarity with respect to superficial aspects of race.

Along these lines and in several ways, this study has advanced research on the relationship between racial-identity attitudes and the perceptions of White and Black clients of counselors of similar and dissimilar racial backgrounds. First, in contrast to prior studies, evidence seems to point up changes in racial attitudes specifically as it relates to superficial differences (i.e. beliefs about the therapist). Second, this examination appears to suggest that the race of the counselor may no longer be considered an important factor when choosing a therapist.

The clients were all from suburban areas around New York and were all voluntary and fee-paying marital therapy clients. These factors suggest that they had a certain level of affluence and in all likelihood generally positive attitudes toward therapy. Rokeach, Smith, and Evans (1960) contended that the prejudiced person does not reject a person of another race, religion, or nationality because of his ethnic membership per se, but rather because he perceives that the other differs from him in important beliefs and values" (p. 281). Yet again, Moore and Williams (1991) demonstrated that people see as credible and attractive those individuals whom they perceive to be similar to them. In the current research study, the clients appeared to be very similar to their counselors and social-influence theory would suggest that such clients would tend to be predisposed to assigning their counselors rather high ratings on attractiveness and effectiveness. One could speculate that the client

sample was too geographically similar. It is possible that greater differences might have been observed if the clients had been a more heterogeneous group. For this reason, it would be highly desirable to replicate this study using a client sample representing a greater diversity with respect to geographical areas and educational and income levels. It would also be desirable to include some clients who have been mandated to come to counseling, and who therefore would not necessarily be expected initially to have uniformly positive attitudes toward treatment.

These findings could also be interpreted as running contrary to social-influence theory and to the studies carried out during the late 1960s and early 1970s suggesting that Black clients tend to prefer counselors of their own race (Banks, Berenson, and Carkhuff, 1967; Gardiner, 1972, Hefferon & Bruehl, 1971). However, the results of the present study cannot be compared directly to those of earlier studies, because the clients in the present study did not have the opportunity to express a preference for a therapist of the same or a different race. The couples who participated in the current study simply had therapists assigned to them through whatever mechanism was in place in the particular treatment setting where they were receiving counseling, which in most cases was simply on the basis of which staff therapist happened to have a free hour at a time when the couple could attend. Further, therapists in this study appeared to emerge as very similar (i.e. same beliefs, socioeconomic status) to the client. Thus, therapist demographics seemed to play a key role here. Therapists were of the same geographical location and seemingly same socioeconomic status as their clients (regardless of race) which also seemed to affect how clients rated their therapist. Suggesting that no matter what the therapist

race the client viewed the therapist as similar to them, which infers that the therapist will understand me because they are like me. This is extremely important given the way in which race and socioeconomical status is viewed in the United States.

We have no idea of whether or not any of these clients would have stated a preference for a therapist of a particular race. We only know that their ratings of their therapists on most of the CRS and CERS subscales did not differ on the basis of the race of the therapist. It is quite possible that these clients might have indicated a preference for a therapist of the same race, had they been given this option. It is also possible that these clients might have rated their therapists differently, had they been given such a choice. If this were the case, one could not be certain that the ratings did not reflect a degree of self-validation. That is, having selected a therapist of the same race, a given client might well tend to assign high ratings to that therapist, in order to justify having made that selection.

Alternatively, even if these clients had been given a choice with respect to the race of their therapist, it is quite possible that they would not have systematically tended to choose a therapist of the same race, as did the subjects in the earlier studies noted above. Those studies are now more than 30-years-old, and it appears that attitudes have changed to the point where the race of one's counselor is no longer considered an important factor in the selection of the therapist or the manner in which the therapist is perceived at least within the cohort of marriage therapy clients from which the sample for this study was drawn.

At any rate, notwithstanding social-influence theory, racial-identity development theory and the impact of historical changes in social attitudes, the

findings obtained with respect to changes in client attitudes over the first four counseling sessions are perfectly consistent with common sense, which suggests that clients are likely to think better of their therapists as they get to know them better. In addition, one might suppose that at least some clients who began treatment and had very poor opinions of their therapists following the first session or the first few sessions would have dropped out of treatment and, therefore, been unavailable for inclusion in the present study.

