

Journal of Counseling Psychology

Inverting the Power Dynamic: The Process of First Sessions of Psychotherapy With Therapists of Color and Non-Latino White Patients

Lia Okun, Doris F. Chang, Gregory Kanhai, Jordan Dunn, and Hailey Easley

Online First Publication, May 22, 2017. <http://dx.doi.org/10.1037/cou0000223>

CITATION

Okun, L., Chang, D. F., Kanhai, G., Dunn, J., & Easley, H. (2017, May 22). Inverting the Power Dynamic: The Process of First Sessions of Psychotherapy With Therapists of Color and Non-Latino White Patients. *Journal of Counseling Psychology*. Advance online publication. <http://dx.doi.org/10.1037/cou0000223>

BRIEF REPORT

Inverting the Power Dynamic: The Process of First Sessions of Psychotherapy With Therapists of Color and Non-Latino White Patients

Lia Okun, Doris F. Chang, Gregory Kanhai, Jordan Dunn, and Hailey Easley
The New School for Social Research

The present study is the first to apply Trawalter, Richeson, and Shelton's (2009) stress and coping framework to qualitatively examine interracial interactions in initial sessions of psychotherapy. The sample included 22 dyads: 15 therapists of color administering various treatment modalities to 15 treatment-seeking non-Latino White (NLW) patients and a comparison group of 7 intraracial (NLW-NLW) dyads. In Phase 1, videorecordings of the first session of treatment were analyzed using inductive thematic analysis (TA) to describe patient and therapist behaviors. In Phase 2, a deductive TA approach was used to interpret and cluster those dyadic behaviors according to Trawalter et al.'s (2009) framework. NLW patients paired with therapists of color made more efforts to bridge differences and more often questioned the therapist's professional qualifications compared with those matched with NLW therapists. Therapists of color made more self-disclosures than NLW therapists and maintained a more formal stance, compared with NLW therapists. The deductive TA operationalized 4 of Trawalter and colleagues' (2009) coping responses within a therapeutic framework. Findings highlight the ability of therapists of color to engage positively with their NLW patients even in the face of challenges to their expertise and credibility.

Public Significance Statement

The findings of this research highlight the ability of therapists of color to engage positively with White patients even in the face of challenges to therapists of color expertise and credibility. These findings begin to address the unique training needs of therapists of color.

Keywords: therapists of color, White patients, first sessions, coping responses

Between 1996 and 2004, the rate of students of color completing doctoral studies in psychology increased 17% (APA Office of Ethnic Minority Affairs, 2008). However, multicultural research has rarely examined the unique clinical practice issues facing therapists of color. The present naturalistic study examines processes of engagement in first sessions of therapy involving therapists of color and non-Latino White (NLW) patients.

Interracial Therapy Relationships Involving Therapists of Color

Interracial therapy relationships are likely to reflect the broader societal conflicts and racial anxieties that can be traced to the long

U.S. history of systematic oppression of racial minorities (Gaztambide, 2012). As a result, visible racial differences often activate negative affect, stereotyping, cultural mistrust, self-consciousness, and assumptions of misunderstanding, which can hinder the establishment of a strong therapeutic relationship (Jordan, Lovett, & Sweeton, 2012; Watkins, Terrell, Miller, & Terrell, 1989). However, there is scant empirical research examining how these dynamics may play out in interracial therapy involving therapists of color, particularly those working with NLW patients. (Note: for studies that do not specify the ethnicities of the White sample, the racial category White will be used). Although their meta-analysis of racial/ethnic matching studies found that the effects of matching were weaker for White patients, Cabral and Smith (2011) speculated that "White/European American patients may implicitly expect to see a therapist of their own race and may therefore initially mistrust a therapist of color . . . but this possibility has not yet been confirmed (p. 539)." To date, researchers have yet to systematically examine mistrust, as well as outward displays of prejudice, avoidance, and other therapy-interfering behaviors directed toward therapists of color by White patients, and how therapists overcome those barriers to engage patients in treatment.

A key issue that distinguishes the therapist of color-NLW patient dyad is *power reversal*. When a NLW therapist treats a patient of color, the power relationship mirrors larger societal

Lia Okun, Doris F. Chang, Gregory Kanhai, Jordan Dunn, and Hailey Easley, Department of Psychology, The New School for Social Research. This research was supported by the New School for Social Research Heckscher Dissertation Fellowship. We extend our appreciation to J. Christopher Muran and Jeremy Safran, as well as the Brief Psychotherapy Research Program for their guidance and support of this project.

Correspondence concerning this article should be addressed to Lia Okun, Department of Psychology, The New School for Social Research, 80 Fifth Avenue, 7th floor, New York, NY 10011. E-mail: lokun.phd@gmail.com

dynamics. However, the opposite case contradicts the historic racial divisions of labor and class that have shaped U.S. society (Comas-Díaz & Jacobsen, 1995). Bartoli and Pyati (2009) note that patients may be unaccustomed to interacting with people of color in positions of authority.

Much of the early writings by or about therapists of color were psychoanalytic case studies that observed that White patients' reactions were often tinged with racial stereotypes, including hostility and paranoia about the therapists' aggressive power (Tang & Gardner, 1999; Yi, 1998), and concerns about their professional competence (Comas-Díaz & Jacobsen, 1995; Leary, 1997). Therapists of color report feeling isolated, incompetent, or like spokespersons for their race/ethnicity when working with White patients (Nezu, 2010), at the same time feeling pressure to conceal signs of their ethnicity (Nezu, 2010; Tinsley-Jones, 2001).

