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DO THERAPISTS ADDRESS ETHNIC AND RACIAL DIFFERENCES IN CROSS-CULTURAL PSYCHOTHERAPY?

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Ethnic and racial differences between client and therapist affect therapy processes and outcomes, but little is known about the extent to which therapists have dialogues about their differences in therapy. A survey on this topic was completed by 689 APA-licensed psychologists with experience conducting cross-cultural therapy. Most psychologists reported having such discussions, but with less than half of their cross-ethnic/racial clients. Therapists and clients were equally likely to initiate discussions. Reasons for discussing differences varied greatly. Therapists consistently described themselves as comfortable with and skilled at these discussions, and reported that discussions facilitated therapy. Therapists who were female, older, nonminority, less experienced with diverse clients, and viewed training as an important factor were more likely to have discussions about differences. Results point to the need to better understand if, when, and how ethnic and racial differences should be addressed in therapy.

Keywords: cross-cultural therapy, multicultural counseling, cultural competency, race and ethnicity

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As the United States population becomes increasingly diverse, greater cultural and ethnic differences will exist in psychotherapy relationships. Cross-cultural[1] psychotherapy dyads are inevitable, and differences between client and therapist may include ethnicity, race, socioeconomic status, sexual orientation, religion, age, and gender. Moreover, clients and therapists possess individual values, attitudes, and worldviews that may not be the same. Understanding if, when, and how therapists should address differences with clients is critical in knowing what works best in psychotherapy and guiding clinical training. Although research has addressed the effects of cultural differences on psychotherapy, there has been little research on what dialogues take place between therapists and clients about their differences. This study surveys therapist practices and attitudes about discussing ethnic and racial differences, and examines therapist characteristics as potential moderators of these practices.

There is a body of research examining how ethnic and racial differences in psychotherapy dyads influence therapeutic processes and outcomes (Comas-Diaz & Jacobsen, 1995; Karlsson, 2005; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Shin et al., 2005). Many process variables have been investigated, including how difference affects therapist clinical judgment and assessment (Russell, Fujino, Sue, & Cheung, 1996), client

[1] The present study focuses on ethnic and racial differences, although other forms of difference such as social class, religion, and sexual orientation are equally understudied. Race, ethnicity, and culture are often used interchangeably, although there are distinct differences in the terms (Abreu & Gabarain, 2000; Betancourt & Lopez, 1993). It is beyond the scope of this paper to discuss the limitations of these labels; however, a clearer understanding of the unique aspects of these constructs will be important in future research. We have used the term “cross-cultural therapy” to refer to therapy dyads in which important cultural differences exist between therapists and clients. Given the vast array of possible differences, one might well argue that all therapy falls into this category.

and therapist self-disclosure (Ridley, 1984; Jenkins, 1990), transference and countertransference (Comas-Diaz & Jacobsen, 1995), and client judgment and preferences for therapists (Coleman, Wampold, & Casali, 1995). For example, therapists may overpathologize a client who is culturally different (Whaley, 1997) or communication may vary as a function of cultural differences, with less self-disclosure when there is dissimilarity between client and therapist (Ridley, 1984; Mehlman, 1994). There is evidence that ethnic and racial minority clients prefer counselors who are similar (Abreu & Gabarain, 2000; Coleman et al., 1995), though some studies find little or no difference in preference (Speight & Vera, 1997; Vera, Speight, Mildner, & Carlson, 1999). Outcome studies have explored the effect of cross-cultural dyads on premature termination, utilization of services, and improvement in mental health status. Some studies have demonstrated that ethnic matching leads to better outcomes, but the results are far from conclusive (Karlsson, 2005). One meta-analysis reviewing seven studies found that clients matched with therapists of the same ethnicity were less likely to drop out of therapy and more likely to attend more sessions; however, the effect was small, indicating that ethnic match alone was a weak predictor (Maramba & Nagayama Hall, 2002). Moreover, a recent meta-analysis of 10 studies evaluating the effectiveness of ethnic matching found no significant difference between ethnic-racial matched dyads and those that are unmatched with respect to staying in treatment and overall functioning for African American and Caucasian American clients (Shin et al., 2005). One factor in the inconsistent findings may be a lack of attention to within-group differences in both clients (e.g., cultural affiliation, racial identity development, acculturation) and therapists (e.g., cultural knowledge, racial identity, experience, communications skills). Findings on the effects of ethnic and racial differences in psychotherapy indicate that cultural differences can have either positive or negative effects and point to the importance of better understanding associated with therapeutic processes.

There has been considerable debate in the literature regarding cultural competency in psychotherapy. The dialogue has centered on what specifies cultural competency and what should be the appropriate role of multiculturism in the mental health profession (Sue, 1998). In the past, multiple standards have been set forth including the APA Guidelines for the Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1993). It is unlikely that proficiency in cultural competency can be completely operationalized given that the achievement of this competency is process-oriented rather than static. Nonetheless, several common dimensions are often discussed in the theoretical literature (Sue, Arredondo & McDavis, 1992; Sodowsky, Taffe, Gutkin, & Wise, 1994). First, therapist knowledge is viewed as critical to the provision of effective or competent treatment. This knowledge would encompass understanding norms, values and beliefs of dissimilar clients, various sociopolitical influences (e.g., the legacy of oppression, White privilege), and other contextual factors impacting the therapeutic relationship (Atkinson & Lowe, 1995; Gonzalez, Biever, & Gardner, 1994). Second, it is also thought that therapists' attitudes and beliefs toward culturally different clients and therapists' self-understanding of their racial, ethnic and cultural identity, and stereotypical views and biases, significantly influence their ability to strive for cultural competency (Helms & Cook, 1999). Further, given the transactional nature of therapy, the interaction between clients' and therapists' racial identities is likely to be very important (Helms, 1984). Third, specific skills, interventions, and strategies have been set forth from various competency models and may include guidelines for providing therapeutic services (Matthews & Peterman, 1998; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994).