### **Higher Ratings**

Admittedly and unexpectedly, most Blacks and Whites identified scored higher on Pseudo-Independent and Autonomy (Whites) and Emersion and Internalization (Blacks). This suggests that both Blacks and Whites appear more conscious of race and racism. In Whites, Pseudo-Independence signifies that they are beginning to question innate Black inferiority and that they are beginning to recognize and take “responsibility for racism” (Carter, 1995, p. 106). This person is on a course toward rejecting external worldviews of race. The Autonomy stage suggests that a White individual “internalizes, nurtures, and applies the new meaning of Whiteness to his or her interactions and does not oppress, idealize, or denigrate people of color based on racial group membership” (Carter, 1995, p. 108). Thus, Whites are more in tune with their racial worldviews and internalize a nonracist “White identity.” Among the Black clients in the study, racial-identity development was a factor in determining initial attitudes toward therapists. Black clients in the less-advanced stages (i.e., Preencounter, Encounter) of racial-identity development tended to assign higher ratings to therapists of a different race. Black clients with

more advanced racial-identity (i.e., Emersion, Internalization) development did not differentiate therapists on the basis of race. Thus, Carter (1995) stated,

This individual, motivated by personal preferences rather than a denial of his or her racial group or racial identity, may associate with Whites and even date interracially. This person becomes socially flexible and able to move comfortably in varied racial contexts. He or she can adapt to and function in a White environment, even though the closest social support system may still consist of a few, if any, Whites, unlike a Pre-encounter Black person. (p. 94)

Thus, the client is ready and, most importantly, willing to build associations and alliances with other groups.

### **Internalized Racism**

As stated previously by Smedley (1993) one's own racial-identity can have an impact on how a person perceives individual's of other racial groups. Both Black and White clients scored high on emersion and internalization (Blacks) and pseudo-independence and autonomy (Whites) which suggests a conscious awareness and understanding of the implications of race and culture and a secure sense of self (Helms, 1990). This would suggest that these clients support, consciously or unconsciously, the dominant culture (i.e. White). By definition, internalized racism is the belief that individuals, as part of their self-image, internalize specific views (e.g. racist, stereotypical, biased, etc.) of self. In addition, these beliefs may cause one to feel unworthy, incapable, not as intelligent as, or better than the majority culture. This view results in making an individual think, act, or feel a certain way, which then results in

criticizing, diminishing, discriminating, and hating one's self, all while accepting the dominant culture.

High scores of the clients in this study indicate that they have analyzed and perhaps resolved their issues of race. It seems apparent that White clients who scored high on pseudo-independence and autonomy tend to ask themselves the hard questions about race, wanted true change, and needed to grow beyond one point of view. Black clients who scored high on emersion and internalization tended to view themselves as socially adaptable, navigating with ease through varied racial environments. It appears that these clients have prevailed over internalized racism. Either these clients are truly enlightened individuals who take a positive worldview and have found a way to abate internalized racism, or they answered the survey in the way that they would like to be seen. Black clients appeared more inclined to work on their problems, accepting help from White counselors; and White clients seemed interested in pursuing their feelings with a Black counselor without a sense of defensiveness or guilt. In any event, this could explain why clients rated high on racial-identity and self-esteem. In addition, these clients appear more similar than dissimilar, thus, assigning more favorable ratings to individuals who are superficially more similar to oneself.

Although Black and White clients in this study appear to have embraced strong, positive feelings about race awareness, the way in which they adapt these feelings is vital. Scoring high on racial-identity may affect the client's counseling experience in productive ways, which helps abate internalized racism. Phinney and Kohatsu (1997) believe "a secure, committed sense of one's racial or ethnic group membership is

assumed to provide the foundation for healthier adjustment among members of ethnocultural groups. (p. 435).

### **Gender Differences**

Client gender was not a factor in determining assessments of therapists, either following the first counseling session or following the fourth counseling session. This finding is contrary to the stereotypical view of couple's treatment, which suggests that men tend to be initially less receptive to the idea of couples counseling than are women. If this viewpoint were accurate, one would expect that men might evaluate their therapists less favorably than women, at least initially. It is possible, however, for men to separate their negative view of therapy from their evaluation of the therapist. The finding that gender would be a factor in determining assessment of a therapist may reflect changes in social attitudes that have occurred over time. It may well be that in the past men were unfavorably disposed toward psychological treatment, but that this mind set has changed as society in general has become more accepting of such treatment. In a sense, this view would imply a parallel course of development between men and minority ethnic and cultural groups with respect to attitudes toward therapy. Attitudes may have simply become generally more favorable, and differences between groups of individuals, based on any demographic distinctions, including gender and race, may be losing their salience.