Empirical studies comparing Black and White therapists have found that Black therapists report being more aware of racial similarities and differences, experience less subjective distress, and more often address race directly because of perceptions of client discomfort (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Turner & Armstrong, 1981). Yet, it remains unclear the extent to which these differences affect White patients' experiences of therapy. Fuertes and Brobst (2002) found that White patients' perceptions of their therapists' multicultural competence accounted for only 2% of the variance in their ratings of satisfaction with psychotherapy services, compared with nearly 16% of the variance for racial/ethnic minority clients. However, as Owen, Tao, Leach, and Rodolfa (2011) argue, patient ratings on multicultural competence measures may be more accurately understood to be indicators of "multicultural orientation," whereas "multicultural competencies can be viewed as 'ways of doing' or perhaps how well a therapist engages in and implements his or her multicultural awareness and knowledge while conducting therapy" (pp. 274–275). In the case of therapists of color, observational studies are needed to examine how the "ways of doing" multiculturally competent therapy with NLW patients may necessarily vary as a function of patient's reactions and behaviors in the engagement phase of treatment.

Stress and Coping in Interracial Interactions

To examine the particular interracial dynamics of initial sessions involving NLW patients and therapists of color, we draw on Trawalter et al.'s (2009) sociopsychological framework, which describes the initial stress and coping behaviors employed in response to interracial encounters. Their model posits that individuals' coping responses are shaped by primary and secondary appraisals processes. Primary appraisals assess the demands of the situation to determine whether the interaction partner poses a threat. Although interracial interactions are typically experienced as threatening, individual and contextual factors have been found to moderate those appraisals (Blascovich, Mendes, Hunter, Lickel, & Kowai-Bell, 2001). For example, threat appraisals vary by race. Whereas Whites worry about offending others or being perceived as racist, people of color fear being the target of prejudice (Trawalter et al., 2009).

Another moderator affecting threat appraisals is self versus partner focus. Trawalter et al. (2009) propose that among Whites, the motivation to not offend their partner creates a more self-

focused appraisal, whereas the wish to not be offended for people of color results in a greater partner focus. Hooks and colleagues (2013) also discuss partner focus, describing it as cultural humility. In initial sessions of therapy, the therapist's efforts to gather information and build rapport with the patient calls for a clear partner focus. The demands of the session also orient the patient toward greater self focus, as they present their concerns to the therapist. However, introducing an interracial context to initial sessions of therapy may result in impression management efforts by both parties, making it difficult to predict their target focus. Further, people attend to others more if their outcomes are dependent on them (e.g., Berscheid, Graziano, Monson, & Dermer, 1976). In interracial therapy, patients' therapeutic outcomes depend, at least in part, on the outgroup therapist; recognizing this possibility may induce a partner focus in one or both parties.

In the secondary appraisal process, individuals consider the physical and psychosocial resources they have to counter the perceived threat. Resources may include social scripts, namely knowing what to say and do during interracial interactions (Trawalter et al., 2009). In the therapy context, social scripts guide the performance of the patient and therapist roles. However, when the therapist is a person of color, those scripts may be harder to access or conflict with the scripts governing interracial interactions as predicted by Trawalter et al. (2009).

The authors identified a number of other variables that may moderate coping strategies but have thus far been understudied in the interracial interaction literature. Pertinent to the current study, the question of "what are they [the interracial dyad] doing?" is key. The demands and stakes in psychotherapy shape the experience of interracial contact in meaningful ways that distinguish it from commonplace interracial interactions. Both parties' interest in fostering a stronger bond in order to meet treatment goals is likely to affect their choice of coping strategies. However, the inherent power reversal involved in therapist of color-White patient dyads is not well addressed in their framework, as most applications have focused on peer interactions.

The Present Study

The present study is the first to apply Trawalter et al.'s (2009) stress and coping framework to qualitatively examine how NLW patients and therapists of color negotiate the relational and clinical tasks involved in the initial session of therapy. The demands of an intake, including establishing rapport, developing a shared understanding of the problem, and engaging the patient in treatment, become exponentially more challenging in the presence of racial and cultural difference (Alegría et al., 2012; Thompson & Carter, 1997; Tsang & Bogo, 1998). To clarify the behavioral processes that may be uniquely elicited in interracial sessions involving NLW patients paired with therapists of color, a smaller group of intraracial cases (NLW patient-NLW therapist dyads) will serve as a comparison group. Two exploratory questions were examined through observational coding of videorecordings of initial sessions: First, are there behavioral differences in how NLW patients respond to the therapist as a function of therapist race? Second, are there differences in how therapists of color and NLW therapists interact with NLW patients and manage the therapeutic tasks of the session?

Method

Study Design and Procedures

Building on other studies that investigate the engagement process of interracial therapy dyads (Tsang, Bogo, & Lee, 2011), this study adopted an exploratory qualitative design and constructionist epistemology, recognizing that “reality” is socially constructed and actively created by social interactions and relationships. Thus, we intentionally assembled a racially and ethnically diverse research team to engage multiple perspectives in interpreting the data as described below.

As the primary focus of this investigation was experiences of therapists of color, a group that is significantly underrepresented in the multicultural competency literature, we began with a sample of 15 interracial dyads. However, as the study progressed, we determined that including a comparison sample of intraracial dyads would help disentangle dyad-specific features from general racial dynamics produced in therapeutic relationships involving a therapist of color (Betancourt & López, 1993). Thus, we added a smaller sample of 7 NLW-NLW dyads to clarify the behavioral processes that differ as a function of the therapist race.

All patient–therapist dyads were drawn from the data archives of the Brief Psychotherapy Research Program, a research clinic located in a large urban hospital. This study was exempt from Institutional Review Board approval because only de-identified archival data was used. Patients consented to have their sessions videotaped. Clinicians were graduate student trainees in clinical and counseling psychology and psychiatry residents who were supervised on a weekly basis.