In the competency literature, distinctions are made between general counseling skills that may include active listening, empathy, and a collaborative stance (Sodowsky et al., 1994) and the specific skills that are central to working with a client who is culturally different (Matthews & Peterman, 1998). Examples of skill requirements specific to cultural competency are (a) determining effective ways to communicate with a client that may use a different style of thinking, information processing, and communication (Sodowsky et al., 1994); (b) discussing race and racial differences early in the counseling process (Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002); (c) engaging in multiple verbal and nonverbal helping responses (Sue et al., 1992), recognizing responses that may be appropriate or inappropriate within a cultural context; (d) using

resources outside of the field of psychology, such as traditional cultural healers (Leong, Wagner, & Tata, 1995); and (e) modifying conventional forms of treatment to be responsive to the cultural needs of the client (Atkinson & Lowe, 1995). Critics of the work that has been done in specifying cultural competency assert that the requirements are too general and abstract and must go beyond requesting therapists to be more "culturally sensitive." Other theorists in the field have responded that there is no simple methodology or approach that can easily define the "how to" in the therapeutic session with the culturally diverse client (Sue, 1998). Sue (1998) asserts that one of the greatest dilemmas in the area of cultural competency is determining whether therapists are appropriately taking into account cultural issues versus stereotypically placing a lens on their view of the client that may actually hinder the therapeutic process. Discussions regarding ethnic and racial differences may be one of many ways for therapists to be informed about the relevancy of culture with clients as they approach therapeutic assessment and intervention.

It is likely that therapists' views on discussing differences can be understood from three different perspectives: universalistic, particularist, and transcendist (Tyler, Brome, & Williams, 1991). Therapists assuming a purely universalist view would identify common experiences with clients and may believe that identifying differences can interfere with this understanding and reinforce stereotypes (Pinderhughes, 1989; Wohl, 1989). Particularists emphasize differences in human experience and purport that discussing differences is important (Sue & Sue, 1999). Transcendists assert that therapists must utilize both commonality and difference (Tyler et al., 1991) and may or may not choose to address ethnic and racial differences explicitly. At present, there is no dominant view regarding when, whether, or how discussions about differences should take place (Carter, 1995; Gopaul-McNeil & Brice-Baker, 1998; Paniagua, 1998; Pinderhughes, 1989; Sue, 1998; Tyler et al., 1991; Wilkinson & Spurlock, 1986). Analogue studies (Pomales, Claiborn, & LaFromboise, 1986; Rogers, 1998; Thompson & Jenal, 1994; Thompson, Worthington, & Atkinson, 1994) have found that making sensitive responses to clients' concerns about racial issues is preferable to ignoring or avoiding clients' concerns. Some theorists assert that therapists should address differences in the first session (Gopaul-McNeil & Brice-Baker, 1998; Paniagua, 1998), particularly given termination rates as high as 50% after one session for minority clients (Sue et al., 1991). Others assert that differences should not be brought up during a crisis intervention because other mental status priorities would prohibit effective dialogues (e.g., Wilkinson & Spurlock, 1986).

Understanding therapist practices and attitudes about discussing ethnic and racial differences is an important area of research for several reasons. First, although recent recommendations have been offered regarding discussions of differences (Cardemil & Battle, 2003), few empirical studies have addressed actual therapist practices. In one investigation, European American therapists reported on their experience with African American clients and viewed discussing racial differences as important in establishing rapport, forming alliances, and facilitating effective counseling with clients that were different (Fuertes et al., 2002). Second, much of the literature on process and outcome variables provides strong support that ethnic and racial differences in therapeutic encounters matter. In areas where mixed results are found (e.g., ethnic matching), it substantiates the need to know more about this complex human interaction. As a human interaction, psychotherapy is a dynamic process in which both client and therapist responses influence each other (Helms, 1984; Stiles, Honos-Webb, & Surko, 1998). This mutual influence may be particularly relevant in therapeutic situations in which clients and therapists are ethnically and racially different. Third, ethnic and racial minority populations may underutilize mental health services due to system factors that include unavailability of therapists who share the same ethnicity and culture (Flaskerud, 1990; Sue, 1998; Vessey & Howard, 1993). Therefore, when ethnically and racially different clients present to White and European American therapists, the service delivery system should be doing everything possible to improve utilization and effectiveness of needed services. This may translate to knowing more about effective approaches to facilitating dialogues. There is wide agreement on the critical need for future research to understand more about what takes place in psychotherapy when ethnic and racial differences exist between therapist and client (Sue, 1998). Such research will inform theory as well as facilitate culturally competent treatment (Maramba & Nagayama Hall, 2002).