### **Limitations and Recommendations for Future Research**

The present study measured racial-identity development but it did not measure directly the clients' attitudes toward individuals of different races or their specific attitudes toward mental-health professionals of different races. This is a limitation because an individual could well make no distinction between individuals

of different races in general, but at the same time make such distinctions with respect to mental-health professionals specifically. For example, a client might feel that people are generally the same in terms of competence and disposition, but that client might still have a reservation regarding the ability of a therapist of a different racial or ethnic group to understand specific aspects of the his or her experience. An individual might well feel perfectly comfortable having an individual of a different race fix a computer or perform surgery, yet still have doubts with respect to sharing highly personal details of one's relationship with father, mother, or spouse.

This study did not reflect the interaction of racial-identity development of the couple as a dyad. Rather, the couples were viewed as individuals within the dyad. This is an added limitation in that the racial identity of individuals' within the dyad could be equal or at least one stage or more advanced than a spouse (Helms, 1999). These stages can vary depending upon how much more advanced (i.e. how many stages beyond) one spouse is above or below the other. That is to say, it is not clear whether spouses were similar or dissimilar in their stage of racial development. Since the data were analyzed by gender it is unclear whether the data would have yielded anything noteworthy had the data been mutually inclusive. This could have clearly affected the outcome of the study. Further research should use a statistical procedure to garner absolute judgments of therapists connecting the dyad rather than making comparative ones.

It was clear that after the study was completed that the demographics of the therapist were important (e.g. SES, age, gender). This was limiting in that the therapists appeared to be of the same socioeconomic status as the client. If this is true then this study had no real basis for comparison with regard to racial-identity as it related to therapists' demographics. Case in point, if the client assumed that the therapist was of the same socioeconomic status then he or she would automatically assume that they were similar and thus not be concerned about race. It may be

worthwhile to conduct future research with therapists who identify themselves as socioeconomically higher or lower than some of their clients. Also not taken into consideration was therapists' ages. Clients and therapists of comparable age may view certain life events similarly. Notwithstanding race, certain life stressors (e.g. health concerns, divorce, etc.) may be solely based on age. Pope-Davis and Ottavi (1994) suggested that as a therapist ages he or she may become more comfortable and thus, more accepting of racial differences.

Conducting research to consider whether clients view therapists' age as an indication of therapist competence and racial acceptance may prove valuable. Another important area for future research should assess the impact that a therapist's gender has on client outcomes. Research indicated that women reported being more comfortable with racial interactions and discussing racial issues than men (Pope-Davis and Ottavi, 1994). Given that this field and a great deal of its research had been male dominated; is it fair to suggest that women will have better client outcomes than their male counterparts? Although there is limited research on gender differences, "the limited information available suggests that racial-identity development may be more conflictual for White females than White males and Black males than Black females" (Helms, 1993, p. 100). This suggests a need to investigate further the issues of gender power and/or privilege.

The present study also did not contain any measures of therapy outcomes. Thus, one cannot compare the findings of the present study to early reports that there is a low probability of successful outcomes in psychotherapy when the counselor and client are of different races (Banks, 1971; Kincaid, 1969; Vontress, 1970, 1971). However, based on the similarity of ratings assigned to therapists of the same or different races following session four, there is certainly no reason to expect that outcomes would differ as a function of the race of the therapist. The major problem here is that the outcome studies that have indicated greater success with racially

matched client/therapist dyads are terribly dated. Further research must be carried out to determine whether there are currently any race-related differences in counseling outcomes.

Given the very limited initial differences observed in this study based on the race of the therapist, one cannot draw any firm conclusions regarding the validity of the Elaboration Likelihood Model (ELM) of McNeil and Stoltenberg (1989). This model was used to support the expectation that any initial race-related differences in the ratings assigned to therapists would disappear by the end of the fourth session, as clients learned more about their therapists and were increasingly able to rate the therapists on the basis of greater information. The results of the present study offer some support for this view, but the findings can hardly be considered conclusive.