Case selection. Inclusion criteria for the therapist of color-NLW patient sample included (a) therapists that self-identified as Black or African American, Asian American, Latino, Native American or American Indian, or multiracial; (b) patients that self-identified as White but not Latino; and (c) treatment length of 3 or more sessions. Out of 65 cases seen by self-identified racial/ethnic minority therapists in the available dataset, 20 were excluded because the patient identified as a person of color. Another 7 cases were excluded because the patient did not return after the second session, which indicated a potentially contentious dynamic that would have less transferability to the greater population. Of the remaining 38 therapist of color-NLW patient dyads, 15 cases were purposively selected based on video availability and diversity of therapists.

Inclusion criteria for the intraracial dyads included (a) self-identification as White but not Latino; and (b) treatment length of 3 or more sessions. Where possible, cases were selected to proportionally correspond to the interracial dyad sample with regard to patient/therapist gender, patient diagnosis, and treatment type.

Participants

Table 1 presents demographic characteristics of the two groups. The therapists of color ($N = 15$) included 1 Black, 5 Hispanic, 5 Asian/Pacific Islander, and 4 multiethnic/racial therapists. Ages ranged from 21 to 39 years old. Patients were NLW and were aged 21 to 62 years old. The majority of patients were single, college educated, and employed.

Qualitative Data Analysis: Hybrid Approach Combining Inductive and Deductive Analysis

Phase 1-Inductive thematic analysis. To describe patients and therapists behaviors as a function of interracial versus intraracial dyads (Questions 1 and 2), the 6-stage process of inductive thematic analysis (TA) outlined by Braun and Clarke (2013) was applied to identify themes/patterns of meaning in the data. Stage 1 began by orthographically transcribing the session videorecordings (Braun & Clarke, 2013). Stage 2 was the construction and generation of initial codes for the codebook. Stages 3 and 4 consisted of the expansion and iterative refinement of the codebook, including combining, refining, and discarding codes as needed. The first 8 cases (including those initially coded by the entire team) were recoded with the finalized codebook. In Stage 5, codes were collected into themes to make meaning of the therapy interactions. Once coding was complete, themes for the two groups were compared (Braun & Clarke, 2013).

The coding team included three doctoral students of psychology in addition to the principal investigator (PI). Coders were chosen to be diverse as possible to provide reflexivity and represent varying perspectives through the coding process. Agreement across multiple coders demonstrates that themes are shared constructs and not the subjective interpretation of a single author (Kurasaki, 2000). The first coder identified as a 28-year-old Asian American-Latina, straight cisgender female born in the United States. The second coder identified as a 29-year-old White Jewish, gay cisgender male born in the United States. The third coder identified as a 37-year-old mixed race, West Indian nonheterosexual cisgender male born in Guyana. The PI identified as a 31-year-old biracial, half Chinese-half Eastern European, American-born heterosexual, able-bodied cisgender female. Coders were trained as a group. The process began with the entire coding team viewing videorecordings alongside transcripts from 4 sessions from the therapist of color group. The PI explained the process of open coding and guided the team through the process. Coders were then divided into interracial coding teams of two. Coders individually viewed and coded each session, then met with their partner to discuss discrepancies in coding, and lastly, codes were discussed with the coding team. The PI reviewed and resolved any discrepancies in the coding. Final codes were entered for presence or absence, to identify salient patterns between interracial and intraracial dyads.

Phase 2-Hybrid: Deductive TA informed by inductive TA results. In Phase 2, deductive TA (Crabtree & Miller, 1999) was used to organize and interpret the dyadic behaviors identified in Phase 1 in terms of Trawalter et al.’s (2009) stress and coping framework (see Table 2). Phase 2 was completed by the PI alone and audited by a supervisor. Drawing on existing literature, TA themes and codes from Phase 1 were conceptualized as behavioral markers used to operationalize Trawalter and colleagues’ (2009) five interaction styles (engagement, overcompensation, antagonism, avoidance, and freezing). Although the framework was created to describe interracial interactions, it was also applied to NLW-NLW dyads as it was developed from Lazarus’ (1966) more general stress and coping framework.

Table 1
Demographic Characteristics of Patients and Therapists

Demographic characteristics	Therapist of Color-NLW patient dyads (<i>N</i> = 15)	NLW therapist-NLW patient dyads (<i>N</i> = 7)
	<i>n</i> (%)	<i>n</i> (%)
Patient characteristics		
Age, mean (<i>SD</i>)	34 (11.6)	48.1 (13.4)
Race		
Non-Latino White	15 (100)	7 (100)
Marital status		
Single	11 (73.3)	4 (57.1)
Married/Remarried	4 (26.7)	3 (42.9)
Education		
High school graduate	1 (6.7)	1 (14.3)
College graduate	8 (53.3)	3 (42.9)
Graduate degree	6 (40.0)	3 (42.9)
Employment		
Employed	11 (73.3)	5 (71.4)
Unemployed	3 (20.0)	—
Retired	1 (6.7)	2 (28.6)
Diagnosis Axis I		
Mood disorder	8 (53.3)	4 (57.1)
Anxiety disorder	5 (33.3)	2 (28.6)
No Axis I diagnosis	2 (13.4)	1 (14.3)
Diagnosis Axis II		
Cluster A	1 (6.7)	—
Cluster B	1 (6.7)	1 (14.3)
Cluster C	3 (20.0)	2 (28.6)
PDNOS	3 (20.0)	—
Treatment modality		
Cognitive-behavioral therapy	8 (60.1)	6 (85.7)
Brief relational therapy	6 (39.9)	1 (14.3)
Therapist characteristics		
Age, mean (<i>SD</i>)	30.6 (5.7)	28.1 (3.2)
Years of clinical experience	3.2 (3.1)	1.1 (.7)
Gender		
Male	4 (26.7)	3 (42.9)
Female	11 (73.3)	4 (57.1)
Race/Ethnicity		
Non-Latino White	—	7 (100)
Black, not Latino origin	1 (6.7)	—
Latino/a	5 (33.3)	—
Asian/Pacific Islander	5 (33.3)	—
Multiracial/Other	4 (26.7)	—