Therapists hold different views of whether it is useful to discuss ethnic and racial differences and when it may be appropriate, useful, and therapeutically beneficial rather than counterproductive (Gopaul-McNeil & Brice Baker, 1998; Paniagua, 1998; Wilkinson & Spurlock, 1986). Some theorists assert that whether therapists choose to address difference may be a product of how they conceptualize culturally competent treatment or of their theoretical orientation or training. We were interested in examining the extent to which therapists discuss ethnic and racial differences with their clients and whether these discussions relate to therapist characteristics, theoretical orientation, training, or experience with diverse clients. Thus, we had several specific goals with respect to describing discussions of ethnic and racial differences in therapy. First, we examine the extent to which therapists and clients discuss ethnic and racial differences in therapy and who initiates discussions. Second, we describe reasons for discussions. Third, we examine therapists' perceptions about their comfort and skill in discussing differences and the perceived benefit of discussions. Fourth, we evaluate therapists' theoretical orientation, experience with diverse clients, age, and gender as potential moderators of discussions and attitudes. Finally, we describe characteristics of those who report being influenced by their training.

Method

Participants

Two thousand psychologists were randomly selected from all APA-licensed psychologists residing in the U.S. who provide mental health services as a primary professional activity. Of the 2000, 808 (40%) returned surveys. Of this number, 34 had retired or exclusively focused on testing, and 85 had had no experience with ethnically different clients in the past two years. The 689 remaining psychologists are the study participants. Their profile is very similar to that provided by APA of all members. They averaged 51.8 years of age (*SD* = 9.1) and 23.6 years of experience (*SD* = 8.3). A slight majority of the participants were female (52.4%). Most of the respondents (93.3%) described themselves as White, 1.6% as Asian, 1.3% as Latino/a, 1.2% as African American, and 2.6% as other. With respect to theoretical orientation, participants most commonly described themselves as cognitive–behavioral (32.2%), eclectic (22.6%), or psychodynamic (22.1%). Other respondents described themselves as integrative (9.3%), psychoanalytic (3.9%), humanistic (2.9%), or behavioral (1.2%).

Procedure

An anonymous survey was used to optimize representative sampling, honest reporting, and generalizability. The survey and an accompanying cover letter were sent through the mail. A follow-up reminder card was sent three weeks later.

Survey Design

The survey was pretested with psychology graduate students and faculty to ascertain question clarity. As a result, several items were reworded or eliminated. Recommendations from APA's Research Division led to further revisions. The final survey contained three sections.[2] The first section consisted of 14 questions regarding experience with ethnically different clients. The second section asked respondents' gender, age, experience, region of residence, work setting, theoretical orientation, ethnic and racial membership, and sexual orientation. These two sections took approximately 10 minutes to complete. The third section was an optional open-ended question asking for descriptions and examples of approaches used in addressing difference with clients, or any general comments. The question read as follows: "Please briefly describe what approaches you have used in the past in addressing difference with clients. You can give an example of a question you may pose or any general statements that you have communicated to your client. Please feel free to also add any comments that you have on the survey topic."

Narrative Analysis

A narrative analysis was conducted based on results obtained from the optional open-ended question. Responses from all 278 psychologists that answered the question (36% of the sample) were utilized. The narrative analysis was conducted prior to the quantitative analysis to mini-

[2] The complete survey is available upon request; MaxieAprile@aol.com.

mize potential biases in interpretation because of the knowledge of the quantitative results. A coding scheme was developed based on a process of analysis recommended by Miles and Huberman (1994). The multistep analysis was conducted by the first author and a research assistant. Initially, all responses were read while taking notes on areas of potential significance. Second, preliminary codes were identified based on major themes and patterns identified in the first step and also influenced by the literature review. Third, a second reading was conducted of all narrative responses for the purpose of systematically applying codes. Fourth, theme documents were created around major categories. Lastly, themes that were weak and lacked sufficient evidence were eliminated during the process. In contrast, other patterns emerged that were not obvious in the initial reading of responses. The narrative data provided information that helped to interpret the results of several survey items.

Results

Descriptive Statistics

Intercorrelations among central variables are presented in Table 1.

Experience with dissimilar clients. Therapists reported working with a considerable number of ethnically dissimilar clients within the previous two years (M = 37.8, SD = 65.7). As the large standard deviation suggests, the distribution of experience was positively skewed (median = 15); 26 therapists reported seeing more than 200 clients. The range of clients seen during this time period was 1 to 500 clients.

Addressing difference. A large majority reported that ethnic/racial differences had been discussed with at least one client during the previous two years (84.5%). However, therapists reported that difference arose in less than half of cross-ethnic/racial therapies (M = 43.0%, SD = 35.1), and that less than half of the therapists they knew discussed differences (44.1%). Therapists indicated that they and their clients initiated approximately equal numbers of discussions (53.7% vs. 46.3%).