In order to test this hypothesis adequately, it might be necessary to employ an experimental manipulation, which would generate some initial doubt on the part of the participating clients with respect to the attractiveness, expertness, or trustworthiness of the therapist. Perhaps the therapist could be described as an intern or trainee. Assuming that such a description would lead to relatively low client ratings of the therapist initially, it would be possible that there might be additional significant differences in therapist ratings based on the race of the therapist. Then, if these effects due to race no longer pertained at session four, the ELM paradigm would be supported more fully than is the case in the present study.

The paucity of main or interactive effects due to racial-identity attitude calls into question the notion that racial-identity as measured by the BRIAS and the WRIAS is related to clients' attitudes toward therapists of the same or different races. It is possible that the few significant effects involving therapist race, which were observed following the initial therapy session, were simply the result of type one errors, due to the large number of tests that were carried out. MANOVA's were used to help to control for possible type one errors, but a large number of tests were run nevertheless.

It is also possible that race-related differences in perceptions of therapists would be better predicted from more direct measures of racial prejudice. Perhaps a social distance measure would be more effective in differentiating subjects who would and would not hold negative attitudes toward a therapist of a different race.

However, it should also be noted that the typical White respondent tended to score quite high on the Pseudo Independence and Autonomy Scales of the WRIAS, and the typical Black respondent tended to score quite high on the Emersion and Internalization Scales of the BRIAS. Thus the participating clients tended in general to be quite highly developed with respect to their racial- identities. Therefore, the relatively more and relatively less advanced groups constructed in the present study were not as distinct from each other as one would have wanted to insure the maximum possible opportunity to observe significant effects due to racial identity attitudes. Here again, the chance of obtaining significant effects due to racial-identity may have been enhanced if the participants had been a more heterogeneous group.

### Summary

Having considered a number of methodological issues which may explain the relative lack of significant findings in the present study, we must also consider the possibility that the relative many non-significant findings simply point to the irrelevance of racial-identity attitudes and perhaps the irrelevance of race itself as a predictor of clients' preferences for a counselor or as a predictor of counseling process and outcomes. Such a conclusion certainly runs contrary to prevailing wisdom as embodied in such texts as *Multicultural Counseling Competencies* (Sue & Carter, 1998). These authors stressed the impediments to effective counseling faced by White counselors when working with Black clients. These ostensible impediments include possible unconscious racist attitudes, lack of an adequate understanding of the life experience and worldviews of Black clients, and the

tendency to attribute all of the Black client's problems to his minority status. Sue & Carter (1998) also argued that Black clients are often distrustful of White counselors. This argument may be becoming increasingly anachronistic.

The findings of the present study tend to call into question the focus of research in counseling on the variable of race. One begins to wonder the extent to which the cultural differences alluded to by Sue & Carter (1998) is a function of race per se, as opposed to race-related differences in socio-economic status and related life experiences. Here again, we must point out that the Black and White clients included in the present study were hardly representative of the general population. They were a select group. Perhaps within this group the issue of distrust of a person of a different race simply does not pertain. Perhaps the Black and White clients in this sample were much more similar to each other than different from each other.

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## APPENDIX A

Letter of Recruitment--Mental Health Professionals

Dear \_\_\_\_\_:

As discussed in our recent telephone conversation, I want to thank you for your interest in helping to identify participants for the dissertation I am completing at Seton Hall University to empirically determine, in actual counseling situations within the marital dyad, individuals' perceptions of counselors based on client Racial Identity Attitudes and to determine the stability of these perceptions over time. Research in this area may have an impact on client perceptions of the counselor in the therapy process, resulting from one's racial worldview, which may influence how counseling participants perceive and interact with each other.

I have enclosed a packet of the materials, which will be distributed to the participants who choose to participate in my study: an Introduction Letter, Consent Form, Personal Data Form, and copies of the Rosenberg Scale, Racial Identity Attitude Scale (white/black Racial Identity Attitude Scales, depending on the participant's race), Counselor Rating Form-Short, and the Counselor Effectiveness Rating Scale. The participants will anonymously complete the questionnaires in 30-40 minutes on their own. Participants should complete the measures in the following order: Participants will give written responses on the Personal Data Form, the Rosenberg Scale and the Racial Identity Attitude Scales. After four sessions, using the Counselor Rating Form-Short and the Counselor Effectiveness Rating Scale, participants will record their responses (via tape recorder). After completing the above, participants will return the completed questionnaires directly to me.