Researcher as Instrument

Per Morrow's (2005) recommendation, it is important to note the researchers' more rigorous training in post/positivist frameworks. However, the PI's personal experiences as a therapist of color working with NLW patients in therapeutic settings guided the team toward a constructivist framework, with the goal of highlighting the experiences of a group underrepresented in the literature. It was expected that most NLW patients would exhibit discomfort working with a therapists of color. Although there were precautions taken in the coding of transcripts to enhance the trustworthiness of the analysis—for example, a diverse team to conduct the inductive TA, consensus coding on each case and structured discussions to examine coders' biases during each phase of the study—the authors acknowledge that their expectations may have unconsciously influenced their understanding and interpretation of the data presented.

Results

Differences in NLW Patient Behaviors as a Function of Therapist Race

The inductive TA identified how therapist and patient strategies for negotiating the relationship were mutually shaped by the contextual field. In other words, the strategies therapists used to manage interracial dynamics may simultaneously influence, and are likely influenced by, patient strategies. Behaviors observed in each group were similar in many ways. Given space limitations, we presented key themes that distinguished cases involving therapists of color from their NLW counterparts (see Table 3). Patient behavioral codes clustered into 2 main themes: (1) Confrontational behaviors and (2) Disclosures aimed at bridging differences.

Confrontational behaviors. Confrontational behaviors refer to patient behaviors that are challenging in nature. NLW patients

Table 2
Trawalter et al. (2009) Interaction Types: Definitions, Description, and Behavioral Markers

Engagement style	Interaction type	Definition	Behavioral marker
Positive	Engagement	Sufficient resources to meet demands, positive engagement	<ul style="list-style-type: none"> Affirming interaction partner's comments Smiling Head nodding Forward leaning (Trawalter et al., 2009)
	Overcompensation	Moderate but insufficient resources to meet demands, positive engagement for the interaction partner	<ul style="list-style-type: none"> Over-friendly verbal behavior (Mendes & Koslov, 2013) Excessive blinking/fidgeting (Dovidio & Gaertner, 2004) Deference to interaction partner (Trawalter et al., 2009)
Negative	Antagonism	Moderate but insufficient resources to meet the demands, antagonize to manage stress	<ul style="list-style-type: none"> Angry/hostile response style Belittling interaction partner Interrupting partner (Trawalter et al., 2009)
	Avoidance	Low and insufficient resources to meet demands, try to terminate interaction as quickly as possible	<ul style="list-style-type: none"> Averted gaze Curt response style Closed body posture (Trawalter et al., 2009)
	Freezing	Very low to no resources to meet demands, immobility	<ul style="list-style-type: none"> Immobility Silence/quiet speech (Trawalter et al., 2009)

working with therapists of color more often questioned their therapist's expertise compared with those in intraracial dyads. For example, a NLW female patient asks at the beginning of the session which treatment group she was in, and if her Latina female therapist "ha[s] some expertise in all of them."

In the following vignette, the patient continually answers her Latina therapist's question before she is done speaking. The patient attempts, rather concisely, to end the therapist's line of questioning about the patient's panic attacks.

Therapist. Do you have . . . do you feel like some of the . . . some of the issues is revolving [*sic*] the texture of the food?

Patient: No.

Therapist: Because you said that your throat sometimes feels like it's closing up.

Patient: Yeah, but no.

Therapist: So [*Pt*: No] it doesn't matter if it's wet, dry, grainy [*Pt*: no] no, no texture issues [*Pt*: Nu-uh] okay um, let's see . . . do you have rules about food? [*Pt*: Nu-uh] "cause you're an actor so I was just wondering like, is there like some things about your body that maybe in some way are associated with food. You're totally comfortable

Table 3
Definition of Themes That Differ by Therapist Race: Frequencies by Group

Themes	Definition	Examples	Therapists of Color (N = 15) N (%)	NLW Therapists (N = 7) N (%)
Patient themes				
Confrontational behaviors	The patient questions and challenges the therapist's expertise, skills, or the treatment in general.	"So can I ask, you have a PhD? Does [this hospital] have its own training program?"	7 (46.7)	2 (28.6)
Disclosures aimed at bridging differences	The patient tries to presents self as similar to the therapist by disclosing oppressed identity statuses.	"Well I grew up in an orthodox Jewish home and um went to study at a sort of Talmudic um, school."	11 (73.3)	4 (57.1)
Therapist themes				
Amiable behaviors	Therapist relates in a more personal manner with the patient.	Pt: One thing I'm really bad at is introspective reaction, you know what I mean? Th: You can call me sadistic but that's why I asked.	5 (33.3)	5 (71.4)
Self-disclosures	Therapist self-discloses information to the patient.	"I don't like feeling like I'm telling you what to do."	6 (40.0)	—

in your own skin and everything's great? [*Pt*: Mm-hm] Okay that's good, that's really good. Um because I can imagine that your kind of work is very stressful and pressured.

Patient: It is but y'know when you're this skinny it's like . . .

Therapist: Right, but but is it . . . is [*sic*] there any thoughts about maintaining that thinness?

Patient: No, I'm too skinny.

Therapist: You're too skinny.

Patient: Way too skinny.

Disclosures aimed at bridging differences. NLW patients working with therapists of color more frequently attempted to introduce themselves to their therapists by bridging perceived differences. Unlike behaviors that *broach* differences, which focus on the ways in which the therapist and patient are different, behaviors that *bridge* differences highlight their shared social identities (Chang & Berk, 2009). One tactic was to “other” someone else in the therapeutic conversation as a way of creating a shared ingroup between patient and therapist. Patients paired with therapists of color also more frequently referenced their socioeconomic difficulties perhaps in an effort to present themselves as more similar to their therapist. For example, two NLW female patients working with female therapists of color allude to limited finances and the need for “affordable psychotherapy.” A NLW male patient also spoke to his female therapist of color about how he “can’t afford” certain things he would like, and his growing debt to his parents.

