Therapy Experiences of Depressed Black Women Receiving Culturally Sensitive Treatment Delivered by White Clinicians: A Phenomenological Study

by

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TABLE OF CONTENTS

Chapter I: Introduction ........................................................................................................ 1
  Introduction: Problem in Perspective ............................................................................. 1

Chapter II: Literature Review .............................................................................................. 8
  Historical and Contemporary Descriptors of Depression ............................................. 8
  Etiology of Depression .................................................................................................... 12
    The Medical Model ........................................................................................................ 13
    The Psychological Models: Interpersonal and Cognitive/Behavioral ....................... 14
    The Biopsychosocial Model ............................................................................................ 19
  Sociocultural Risk Factors for Depressed African American Women ....................... 22
    Types of Discrimination ............................................................................................... 23
    Sociodemographic Variations ...................................................................................... 24
    Racism and Mental Health ............................................................................................ 31
    Intersection of Racism, Sexism, and Depression ....................................................... 38
      Sexism: Definition and Impact on Mental Health ..................................................... 39
      Intersection of Sexism and Racism ......................................................................... 42
    Poverty and Depression ............................................................................................... 48
      Prevalence and Context of Poverty .......................................................................... 48
      Poverty and Depression for African American Women .......................................... 50
  Treatment for Depression ............................................................................................... 55
    Effectiveness of Psychotropic Medication .................................................................. 55
      Psychotropic Medication and African American Women ........................................ 58
    Effectiveness of Psychotherapy .................................................................................. 62
      Psychotherapy and African American Women ......................................................... 65
  Factors Influencing the Experience of the Therapeutic Process ................................. 70
    Extratherapeutic Factors ............................................................................................. 72
    Therapist Factors ......................................................................................................... 77
    Relationship Factors ................................................................................................... 80
    Treatment Model/Technique Factors .......................................................................... 86
  African American Women’s Experience of Psychotherapy ............................................ 92
   Conclusion ..................................................................................................................... 97
   Purpose of Study .......................................................................................................... 98

Chapter III: Methodology .................................................................................................. 99
  Qualitative Methodological Framework: Transcendental/ Psychological Phenomenology .................................................................................................................................................. 99
  Design ............................................................................................................................ 102
CHAPTER IV Results ........................................................................................................... 128
Participant Demographic Information ................................................................. 129
Theme One: Preconceptions of Group and Facilitators ............................................. 131
Theme Two: Critical Incident .............................................................................. 135
Theme Three: Process of Healing ....................................................................... 137
Theme Four: Therapeutic Qualities of Facilitators .................................................. 141
Theme Five: Cultural Differences Not a Barrier
to connecting to Facilitators ................................................................................ 145
Theme Six: Therapeutic Gains ............................................................................. 147
Invariant Structure: “Essence” of the Phenomenon ............................................... 152
Quantitative Data ................................................................................................... 156

CHAPTER V Discussion ................................................................................................. 160
Extratherapeutic Factors: Importance of Open/Flexible Attitudes and Affirming Environments ........................................................................................................... 161
Unanticipated Preconceived Cultural Barriers ......................................................... 168
Therapeutic Factors: Empathy, Transparency, and Willingness
to Learn Decreases Salience of Difference ............................................................. 170
Group Dynamic as a Buffer for Racial Barriers ....................................................... 175
Culturally Adapted Treatment: Implications of Cross-Racial Therapy .................. 179
TABLE OF CONTENTS CONTINUED