Participants receiving information about my study must meet the criteria listed below for inclusion in the research sample:

- Participants will have been married for at least two years before counseling
- The marriage would have to be the first for both participants
- This would be the first attempt at marital therapy for participants
- Marital dyads must be of the same race (i.e. black/black husband and wife; white/white husband and wife).

I will call you within a week to answer any questions you might have as well as to set up a brief meeting with you to discuss the procedures for the study. Thank you again for your cooperation.

Sincerely,

Harriett Gaddy, M.A.

## APPENDIX B

### Statement of the Nature of the Study

I have received information about a research study, which is being conducted by Harriett Gaddy, who is a doctoral student at Seton Hall University. Ms. Gaddy has sent the materials to me and other therapists in the New York metropolitan area. She has asked that we read this description of the study to married couples who are attending marital therapy for the first time, who have been married for at least two years before counseling and this is the first marriage for both participants.

The study is being completed to determine empirically, in actual counseling situations within the marital dyad, individuals' perceptions of counselors based on client attitudes and to determine the stability of these perceptions over time. Research in this area may have an impact on client perceptions of the counselor in the therapy process, resulting from one's worldview, which may influence how counseling participants perceive and interact with each other. If you choose to participate in the study, you will be asked to complete five questionnaires, which include generic questions about you and how you feel about yourself, your social and political attitudes, and questions pertaining to your perceptions of the counselor.

Once you have completed the questionnaires, you will be asked to mail them directly to Ms. Gaddy in an envelope that she will provide for your convenience. Your actual responses to the questionnaires will be kept confidential and no information that identifies you in any way will appear on the questionnaires. Your answers for two of the questionnaires will be audiotape responses. These tapes will be destroyed after the conclusion of the study.

In addition, your participation or refusal to participate in this study will have no effect on your continued treatment by the clinic or me. There is no way for me to be informed that you have participated in the study by Ms. Gaddy. I will have no knowledge of whether or not you chose to participate in the study, since you will be provided with the research packet in the following way: FOR PROFESSIONALS WITH ADMINISTRATIVE STAFF: "you can pick up an envelope containing the questionnaires when you first arrive or when you leave the office by asking (staff member's name) for the 'research packet'. (Staff member) will not reveal to me the names of those participants who requested the packet." FOR PROFESSIONALS WITH NO ADMINISTRATIVE STAFF: (A) "You can pick up an envelope containing the questionnaires when you arrive or leave the office. The research packet will be located in the box (location of box)."  
(B) "You can obtain the packet of research materials by sending this self-addressed postage card to Ms. Gaddy. Upon receipt of the card, she will mail you the packet in a plain envelope to whatever name and address you indicate. Ms. Gaddy will have no way of knowing whether or not you participate in the study as your name will not appear on the completed questionnaire you return to her."

If you have any questions about the study, you can reach Ms. Gaddy at (973) 927-4112 or (908) 852-1300 ext. 2119.

## APPENDIX C

### Letter of Introduction—Participants

Dear Participant:

This packet of research materials has been given to therapists and therapeutic clinics in the New York metropolitan area. They were asked to make these packets available to married couples, who are attending therapy for the first time, who have been married for at least two years before counseling and this is the first marriage for both participants.

I am a doctoral student at Seton Hall University in the Professional Psychology and Family Therapy department in the College of Education and Human Services. I ask that you complete this packet of materials as part of a research study I am conducting about individuals' perceptions of counselors based on client attitudes and the stability of these perceptions over time. This research is being completed to determine the impact of client perceptions of the counselor in the therapy process, resulting from one's worldview, which may influence how counseling participants interact with each other.

The questionnaires that follow are designed to obtain generic information about you and your current well being and views about yourself and your social and political attitudes. Specific questions will obtain information pertaining to your perceptions of the counselor. Your actual responses will be kept confidential. Please complete all of the items on the questionnaires.

No information that identifies you in any way is collected as part of this study. Upon receipt of your completed questionnaires, I will place a number on them for identification purposes only. This procedure is being used to maintain the anonymity of your identity.

You are free to withdraw from the study at any time. Your participation or refusal to participate in this study will have no effect on your continued involvement with the therapist or clinic that told you about the research.