NLW patients in interracial dyads also more often presented themselves as “cultural beings” (Sue, 2010). For example, one NLW female patient seeing a male therapist of color described her religious upbringing and ethnic heritage as part of her cultural identity. She described being unsure about her religiosity and concerns about her family’s reaction: “It’s gonna affect them if you don’t get confirmed into the Church, where I come from, an Italian family.”

Differences in Therapist Behaviors as a Function of Racial Match/Mismatch

Therapists across both groups performed their clinical duties and demonstrated appropriate therapeutic skills. Themes that distinguished NLW therapists and therapists of color included (1) amiable behaviors and (2) therapist self disclosures.

Amiable behaviors. Across cases, therapists would occasionally adopt a more personable tone in interactions with their patients. However, amiable behaviors were more frequently observed in NLW therapists than therapists of color. In the following interracial dyad, the NLW therapist explains the concept of homework in CBT:

Therapist: But we do something called giving homework, so to speak. Are you familiar with that?

Patient: Yeah.

Therapist: {Laughs} well I know you're a teacher, so you probably hear that word a lot.

Patient: {smiles} Yeah.

Therapist self-disclosures. Therapists of color made personal or experiential self-disclosures to their patient, while NLW therapists did not. In the following example, a Black female therapist initially discloses about her training and then the patient becomes curious, asking the therapist more questions about herself.

Therapist: Okay and as we go I'll be saying you know this and that because I'm being trained in this as well and I actually come from a different type of background.

Patient: What's your background?

Therapist: So it's more psychoanalytic. So, it's a bit of a switch for me too, but in terms of the training that we've done around here, it does make a lot of sense to me in terms of understanding what motivates someone to take a certain action because you know, a lot of times sometimes we do something, and we do not know why so.

Patient: So can I ask, you have a PhD? [*Th*: hmm] Does [the hospital] have its own training program?

Therapist: You have to do a year-long fellowship in order to qualify for the PhD. And so that's the stage where I am. But um, we've all had 6 years of coursework and a masters and have seen lots of people so. Not in this particular framework but in lots of different other settings, so you're not my first.

Patient: {laughs} Good.

Differences in Dyadic Coping Responses as a Function of Therapist Race

Themes and codes from the inductive analysis were used as behavioral markers to operationalize Trawalter et al.'s (2009) coping strategies. As seen in Figure 1, only 4 of the 5 strategies (*engagement*, *overcompensation*, *antagonism*, *avoidance*, and *freezing*) were used by participants in this sample. Notably, *avoidance* behaviors were not represented in this sample, thus the category was excluded. Additionally, no behavioral markers that emerged in the inductive analysis were reflective of the *freezing* strategy. Four behavioral codes from the inductive phase were excluded in this deductive phase because they did not directly apply to a single coping strategy. Patient and therapist strategies were coded and analyzed separately and compared across the interracial and intraracial dyads.

As seen in Figure 1, *engagement* was operationalized by the patient markers of identity disclosures and informal behaviors, as well as by therapists' responsive and amiable behaviors, and interest in details of patients' stories. *Overcompensation* was characterized by an apologetic and/or deferential stance toward one's partner, as well as self-derogation. *Overcompensation* was seen across cases in patients and therapists; it was operationalized with formal approach behaviors in patients and laughing on one's own