Reasons for bringing up difference. On average, respondents selected 2.8 reasons for addressing differences with clients (SD = 1.2). The most frequent primary reasons were "a cultural component to the client's presentation" (39.8%), and "something the client said" (35.9%). Another common reason was "clinical training" (14.0%). Fewer therapists cited "presenting problem" (3.9%), "client self-disclosure is limited" (1.6%), or "session not going well" (0.2%); 4.6% cited "other." An examination of the "other" reasons were placed into five categories: (a) *Reasons related to assessment (6 respondents).* Examples included "during intake to assess comfort level," "necessary information," and "rule out cultural issues versus pathology"; (b) *Reasons related to establishing rapport (3 respondents).* These comments were "trust and rapport building," "I want it to be a topic open for discussion that no one has to tiptoe around," and "establishing and reinforcing rapport"; (c) *Reasons related to the relationship (3 respondents).* These therapists noted, "there are interpersonal difficulties between the client and myself," "transference," and "generally consider relational context"; (d) *Reasons related to helping the therapeutic process (7 respondents).* Examples were "relevant to the therapy," "polite and or helpful," and "to clarify my understanding of what the client is saying";

TABLE 1. Correlations Among Central Study Variables

Variable	Gender	Age	Years	Cases	Discuss	TI	Utility	Comfort	Skill
Gender									
Age	−.16***								
Years of therapy experience (Years)	−.25***	.73***							
# of cross-cultural cases (Cases)	−.08*	.05	−.03						
% cases discussed (Discuss)	.16***	.09*	−.01	−.20***					
% discussions therapist initiated (TI)	.03	.01	−.03	−.06	.31***				
Utility ratings (Utility)	.09*	.07	.02	−.14***	.30***	.14***			
Comfort ratings (Comfort)	−.03	.13**	.11**	.10*	.00	−.04	.15***		
Skill ratings (Skill)	−.00	.18***	.14***	.12**	.07	.04	.13**	.51***	

Note. For gender, men were coded as 0 and women were coded as 1.
* $p < .05$. ** $p < .01$. *** $p < .001$.

(e) *Other reasons (15 respondents).* These included "interpreter in the room," "state medical mandate," "intuitively feels right," "spiritual issues," "on diversity committee," and "relates to parenting styles."

Perceptions of comfort, skill, and utility. Most respondents indicated that addressing differences was similar to addressing other sensitive issues in therapy (80.7%). Very few therapists described this topic as more difficult to address than other issues (7.7%). Almost all therapists described themselves as being either very comfortable (64.4%) or somewhat comfortable (32.9%) addressing differences. Similarly, nearly all therapists rated themselves as somewhat skilled (50.1%) or very skilled (47.2%) at addressing cultural differences. With respect to the resulting benefits, three-quarters of therapists thought discussing differences often facilitates (52.0%) or always facilitates (22.2%) the work they do with clients. Almost all the other respondents viewed the discussions as occasionally facilitative (23.5%). Responses to the question regarding discussions of differences hindering therapy mirrored these results, with almost all therapists indicating that addressing ethnic/racial differences never or only occasionally hindered their work.

Factors Related to Frequency of Discussions and Perceptions About Discussions

Therapist experience with diversity. Less therapist diversity experience was associated with more discussions of differences, $r(549) = -.20$, $p < .001$. No significant relation was found between experience and the proportion of discussions that were therapist initiated ($p = .17$). Greater experience was slightly related to therapists reporting more comfort, $r(636) = .10$, $p = .03$, and skill, $r(689) = .12$, $p = .003$, and with the view that discussions were less facilitative, $r(656) = -.14$, $p < .001$.

Therapist age. Age was slightly positively related to the likelihood of difference discussions, $r(571) = .09$, $p = .04$, and to therapists' reported comfort, $r(686) = .13$, $p = .001$, and skillfulness, $r(689) = .18$, $p < .001$. Age was not associated with ratings of discussion helpfulness ($p = .07$) or whether discussions were therapist initiated ($p = .89$).

Gender. Women were significantly more likely to discuss differences than men (48% vs. 37% of their cases; $t = -3.9$ $p < .01$), and to report that discussions facilitated therapy, $t = 2.3$, $p = .02$. There were no significant differences between men and women in the degree to which the therapist initiated difference discussions or their comfort or perceived skill in addressing differences (all ps $> .48$).

Therapist ethnicity/race. Because a small number of minority therapists responded to the survey, analyses were performed by grouping African American, Asian American, and Latino therapists into one minority category ($N = 28$), although there are obvious and serious limitations to such a diverse grouping. No Native American therapists responded. Those who identified as "other" ($N = 18$) were not included, because of the variety of responses within this category. Minority therapists reported difference arising less often ($M = 28.6\%$ of their cases, $SD = 29.4$) compared to nonminority therapists ($M = 43.9\%$, $SD = 35.3$; $t(554) = -2.4$; $p = .02$). Moreover, minority therapists were less likely to initiate the discussion ($M = 46.5\%$, $SD = 33.1$) than nonminority therapists ($M = 53.4\%$, $SD = 34.4$), though this difference was not statistically significant, $t(548) = -1.0$, $p = .33$). Minority therapists reported greater comfort, $t(652) = 3.1$, $p = .004$, and skill, $t(654) = 2.9$, $p = .007$, in having conversations, with smaller variability on each of these compared to nonminority therapists (ps $< .001$). No differences were found in views of the utility of conversations ($p = .88$).

Theoretical orientation. Theoretical groups differed in the percentage of cases in which discussions arose, based on a one-way ANOVA, $F(7, N = 672) = 4.6$, $p < .001$. Eclectic and cognitive–behavioral therapists had fewer discussions about difference than the total group (38.4% and 36.8% of their cases), while psychodynamic (46.6%), psychoanalytic (74.1%), humanistic (46.8%), and integrative (45.8%) therapists all reported more frequent discussions. No significant group differences were found with respect to the percentage of discussions that were therapist initiated, or regarding the comfort, skill, and utility ratings (all ps $> .10$).