Please complete the questionnaires in the order in which they are numbered (1, 2, 3, 4, and 5) and return them directly to me in the stamped, self-addressed envelope I have included in the packet. Thank you for your assistance.

Sincerely,

Harriett Gaddy  
58 Garden Court  
Succasunna, NJ 07876  
(973) 927-4112

## APPENDIX D

### Consent Form

I am a doctoral student at Seton Hall University in the Professional Psychology and Family Therapy Department in the College of Education and Human Services. You are invited to participate in a study whose purpose is to determine, in actual counseling situations, perceptions of counselors based on client attitudes and to determine the stability of these perceptions over time. You are asked to complete five questionnaires, which will take a total of 30-40 minutes. First, you will be requested to fill out three paper and pencil questionnaires prior to the first counseling session. Following the fourth session, you will be asked to record your responses from the last two questionnaires. These questionnaires are designed to obtain generic information about you and your current well being and views about yourself and your social and political attitudes. Specific questions will obtain information about your perceptions of the counselor. Approximately 108 married couples will take part in this study and a summary of these results will be shared with you at your request. At no time will your name appear on these materials or on any report of the results of the study. A number or letter will appear on the questionnaires for documentation purposes only. All audiotaped responses will be destroyed after the conclusion of the study. Results will be kept confidential and will only appear in an aggregate form for publication purposes. This research is being completed to determine the impact of client perceptions of the counselor in the therapy process, which may influence how counseling participants interact with each other.

Your participation is voluntary and you are free to withdraw from the study at any time. Your participation or refusal to participate in this study will have no effect on your continued involvement with the therapist or clinic that informed you of this research.

A summary of the results of this research can be obtained from the investigator upon request. If you have any questions or concerns regarding participation in this research, you may contact the investigator (Harriett Gaddy) at (973) 927-4112.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 378-9809.

I have read the material above, and any questions I asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

\_\_\_\_\_  
Subject

\_\_\_\_\_  
Date

Sincerely,

Harriett Gaddy, M.A.

**APPENDIX E****Personal Data Form**

This survey is designed to obtain background information about the participants of this study. Unless otherwise indicated, please answer all questions with one response by placing a check mark or X in the box beside the appropriate answer.

1. Which of the following age groups best describes you?

- (1) 17-21 years old                       (2) 22-30 years old  
 (3) 31-40 years old                       (4) 41-49 years old  
 (5) 50 years old and over

2. What is your gender?

- (1) Male                       (2) Female

3. What is your race/ethnic group?

- (1) Caucasian                       (2) African American  
 (3) Hispanic                       (4) Asian  
 (5) Native American                       (6) Other

4. What is your religious background?

- (1) Protestant     (2) Catholic     (3) Jewish     (4) Other (specify)

5. What is your marital status?

- (1) Single                       (2) Married                       (3) Widowed  
 (4) Separated                       (5) Divorced

6. If married, how long have you been married?

- (1) Less than two years                       (2) Two to four years  
 (3) Five to ten years                       (4) Eleven to fifteen years  
 (5) Sixteen to twenty years                       (6) Over twenty years

7. How many times have you been married?

- (1) Never been married                       (2) First marriage  
 (3) Second marriage                       (4) Third marriage  
 (5) Over four marriages

8. What is the highest level of education you completed?

- (1) Elementary School     (2) High school     (3) College  
 (4) Graduate school     (5) Other: \_\_\_\_\_

9. What is your socioeconomic status?

- |  |   |
|--|---|
| <input type="checkbox"/> (1) Under - 20, 000 | <input type="checkbox"/> (6) 45,000 - 50,000  |
| <input type="checkbox"/> (2) 21,000 - 26,000 | <input type="checkbox"/> (7) 51,000 - 56,000  |
| <input type="checkbox"/> (3) 27,000 - 32,000 | <input type="checkbox"/> (8) 57,000 - 62,000  |
| <input type="checkbox"/> (4) 33,000 - 38,000 | <input type="checkbox"/> (9) 63,000 - 68,000  |
| <input type="checkbox"/> (5) 39,000 - 44,000 | <input type="checkbox"/> (10) 69,000 and over |

APPENDIX F <sup>a</sup>

## SELF-RATING SCALE

Please circle one response for each of the statements below.