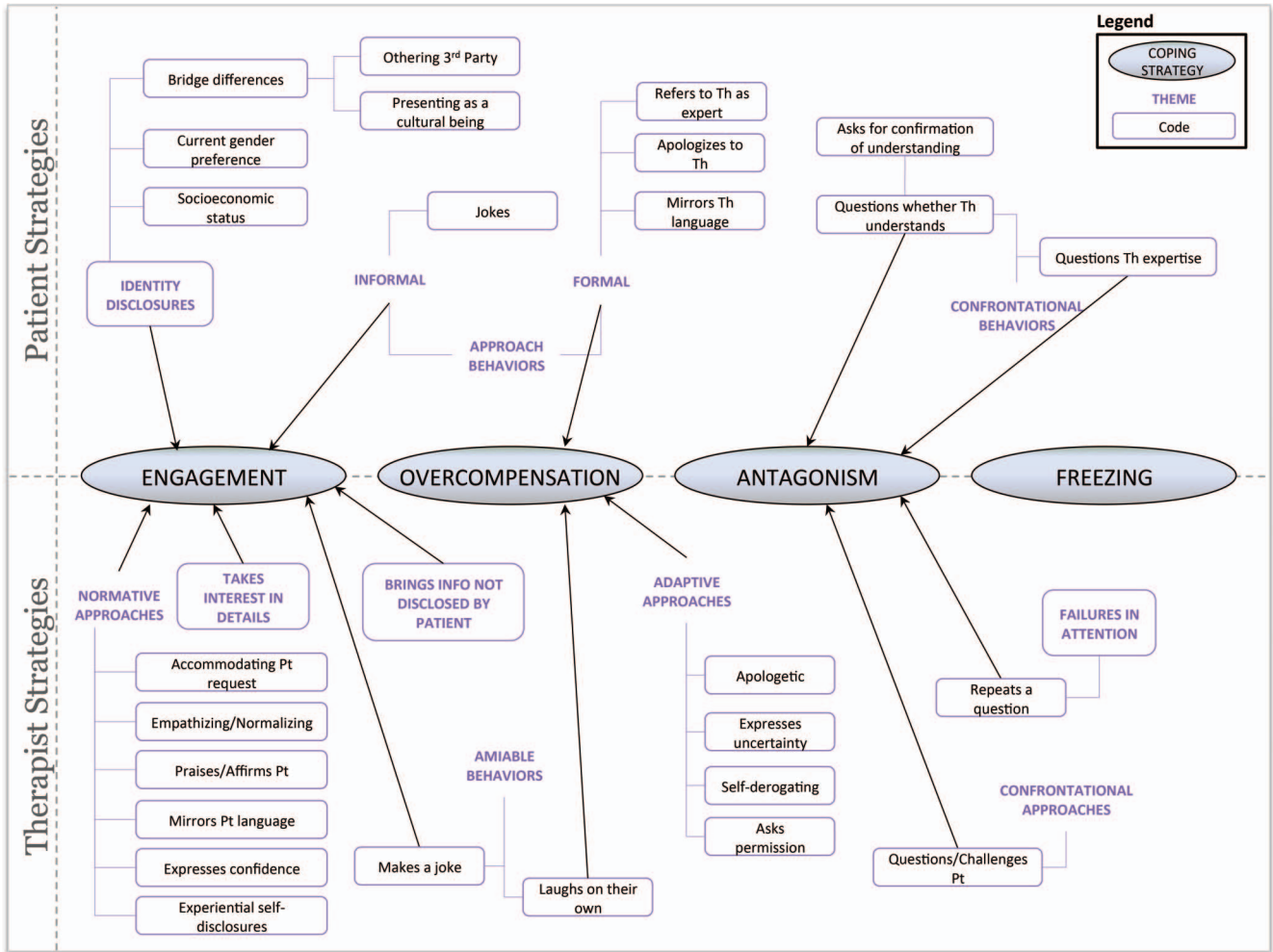


Figure 1. Operationalization of Trawalter et al.'s (2009) Stress and Coping Framework using inductive thematic analysis. Specific behavioral markers (rectangles) are presented in relation to their hypothesized coping strategies (ovals). The behavior codes on the outside of the figure come from the observations of the coding team and were condensed into themes that are written in all caps. Arrows show the operationalization from codes and themes to the corresponding Trawalter and colleagues' (2009) coping strategy. See the online article for the color version of this figure.

in therapists. The following vignette illustrates overcompensation in a patient response to his therapist of color's request for feedback:

Patient: No, no I think it was a great. I think it was a great start. I'm excited to keep moving. There was one thing—everything you said was great—but there was one where I just felt that really got me. I think it was maybe when I came back around said the feeling about the weakness and inadequacy. I think your response—I do not know exactly what it was, I sort of wish I do—because you so got me with that, with what you had to say. So I feel really good . . . about, about our session.

Therapist: So you felt with what I said, it kind of like . . .

Patient: It resonated really well with how I feel, with how I view myself. Everything resonated well with

how I view myself . . . so you got me, you really got me.

Antagonism was operationalized with behaviors that fell under the confrontational behaviors theme by patients and confrontational approaches theme by therapists. For example, in the following excerpt, both the patient and therapist are displaying antagonism as the therapist of color asks the patient to discuss a specific instance of job frustration.

Therapist: Well let's still talk about you and [boss Name].

Patient: Yeah, I was not trying to change the subject but everywhere she goes in the department environment people are saying no. I'm saying no, you know I'm just really fed up. . . . She is getting 5,000 dollars for one week of teaching. I'm not getting anything.

Therapist: Yeah, uh.

- Patient: And I'm sorry, but what I'm angry about is that she is not around. And she still has the [expletive] gall to charge this money.
- Therapist: It seems you are very angry at her.
- Patient: Uhhh, you wouldn't be angry?! {laughs}
- Therapist: Well let's still look at the difficulty you have—
- Patient: Who wouldn't be angry that is the question.
- Therapist: . . . let's look at the difficulty here that you gave me an example, you actually came up with an example that you had a meeting but you still . . . it's difficult for you, for some reason [Pt: I know! I cannot recall] couldn't tell me. . . .
- Patient: . . . but I can tell you how I'm feeling. I do not know if that's any good to you.

The patient and therapist interrupt each other and struggle over whose agenda is most important in the session. Both patient and therapist engaged in the challenge of interracial interaction, but did so with more negative emotions than positive.

Freezing was observed as a strategy used by therapists at certain moments, but was operationalized as an *absence* of therapist activity, for example, very few interventions, long pauses, or a lack of active response from the therapist. In the excerpt below, the patient discusses being easily overwhelmed by everyday stressors.

- Therapist: In a way it sounds like it's hard not to, kind of be punitive, be punishing toward yourself that what you are feeling or thinking is not somehow rational or acceptable.
- Patient: Well it's not to me, so yeah, I guess so.
- Therapist: Mmm hmm.
{10 seconds}
- Patient: Am I supposed to say something or?
- Therapist: Well, I'm just thinking um . . . , so we are starting this new therapy and I'm wondering how it was even thinking about coming here today.
- Patient: Um that's fine. I've been in therapy before. I have to admit I was a little upset cause twice you didn't remember my name and I sorta felt like, "I don't know is she in . . . ?" You know. So I think I was a little weirded out by that.

The therapist cannot be completely inactive (in contrast to Trawalter and colleagues' framework), as the therapist's role requires that they engage the patient.

Discussion

The principal aim of this qualitative study was to explore psychotherapy processes in initial sessions involving therapists of color and NLW patients. The hybrid inductive and deductive approach examined behavioral responses of therapist and patient when confronted with the inversion of social power in the initial clinical encounter. Trawalter et al.'s (2009)'s theoretical frame-

work was applied to organize and compare behavioral responses to those observed in NLW-NLW dyads, where the stress of the interaction was presumed to be lower.