Perceptions of comfort, skill, and utility. Perceived utility of discussions were related to the proportion of cases in which difference discussions occurred, $r = .30$, $p < .001$, and were therapist initiated, $r = .14$, $p = .001$. In contrast, neither comfort nor skill ratings were significantly associated with either of these frequencies.

Multiple regression. Discussions of differences were related to diversity experience, gender, therapist age, and ethnic/racial minority status. Since these characteristics are interrelated (see Table 1), another analysis was conducted to examine their independent influences on discussion frequency. Simultaneous multiple regression allows for the relationship of each independent variable to be estimated, controlling for each of the other independent variables. The overall model was significant, $R = .26$, $F(4, 526) = 9.8$, $p < .001$. Gender ($b = 11.60$, $SE = 3.03$, $p < .001$) and diversity experience ($b = -.09$, $SE = .02$, $p = <.001$) were found to be stronger predictors than age ($b = .40$, $SE = .17$, $p = .02$), but all three independently predicted discussions of differences, controlling for the other independent variables. Minority status was no longer a significant predictor of difference discussions when controlling for the other predictors ($b = 9.86$, $SE = 7.55$, $p = .19$).

Therapists Influenced by Clinical Training

The group that described clinical training as their primary reason for bringing up differences ($N = 61$) did not significantly differ from the rest of the study group on any measured demographic characteristics. All of these respondents reported that differences had come up with ethnically and racially dissimilar clients compared to 84.5% of therapists in the rest of the study group, and the percentage of their cases in which the topic came up was higher (67.9% vs. 42.9%, $p < .001$). These therapists were also much more likely to initiate discussion of difference with their clients (73.4% vs. 53.4%, $p < .001$). No significant differences were identified between the groups on therapists' comfort or skill levels or how facilitative they found discussions (all ps $> .47$).

Narrative Analysis

The optional section requesting descriptions of approaches that therapists used in addressing differences was answered by 278 therapists. Analysis was conducted on all responses. The content of the narrative responses varied greatly, pointing to the complexity and multifaceted nature of this topic. The analysis of these responses resulted in 14 thematic categories, which we have grouped under the larger headings of approaches to, reasons for, and influences on addressing differences. All 14 thematic groups had at least 5 therapist comments, with the larger groups comprising 25 to 50 therapist responses. Table 2 presents examples of each category.

Approaches to addressing difference. Some therapists described using a very *direct approach,* in which difference is acknowledged explicitly. It appeared that these communications were initiated for the purpose of conveying the appropriateness of discussing differences, determining if the client views difference as a problem in therapy, or communicating that there may be limitations in the therapist's cultural understanding. In the latter responses, therapists commented that this was not done to communicate a "lack of qualification" but to express a sincere interest in understanding issues from the client's unique perspective (including ethnicity and race) and to promote a more collaborative working relationship. In addition, many responses supported taking a direct approach for the purpose of putting the client at ease or to facilitate self-disclosure that could be viewed in a cultural context. Responses might then guide therapists in how to proceed in further assessment or therapeutic intervention, or in some cases in providing a referral. Other therapists described an *indirect approach,* in which they do not explicitly state, but rather allude to cultural differences, or ask for clarification about issues that could be culturally influenced. Other therapists reported using *humor* to "break the ice" on a sensitive topic. In these discussions, there could be an exploration of how the client's ethnic and racial background was related to the presenting problem without explicitly discussing client and therapist differences.

Approaches also varied with respect to *timing*. Therapists most commonly described broaching differences in the first session, though others described waiting until the relationship was further developed. Many therapists who brought up differences in the initial session did so within the context of discussing operating practices and confidentiality. Others commented that whether differences was bought up was dependent on multiple assessment factors including client individual characteristics and presenting problems. Some therapists commented that they waited several sessions to bring up differences, which was beneficial because it allowed the client to initiate the discussion. Finally, therapists reported varying stances with respect to taking a *universalist or transcendist view.* Some therapists indicated emphasizing commonalities and minimizing the

TABLE 2. Comments on Discussing Difference

Types of Approaches Described by Therapists in Addressing Differences

The direct approach

For some individuals, working with a therapist of a different race may bring up issues of difference. Do you feel that you would be comfortable bringing up these concerns?

Because you and I come from different backgrounds/cultures, I may ask for clarification at times so that I am fully understanding your experiences. Also, if I ever say something that does not fit your experience or offends you in any way, please call it to my attention.

I am wondering, given the problems you have encountered with White males, how you feel about working with me?

The indirect approach

I usually ask open-ended questions to clients on how racial differences are affecting their experiences at work, at school, and in the community.

Generally, I just try to open the topic of ethnicity/race so that they know that it is not off limits. I also try to communicate that we are on a collaborative enterprise and ask that they try to educate me in reference to their particular experiences in life including race and culture. I want the client to be sure to confront me on any stereotypes or misunderstandings they perceive me to have.

Is there anything that makes you feel uncomfortable about being referred here for treatment?

Humor

You didn't expect to see a bald White man, did you?

Timing

I only initially ask the client in the first interview if the difference in our ethnic and racial backgrounds would cause a problem . . . it never comes up again.

If the client does not bring it up by the third session, I find a way to work it in.

I usually bring up the issue of difference around the third to fifth session.

Universalist or Transcendist view

I approach people as people no matter their ethnic background.

I use ethnic differences the same as other differences, as a process of recognizing there are similarities within the difference just as there are differences within the similarities. It is in respecting both the difference and the similarity that we can be truly intimate.