- |                     |           |              |                        |   |  |
|---------------------|-----------|--------------|------------------------|---|--|
| Strongly agree (SA) |           |              |                        |   |  |
|                     | Agree (A) |              |                        |   |  |
|                     |           | Disagree (D) |                        |   |  |
|                     |           |              | Strongly disagree (SD) |   |  |
| SA                  | A         | D            | SD                     | (1) On the whole, I am satisfied with myself.                                   |  |
| SA                  | A         | D            | SD                     | (2) At times, I think I am no good at all.                                      |  |
| SA                  | A         | D            | SD                     | (3) I feel that I have a number of good qualities.                              |  |
| SA                  | A         | D            | SD                     | (4) I am able to do things as well as most other people.                        |  |
| SA                  | A         | D            | SD                     | (5) I feel I do not have much to be proud of.                                   |  |
| SA                  | A         | D            | SD                     | (6) I certainly feel useless at times.  |  |
| SA                  | A         | D            | SD                     | (7) I feel that I am a person of worth, at least on an equal plane with others. |  |
| SA                  | A         | D            | SD                     | (8) I wish I could have more respect for myself.                                |  |
| SA                  | A         | D            | SD                     | (9) All in all, I am inclined to feel that I am a failure.                      |  |
| SA                  | A         | D            | SD                     | (10) I have a positive attitude toward myself.                                  |  |

<sup>a</sup>NOTE: Rosenberg Self-Esteem Scale (RSE)  
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## APPENDIX G <sup>a</sup>

### Social Attitudes Scale

(Form D)

This questionnaire is designed to measure people's social and political attitudes. You may find that some of the questions refer to sensitive issues. Answer as honestly as possible; there is no right or wrong answer. Use the scale below to respond to each statement. On your answer sheet beside each item number, write the number that best describes how you feel.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

---

1. I hardly ever think about what race I am.
2. I do not understand what Blacks want from Whites.
3. I get angry when I think about how Whites have been treated by Blacks.
4. I feel as comfortable around Blacks as I do around Whites.
5. I involve myself in causes regardless of the race of the people involved in them.
6. I find myself watching Black people to see what they are like.
7. I feel depressed after I have been around Black people.
8. There is nothing that I want to learn from Blacks.
9. I seek out new experiences even if I know a large number of Blacks will be involved in them.
10. I enjoy watching the different ways that Blacks and Whites approach life.
11. I wish I had a Black friend.
12. I do not feel that I have the social skills to interact with Black people effectively.
13. A Black person who tries to get close to you is usually after something.
14. When a Black person holds an opinion with which I disagree, I am not afraid to express my viewpoint.
15. Sometimes jokes based on Black people's experiences are funny.
16. I think it is exciting to discover the little ways in which Black people and White people are different.
17. I used to believe in racial integration, but now I have my doubts.
18. I'd rather socialize with Whites only.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

19. In many ways Blacks and Whites are similar, but they are also different in some important ways.
20. Blacks and Whites have much to learn from each other.
21. For most of my life, I did not think about racial issues.
22. I have come to believe that Black people and White people are very different.
23. White people have bent over backward trying to make up for their ancestors' mistreatment of blacks, now it is time to stop.
24. It is possible for Blacks and Whites to have meaningful social relationships with each other.
25. There are some valuable things that White people can learn from Blacks that they can't learn from other whites.
26. I am curious to learn in what ways Black people and White people differ from each other.
27. I limit myself to white activities.
28. Society may have been unjust to Blacks, but it has also been unjust to Whites.
29. I am knowledgeable about which values Blacks and Whites share.
30. I am comfortable wherever I am.
31. In my family, we never talked about racial issues.
32. When I must interact with a Black person, I usually let him or her make the first move.
33. I feel hostile when I am around Blacks.
34. I think I understand Black people's values.
35. Blacks and Whites can have successful intimate relationships.
36. I was raised to believe that people are people regardless of their race.
37. Nowadays, I go out of my way to avoid associating with Blacks.
38. I believe that Blacks are inferior to Whites.
39. I believe I know a lot about Black people's customs.
40. There are some valuable things that White people can learn from Blacks that they can't learn from Whites.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

---

41. I think it's okay for Black people and White people to date each other as long as they don't marry each other.
42. Sometimes I'm not sure what I think or feel about Black people.
43. When I am the only White in a group of Blacks, I feel anxious.
44. Blacks and Whites differ from each other in some ways, but neither race is superior.
45. I am not embarrassed to admit that I am White.
46. I think White people should become more involved in socializing with Blacks.
47. I don't understand why Black people blame all White people for their social misfortunes.
48. I believe that White people look and express themselves better than Blacks
49. I feel comfortable talking to blacks.
50. I value relationships that I have with my Black friends.