Consistent with previous studies (Comas-Díaz & Jacobsen, 1995; Leary, 1997; Tang & Gardner, 1999), this study found that a greater proportion of patients working with therapists of color questioned their therapists' expertise, compared with those working with NLW therapists. These kinds of questions are examples of racial microaggressions (Sue, 2010), which have been studied in depth in the larger multicultural counseling literature.

NLW patients working with therapists of color were more likely to present identities that served to bridge differences with their therapist. Strategies included joining against a third party and/or describing their socioeconomic, ethnic, or cultural heritage. Findings align with Strauss and Cross's (2005) description of bridging, which they describe as a negotiation of bonding across racial boundaries.

In regards to therapists' strategies and presentations, there were two main findings. First, therapists of color tended to maintain a more formal demeanor with their NLW patients, compared with NLW therapists. Sociopsychological research findings have shown that in interracial interactions, Whites want to be liked while people of color want to be respected (Bergsieker, Shelton, & Richeson, 2010). These divergent goals may explain therapists' of color greater formality compared with NLW therapists. Because NLW patients in this study more often questioned the competence of therapists of color, therapists may employ identity protection to stereotype threat, what Strauss and Cross (2005) described as "buffering."

Interestingly, therapists of color used self-disclosures, whereas NLW therapists did not. As therapist self-disclosures have been theorized to address elements of cultural mistrust in mismatched dyads involving White therapists and patients of color (Constantine & Kwan, 2003), the present study suggests that self-disclosure may be used by therapists of color in a similar way: to humanize themselves, equalize the power reversal, or disrupt the colored-screen projections of NLW patients (Comas-Díaz & Jacobsen, 1995).

This study is the first to apply Trawalter and colleagues' (2009) stress and coping model to a psychotherapy interaction, operationalizing the model with behavior markers relevant to the therapeutic context. The *avoidance* and *freezing* responses were difficult to operationalize because behavioral indicators of that strategy are based on absence, not presence of certain behaviors. Arguably, *avoidance* might not have been observed because the investment that both parties have in psychotherapy make it different from experimental interracial interactions that take place in a laboratory setting (Murphy, Richeson, & Molden, 2011).

Engagement, overcompensation, and antagonism were conceptualized as active behaviors and therefore were more easily operationalized. In overcompensation, the therapist's role as expert affords therapists of color more power and social capital than may be conferred in other interactional contexts. However, as members of an oppressed group, therapists of color may harbor fears of racism from their White patients (Richeson & Shelton, 2007); overcompensation may result from efforts to maintain a professional stance of engagement under conditions of threat. Nevertheless, the observation that the majority of therapists of color exhibited high levels of engagement with their NLW patients, some of

whom are antagonistic in their interactional style, is an important finding that points to the efforts of therapists of color to uphold their professional responsibilities.

Limitations and Future Research

The generalizability of these research findings are limited by the specific features of the sampled cases. The racial diversity of the therapists makes it all the more remarkable that broad thematic differences were observed between the two groups in this study. However, dyadic differences at the subgroup level could not be examined given the small sample size.

Because the qualitative nature of this study relied entirely on observer coding, our findings cannot be validated against patient and therapist reports. As observers of these interactions, the research team can only speculate why participants displayed specific behavioral responses and strategies, and cannot know whether they were consciously employed. Additional studies are needed to replicate and further test the operationalizations described in the present research. Future research could build on this work comparing within-group differences in patients' and therapists' of color subjective experiences of interracial therapy, psychophysiological markers of stress response, and their behavioral coping responses.

In summary, through the use of observational techniques and a hybrid inductive and deductive approach to qualitatively analyzing psychotherapy processes in initial therapy sessions, the present study demonstrated notable differences in the ways NLW patients working with NLW therapists and therapists of color negotiate their first session of psychotherapy. Further, this study found that the majority of therapists of color were able to engage positively with their NLW patients, even when confronted with questions regarding their competence and other antagonistic responses from patients. This study contributes to a growing body of work that describes the unique experiences of therapists of color.