Reasons Why Differences Are Addressed

Client initiated

I live in a community with a small population of African Americans who feel considerable prejudice. They usually hint about it and I ask directly as follow-up.

My client referred to his wife and church as 'very White bread'; realizing that I, too, am White, was embarrassed and apologetic. I clearly indicated that I took no offense and we proceeded.

Racial and ethnic identity development

I see several biracial children for whom race and identity issues are intertwined. This is just one more issue in working out who they are.

I have biracial clients, and the issue of self-identity always comes up. I've learned never to assume what culture a client most identifies with because of physical appearance.

Language differences

I often ask clients how they feel about conversing in English when it is not their primary language.

Treatment outcomes

While addressing race and ethnicity does not guarantee a favorable outcome, not addressing them almost ensures a limited outcome.

Bringing up difference is modeling a healthy behavior.

Initiating the topic of racial difference is only done by a defensive therapist.

Factors Influencing Therapists in Addressing Differences

Therapist experiences and comfort

My husband is African American. On only three or four occasions have I shared with clients that I am a partner in an interracial marriage, but it has had a very positive impact.

It's probably easier to bring up race than to discuss difference in status, wealth, and even age. We can easily agree it exists and people are often relieved to have it acknowledged.

Therapist discomfort and negative experiences

I have attended classes on racism and had many discussions with friends of color but feel uncomfortable in the fluidity of my discussions.

A couple walked out after the first few minutes. I had sensed their mistrust and anger and talked more than usual, immediately addressing our racial difference. They stormed out, stating that I was talking too much and not listening.

TABLE 2 *(continued).*

Therapist discomfort and negative experiences (*continued*)
I told an African American couple that I could be racist unknowingly, that I hoped not but was watching for that. They never came back.
Collegial support
Some of my colleagues and I have been meeting for a few years to discuss racial/ethnic issues as they arise in ourselves and in our work.
Theoretical orientation
In working analytically, I respond to anything that seems relevant, either because the patient brings it up or ignores it; ethnic issues are no different.
It has not arisen during my sessions, as I am cognitive behaviorally oriented, and we really get down to work.
Training
Classroom teaching of diversity is just a chore unless diversity is part of the student's life.
Graduate programs should do more in this area.

role of ethnicity and race or any other differences that exists between client and therapist. More often, therapist responses indicated taking into account commonalities and differences as important vehicles for working effectively with clients.

Reasons why differences are addressed. Many of the therapist comments touched on their reasons for addressing differences. Consistent with the survey data, many therapists described *client initiated* discussions in which conversations about racism, social and professional isolation, or the therapist's ability to understand were frequently mentioned by clients. Therapists commented that discussions regarding societal racism were likely to come up later in the therapy. The client's discussion of their own experience with racism allowed the therapist the opportunity to question how ethnicity and race were affecting the therapeutic relationship. *Racial and ethnic identity development* was another commonly cited reason, when differences were broached because clients were struggling to define their own racial and ethnic identities. Many responses indicated that this was especially relevant when working with biracial clients. *Language differences* also led to difference discussions in many cases. For example, comments indicated that clients were sometimes asked how they felt about conversing in English when it was not their primary language and questioned whether speaking in the nonprimary language was limiting. Finally, most therapists described their convictions regarding the positive effects of discussions on *treatment outcomes*, while a few described no benefits in discussing difference. With regard to positive treatment outcomes, comments indicated that discussions of difference contributed to an effective therapeutic process and hence positive outcomes; however little was stated related to how respondents defined successful treatment. A few therapists stated they believed they were successful in their work because of continual referrals from prior clients that were ethnically and racially different.

Factors influencing addressing differences. Other comments described influences that therapists identified as important in addressing differences. A number of therapists described personal experiences that influenced their ability in this realm, which we categorized as *therapist experiences and comfort.* Several responses indicated that possessing a relatively high comfort level in confronting issues of difference related to their own experiences in personal relationships with ethnically and racially different individuals or experiences living in diverse communities. Others commented that their own political awareness and activism contributed to being able to converse about differences, racism, and other sensitive topics with more ease. These comments suggested that there was a heightened level of sensitivity because of these diverse experiences. In contrast, fewer therapists provided examples in which they felt *discomfort and negative experiences* in the area of addressing differences. Some comments indicated lacking "skill" and having concerns about making an inappropriate statements or being misunderstood. Several therapists identified *collegial support* in the form of consultation or informal dialogues as important. For example, bringing these issues to a consultation group was described as helpful. *Theoretical orientation* was described as relevant only by a very few therapists. Comments were also made about the lack of *training* in this area.

Discussion

The current study examined the extent to which therapists in cross-ethnic/racial dyads have discussions about differences. Many theorists have postulated about how culture influences therapy processes and outcomes (Carter, 1995; Sue & Sue, 1999). The present research was an initial empirical inquiry into dialogues taking place in cross-cultural psychotherapy. Most therapists (85%) report having discussions about cultural differences with their clients, which is perhaps not unexpected given the importance of race, ethnicity, and culture in our society and their influence in any interpersonal exchange. On the other hand, this high percentage is noteworthy considering the history of race relations in the U.S. and a reasonable presumption of difficulty in having such dialogues (Dovidio & Gaertner, 1998). These findings are consistent with past research demonstrating that many therapists seriously consider cultural and social context in assessing clients' problems (Whaley, 1997; Sue & Sue, 1999) and are supported by therapists' opinions that discussing ethnic and racial differences usually facilitates therapy. The narrative analysis suggests that therapists consider both explicit and implicit discussions of differences important.