<sup>a</sup>NOTE: pages 245-251 Black Racial  
Attitude Identity Scale (BRAIS)  
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## APPENDIX G <sup>b</sup>

### Social Attitudes Scale

This questionnaire is designed to measure people's social and political attitudes. You may find that some of the questions refer to sensitive issues. Answer as honestly as possible; there is no right or wrong answer. Use the scale below to respond to each statement. On your answer sheet beside each item number, write the number that best describes how you feel.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

---

1. I believe that being Black is a positive experience.
2. I know through experience what being black in America means.
3. I feel unable to involve myself in White experiences, and am increasing my involvement in Black experiences.
4. I believe that large numbers of Blacks are untrustworthy.
5. I feel an overwhelming attachment to Black people.
6. I involve myself in causes that will help all oppressed people.
7. I feel comfortable wherever I am.
8. I believe that White people look and express themselves better than Blacks.
9. I feel very uncomfortable around Black people.
10. I feel good about being Black, but do not limit myself to Black activities.
11. I often find myself referring to White people as honkies, devils, pigs, etc.
12. I believe that to be Black is not necessarily good.
13. I believe that certain aspects of the Black experience apply to me, and others do not.
14. I frequently confront the system and the man.
15. I constantly involve myself in Black political and social activities (art shows, political meetings, Black theater, etc.).
16. I involve myself in social action and political groups even if there are no other Blacks involved.
17. I believe that Black people should learn to think and experience life in ways which are similar to White people.
18. I believe that the world should be interpreted from a Black perspective.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

19. I have changed my style of life to fit my beliefs about Black people.
20. I feel excitement and joy in Black surroundings.
21. I believe Black people came from a strange, dark, and uncivilized continent.
22. People, regardless of their race, have strengths and limitations.
23. I find myself reading a lot of Black literature and thinking about being Black.
24. I feel guilty and/or anxious about some of the things I believe about Black people.
25. I believe that a Black person's most effective weapon for solving problems is to become a part of the White person's world.
26. I speak my mind regardless of the consequences (e.g., being kicked out of school, being imprisoned, being exposed to danger).
27. I believe everything Black is good, and consequently, I limit myself to Black activities.
28. I am determined to find my Black identity.
29. I believe that White people are intellectually superior to Blacks.
30. I believe that because I am Black, I have many strengths.
31. I feel that Black people do not have as much to be proud of as White people do.
32. Most Black people I know are failures.
33. I believe that White people should feel guilty about the way they have treated Blacks in the past.
34. White people can't be trusted.
35. In today's society if Black people don't achieve, they have only themselves to blame.
36. The most important thing about me is that I am Black.
37. Being Black just feels natural to me.
38. Other Black people have trouble accepting me because my life experiences have been so different from their experiences.
39. Black people who have any White people's blood should feel ashamed of it
40. Sometimes, I wish I belonged to the White race.

1	2	3	4	5
<u>Strongly Disagree</u>	Disagree	Uncertain	Agree	<u>Strongly Agree</u>

---

41. The people I respect most are White.
42. A person's race usually is not important to me.
43. I feel anxious when White people compare me to other members of my race.
44. I can't feel comfortable with either Black people or White people.
45. A person's race has little to do with whether or not s/he is a good person.
46. When I am with Black people, I pretend to enjoy the things they enjoy.
47. When a stranger who is Black does something embarrassing in public, I get embarrassed.
48. I believe that a Black person can be close friends with a White person.
49. I am satisfied with myself.
50. I have a positive attitude about myself because I am Black.

<sup>b</sup> NOTE: pages 245-251 White Racial  
Attitude Identity Scale (WRAIS)  
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**APPENDIX H****Counselor Rating Form-Short (CRF-S)**

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## APPENDIX I

### Counselor Effectiveness Rating Scale (CERS)

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