References

- Alegría, M., Katz, A., Ishikawa, R. Z., Diaz-Linhart, Y., Valentine, A., & Lapatin, S. (2012). The role of sociocultural information in mental health intake sessions. *The Israel Journal of Psychiatry and Related Sciences*, *49*, 194–201.
- APA Office of Ethnic Minority Affairs. (2008). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. Retrieved from <http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx>
- Bartoli, E., & Pyati, A. (2009). Addressing clients' racism and racial prejudice in individual psychotherapy: Therapeutic considerations. *Psychotherapy: Theory, Research, Practice, Training*, *46*, 145–157. <http://dx.doi.org/10.1037/a0016023>
- Bergsieker, H. B., Shelton, J. N., & Richeson, J. A. (2010). To be liked versus respected: Divergent goals in interracial interactions. *Journal of Personality and Social Psychology*, *99*, 248–264. <http://dx.doi.org/10.1037/a0018474>
- Berscheid, E., Graziano, W., Monson, T., & Dermer, M. (1976). Outcome dependency: Attention, attribution, and attraction. *Journal of Personality and Social Psychology*, *34*, 978–989. <http://dx.doi.org/10.1037/0022-3514.34.5.978>
- Betancourt, H., & López, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, *48*, 629–637. <http://dx.doi.org/10.1037/0003-066X.48.6.629>
- Blascovich, J., Mendes, W. B., Hunter, S. B., Lickel, B., & Kowai-Bell, N. (2001). Perceiver threat in social interactions with stigmatized others. *Journal of Personality and Social Psychology*, *80*, 253–267. <http://dx.doi.org/10.1037/0022-3514.80.2.253>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.
- Cabral, R., & Smith, T. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*, 537–554. <http://dx.doi.org/10.1037/a0025266>
- Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*, 521–536. <http://dx.doi.org/10.1037/a0016905>
- Comas-Díaz, L., & Jacobsen, F. M. (1995). The therapist of color and the white patient dyad: Contradictions and recognitions. *Cultural Diversity and Mental Health*, *1*, 93–106. <http://dx.doi.org/10.1037/1099-9809.1.2.93>
- Constantine, M. G., & Kwan, K. L. K. (2003). Cross-cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology*, *59*, 581–588. <http://dx.doi.org/10.1002/jclp.10160>
- Crabtree, B., & Miller, W. (Eds.). (1999). A template approach to text analysis: Developing and using codebooks. *Doing qualitative research* (pp. 163–177). Newbury Park, CA: Sage.
- Dovidio, J. F., & Gaertner, S. L. (2004). Aversive racism. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 36, pp. 1–51). San Diego, CA: Academic Press.
- Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity and Ethnic Minority Psychology*, *8*, 214–223. <http://dx.doi.org/10.1037/1099-9809.8.3.214>
- Gaztambide, D. J. (2012). Addressing cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research and Practice*, *43*, 183–189. <http://dx.doi.org/10.1037/a0026911>
- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L. Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*, 353.
- Jordan, A. H., Lovett, B. J., & Sweeton, J. L. (2012). The social psychology of black-white interracial interactions: Implications for culturally competent clinical practice. *Journal of Multicultural Counseling and Development*, *40*, 132–143. <http://dx.doi.org/10.1002/j.2161-1912.2012.00013.x>
- Knox, S. B., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology*, *50*, 466–481.
- Kurasaki, K. S. (2000). Intercoder reliability for validating conclusions drawn from open-ended interview data. *Field Methods*, *12*, 179–194. <http://dx.doi.org/10.1177/1525822X0001200301>
- Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York, NY: McGraw-Hill.
- Leary, K. (1997). Race, self-disclosure, and "forbidden talk": Race and ethnicity in contemporary clinical practice. *The Psychoanalytic Quarterly*, *66*, 163–189.
- Mendes, W. B., & Koslov, K. (2013). Brittle smiles: Positive biases toward stigmatized and outgroup targets. *Journal of Experimental Psychology: General*, *142*, 923–933. <http://dx.doi.org/10.1037/a0029663>
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*, 250–260. <http://dx.doi.org/10.1037/0022-0167.52.2.250>
- Murphy, M. C., Richeson, J. A., & Molden, D. C. (2011). Leveraging motivational mindsets to foster positive interracial interactions. *Social and Personality Psychology Compass*, *5*, 118–131. <http://dx.doi.org/10.1111/j.1751-9004.2010.00338.x>

- Nezu, A. M. (2010). Cultural influences on the process of conducting psychotherapy: Personal reflections of an ethnic minority psychologist. *Psychotherapy: Theory, Research, Practice, Training*, *47*, 169–176. <http://dx.doi.org/10.1037/a0019756>
- Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*, 274–282. <http://dx.doi.org/10.1037/a0022065>
- Richeson, J. A., & Shelton, J. N. (2007). Negotiating interracial interactions costs, consequences, and possibilities. *Current Directions in Psychological Science*, *16*, 316–320. <http://dx.doi.org/10.1111/j.1467-8721.2007.00528.x>
- Strauss, L. C., & Cross, Jr., W. E. (2005). Transacting Black identity: A two-week daily-diary study. *Navigating the future: Social identity, coping, and life tasks* (pp. 67–95). New York, NY: Russell Sage Foundation.
- Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.
- Tang, N. M., & Gardner, J. (1999). Race, culture, and psychotherapy: Transference to minority therapists. *The Psychoanalytic Quarterly*, *LXVIII*, 1–20. <http://dx.doi.org/10.1002/j.2167-4086.1999.tb00634.x>
- Thompson, C. E., & Carter, R. T. (Eds.). (1997). Race, socialization, and contemporary racism manifestations. *Racial identity theory: Applications to individual, group, and organizational interventions* (pp. 1–14). Mahwah, NJ: Erlbaum.
- Tinsley-Jones, H. A. (2001). Racism in our midst: Listening to psychologists of color. *Professional Psychology: Research and Practice*, *32*, 573–580. <http://dx.doi.org/10.1037/0735-7028.32.6.573>
- Trawalter, S., Richeson, J. A., & Shelton, J. N. (2009). Predicting behavior during interracial interactions: A stress and coping approach. *Personality and Social Psychology Review*, *13*, 243–268. <http://dx.doi.org/10.1177/1088868309345850>
- Tsang, A. K. T., & Bogo, M. (1998). Engaging with clients cross-culturally: Towards developing research-based practice. *Journal of Multicultural Social Work*, *6*, 73–91. http://dx.doi.org/10.1300/J285v06n03_04
- Tsang, A., Bogo, M., & Lee, E. (2011). Engagement in cross-cultural clinical practice: Narrative analysis of first sessions. *Clinical Social Work Journal*, *39*, 79–90. <http://dx.doi.org/10.1007/s10615-010-0265-6>
- Turner, S., & Armstrong, S. (1981). Cross-racial psychotherapy: What the therapists say. *Psychotherapy: Theory, Research & Practice*, *18*, 375–378. <http://dx.doi.org/10.1037/h0088389>
- Watkins, C. E., Terrell, F., Miller, F. S., & Terrell, S. L. (1989). Cultural mistrust and its effects on expectational variables in Black patient-White counselor relationships. *Journal of Counseling Psychology*, *36*, 447–450. <http://dx.doi.org/10.1037/0022-0167.36.4.447>
- Yi, C. (1998). Transference and race: An intersubjective conceptualization. *Psychoanalytic Psychology*, *15*, 245–261. <http://dx.doi.org/10.1037/0736-9735.15.2.245>

Received September 29, 2016

Revision received March 29, 2017

Accepted March 30, 2017 ■