At the same time, discussions are reported in less than half of cross-ethnic/racial therapy cases (43%). Some may suggest that this number is relatively high given the multitude of problems and topics that arise in therapy and the difficult decisions both therapists and clients must make in determining what is most useful to therapy. However, given that most cross-cultural dyads do not address differences, it seems likely there are dyads in which ethnic/racial differences are relevant but not discussed.

Therapists and clients are almost equally likely to initiate discussions of differences. Based on the possible power differential in therapy, this result may be surprising (Brown, 1994; Pinderhughes, 1989). This finding should be interpreted with caution, however, because several therapists commented on actively waiting for clients to raise the issue, or reported difficulty determining whether discussions were therapist or client initiated. For example, one respondent stated that these discussions "just evolved" and was not sure who was the initiator. In the current study, there is no way of knowing what variables influenced clients in bringing up difference. The results suggest that clients may view these discussions as critical to their help-seeking and may feel empowered to bring up race, ethnicity, and culture; although the study design does not allow for an estimate of how many clients wish discussions would occur when they do not.

Therapists reported a high level of comfort in addressing cultural differences. We were somewhat surprised that more therapists did not report discomfort, particularly given previous research that found White therapists experience subjective distress addressing race in therapy (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Turner & Armstrong, 1981). There are several possible explanations for this finding. First, most therapists in the study had many years of clinical practice and considerable experience with treating dissimilar clients, and experience with diversity predicted comfort in addressing difference. This is supported by other research that shows therapists feel more comfortable and skilled in the latter years of their professional work in comparison to early in their career (Knox et al., 2003). Older therapists were more likely to engage in dialogues, were more comfortable with such discussions, and perceived themselves as more skilled in addressing cultural differences. They may generally feel more comfortable in their clinical work; hence, their comfort may not be unique to addressing cultural differences with clients (Coleman, 1998). Second, therapists may also be comfortable because so many clients come relatively prepared to initiate these discussions themselves. Finally, it is plausible that psychologists are hesitant to express discomfort. A 52-year-old European American therapist with 23 years of experience (the mean respondent) may find it difficult to report feelings of discomfort in addressing ethnicity and race if this admission is perceived to suggest incompetence.

Respondent experience with diversity was also found to relate to whether discussions of difference occurred; less therapist diversity experience was associated with more dialogues. More experienced therapists may develop expertise that may make some discussions unnecessary (related to education about the client's cultural group) but other discussions still relevant and important (clarifying cultural perspective and worldview, identifying client apprehensions and concerns). This interpretation is consistent with prior research suggesting that therapists perceive greater competency in working with ethnically and ra-

cially different clients the more experience they have with culturally diverse groups (Allison, Echemendia, Crawford & Robinson, 1996). On the other hand, more experience with diverse clients was also slightly associated with a less positive view of discussion helpfulness, perhaps because experience leads to recognition of the complexity of these issues. The narrative data suggest that at least some therapists are cognizant of their own limitations in conducting cross-ethnic/racial work, and many commented on their strong interest in gaining knowledge about their clients' culture.

Female therapists are more likely to report participating in discussions of differences than male therapists. This finding may reflect the fact that female therapists are more likely than male to be direct in addressing the therapeutic relationship, as described by Jones, Krupnick, and Kerig (1982). In this study, men were more likely to report "uneasy intimacy" and accommodate a conflict rather than address it directly. Alternatively, women may be more empathetic and attuned to issues of prejudice, discrimination, racial oppression, and power dynamics because of their own experiences with sexism, and may thus place a higher priority and value on exploring such experiences with their clients.

Minority therapists were less likely to discuss difference than White and European American therapists. These results may be influenced by the high proportion of dissimilar clients that ethnic and racial minority therapists treat in comparison to White and European American therapists. Another possible interpretation is that minority psychologists treat many White and European American clients, and there may be greater actual or assumed shared mainstream culture by therapist and client in these cases. In short, difference discussions may simply be less relevant for White and European clients. If this is true, then minority therapists may feel less need to bring up differences with a dissimilar client that is not a member of a marginalized group. In addition, there are other notable differences in the minority therapist-European American client dyad versus European American therapist-minority client dyad that may inform this finding (Comas-Diaz & Jacobsen, 1995). The underrepresentation of minority therapists in the mental health field makes alternative therapy choices (seeing someone of similar ethnicity and race) more limited for minority clients than European American clients. Therefore, it seems more critical that discussions of difference are initiated by European American therapists with minority clients when it is warranted. However, these hypotheses are very tentative. It is important to note that the number of minority therapists included in the present study was small, and there are obvious limitations to grouping African American, Asian American, and Latino/a respondents. These results are also inconsistent with a study (Knox et al., 2003) that found African American therapists were more likely than European American therapists to initiate discussion about race with clients and to be sensitive to client's discomfort in cross-ethnic/racial dyads. We agree with the researchers' assertion that this may be due to their own experiences with minority status. However, it is difficult to know specifically how minority therapists' own social-racial histories (Tyler et al., 1991) with discrimination may impact how cross-cultural work is approached and whether they choose to bring up differences. Since little is known about the experiences and approaches of minority psychologists, future studies need to answer these and other important questions. Larger samples would allow for further exploration of minority therapist variables.

This investigation did not focus specifically on the role of training, but did provide some perspective on perceptions of training's influence. A fairly small proportion of respondents identified training as a reason for bringing up differences, perhaps because ongoing clinical experiences play the most important role in shaping therapy practices. However, those who pointed to their training as an influence showed a much greater emphasis on difference discussions, suggesting that training can be an important factor in therapist approaches to addressing ethnicity and race. Several respondents commented on the lack of training they had received in this area, so perhaps this pattern will change with the increasing emphasis on diversity training in general (Sue, 1998; Yutrzenka, 1995) and increased attention to difference discussions specifically (Cardemil & Battle, 2003).

Racial identity developmental theory for Whites and people of color (Helms, 1984, 1990, 1995) would suggest that there are significant limitations to predicting the variables investigated in this study based solely on demographic variables such as ethnicity and race. The theory proposes dynamic processes whereby therapist

actions are influenced by their stage of accepting or rejecting racism and also by an interaction with clients' identity development. It is likely that therapists' racial identities are relevant to whether they address racial and ethnic differences and feel comfortable doing so. For example, if a European American therapist is at the beginning stage (contact), there may be oblivion and denial of the effect of racism on the client's presenting problem. There is no consciousness in addressing the issue, hence, the therapist initiates no dialogue. The client's reaction to this omission would depend on their developmental stage, further influencing the process. On the other hand, a therapist at a more mature stage in the model (immersion/emersion or autonomy) may address racial differences and be attuned to the effects of race and ethnicity on the therapeutic relationship. In sum, therapy processes around these issues are complicated and multifaceted; a variety of research foci and approaches will be needed to improve understanding in this area.

There are other limitations to the present study. The survey provided only one method of measurement (self-report). Psychologists are not always aware of their own knowledge gaps and may overreport competencies (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). As previously stated, therapists may be hesitant to admit, either to themselves or on the survey, to their own discomfort. Many White therapists are unaware of White privilege and are likely to underappreciate the importance of discrimination and racial oppression in clients' lives and in the therapeutic relationship (Ancis & Szymanski, 2001; Ivey, Ivey, D'Andrea, & Daniels, 1997). If clients are aware of therapists' lack of understanding, this may increase the importance of racial differences in therapy. Given that therapists and clients often differ in their assessment of how well therapy is going (e.g., Bachelor, 1991; Hersoug, Hoglend, Monsen, & Havik, 2001), there may also be differences in perceptions of how well conversations about race have gone. Given higher dropout rates for ethnic/racial minority clients, it is quite plausible that clients disagree with therapists' reports that discussions are comfortable and helpful. Clients' perceptions of therapeutic alliance tend to have the strongest predictive validity (e.g., Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000), and their perceptions regarding addressing ethnic and racial differences are likely to be critical as well. A better understanding of clients' experiences and views need to be incorporated into future research. It seems clear that discussions about race and ethnicity have the potential to impede or facilitate relationship building and positive therapy outcomes.

Therapists recalled past experiences and estimated the percentage of time they discussed difference. Based on narrative data, this estimation was difficult and thus may be inaccurate, so future studies should include alternative assessment approaches. Also, participating therapists might differ from other therapists in that they chose to respond because they view culture and diversity issues as important. Finally, this study provides little detail about the types of interventions used by therapists in this area. Given the dearth of previous research, we believe the broad survey approach of the present study is an important starting point for understanding what therapists do and what influences their decision making. Nonetheless, in some respects our findings provide a superficial picture. The results do suggest that there is significant variability in therapist approaches, so future studies of counseling processes are needed to more completely understand what occurs in cross-cultural therapy.

With respect to predicting discussions of difference and accompanying attitudes, effects were reliable but generally small. Therapists who are women, older, and have less experience with diversity are more likely to discuss cultural differences, but given that our measures were rough indicators, it is likely that findings underestimate actual relationships. Nonetheless, it is clear that many important factors were not addressed. There are many potential areas for future inquiry including therapists' personal experiences, client characteristics, specific training experiences, and other individual differences. Convergent information using other assessment methods such as client reports or observations should be used. Variables associated with clients bringing up difference should be examined, as well as differences in therapist- versus client-initiated dialogues. More should be learned about the subjective experience of therapists and clients (Pope-Davis et al., 2001). There may be differences in how both the therapist and client address cultural difference with adults compared to children and adolescents, and differences are also likely in individual therapy compared to group, couple, or family therapy. The effects of discussions also need to be better understood. Therapy

is a dynamic process, and results surely differ depending on various factors including context, approach, and timing; ultimately we need to understand when, how, and for whom such discussions are beneficial.

Therapists should strive to be culturally competent in the treatment of all clients regardless of similarities or differences. Since clients are likely to initiate discussions of difference, it is important to know how to engage in such dialogues in working with diverse clients. How successful therapists are in engaging in discussions of difference can be viewed as part of therapist competency. The current study demonstrates that many clinicians discuss difference and perceive themselves to be comfortable and competent in these discussions. However, the reality of high premature termination rates in cross-cultural dyads suggests that these perceptions may not match clients' experiences. Training programs should continue to emphasize multicultural counseling and diversity, and increased research efforts are needed to guide such training. It is likely that clients will prove to be the best teachers in this area.

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