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom Relief</td>
<td>187</td>
</tr>
<tr>
<td>Limitations</td>
<td>187</td>
</tr>
<tr>
<td>Future Research</td>
<td>190</td>
</tr>
<tr>
<td>References</td>
<td>193</td>
</tr>
<tr>
<td>Appendices</td>
<td>233</td>
</tr>
<tr>
<td>Appendix A: Coping with Depression Course/Oh Happy Day Class</td>
<td>233</td>
</tr>
<tr>
<td>Session Content Summary</td>
<td>234</td>
</tr>
<tr>
<td>Appendix B: AUDIT</td>
<td>235</td>
</tr>
<tr>
<td>QIDS$_{16}$</td>
<td>236</td>
</tr>
<tr>
<td>Appendix C: Demographic Questionnaire</td>
<td>238</td>
</tr>
<tr>
<td>Appendix D: BDI-II Questionnaire</td>
<td>238</td>
</tr>
<tr>
<td>Appendix E: Interview Protocol</td>
<td>243</td>
</tr>
<tr>
<td>Appendix F: Suicide Prevention Protocol</td>
<td>247</td>
</tr>
<tr>
<td>Appendix G: Resources for Participants</td>
<td>251</td>
</tr>
<tr>
<td>Appendix H: Recruitment Flyer</td>
<td>252</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1  Summary of Participant Demographic Information……………………… 131
Table 2  Summary of Themes and Textural Descriptors…………………………… 151
Table 3  Symptom Reduction Results…………………………………………… 158
Table 4  Graph of Symptom Reduction Trend…………………………………… 159
ABSTRACT

Nearly 60% of Black women experience symptoms of depression at some point in her life. Similarly, they have the highest prevalence of depressive symptoms among other racial groups. Despite high prevalence and risk factors, there remains a paucity of literature aimed at treatment for this group. Specifically, little is known about the experiences and outcomes of this population in psychotherapy, which is an established treatment for depression. Recent research suggests that race can influence the experience of therapy and that racial and ethnic minorities benefit from culturally adapted treatment (CAT). However, research examining culturally sensitive treatment seldom examines treatment within a cross-racial context.

The purpose of this study was to understand the experiences of Black women receiving culturally sensitive care within a cross-racial context. Utilizing a mixed method phenomenological approach, six Black women experiencing symptoms of depression participated in 12-week culturally-sensitive group counseling treatment that was provided by two European American clinicians. The women completed the BDI-II at baseline, week 6, and week 12 of treatment. After treatment was complete, the participants were interviewed about their experience of therapy.

Results demonstrated that the participants reported initial skepticism regarding working with European American clinicians and felt the group would not be helpful. However through forming connections with other group members and becoming more comfortable with the facilitators, the women reported having a positive experience. Participants identified therapist characteristics such as being real, non-judgmental, being open to learning from others, and caring as important factors contributing to having a positive experience. They also discussed race not being an issue as the group progressed. Quantitative data demonstrated no significant
differences in symptoms reduction; however the trend of the data was consistent with symptom reduction and report of the participants.

The implications of this study suggest further exploration of the effectiveness of delivering CAT within cross-racial contexts. The experiences of the participants suggest that for some Black women cultural mistrust is experienced within cross-racial contexts but other factors (e.g. therapist factors, group dynamics) can assist with reducing the perception of cultural difference as a barrier. Implications for clinical practice and training are discussed.
CHAPTER I

Introduction

Problem in Perspective

“Who is going to be our therapist after you leave?” was the question a former client asked after inquiring if I was going back to California after finishing graduate school. She indicated that working with another Black\(^1\) individual made her feel more understood and that other Blacks in our community would benefit from having me stay after completing my studies. Although touched by the feedback that I had been a helpful therapist, her comment made me ponder the degree to which my race played a role in her positive experience. Behind her comment was the assumption that her experience of therapy within a cross-racial context would be less positive and affirming. The reality is that only 2% of psychologists self-identify as Black (American Psychological Association [APA], 2007). Therefore the probability of Black individuals working with Black clinicians is low. The conversation with my former client is representative of the need to address and improve the experience of cross-racial therapy.

Cross-racial therapy occurs when there are racial differences between therapists and clients. It is estimated that by 2050 nearly half of the United States population will be comprised of racial and ethnic minorities (U.S Census Bureau, 2001). Consequently, the experience of cross-racial therapy will be increasingly more common. Race often shapes or influences our culture and worldview or how we understand the world to work. Within the context of cross-racial therapy, differences in culture and worldview (which can be attributed to one’s race) between the therapist and client may become more salient. Ultimately, how therapists and clients respond to and negotiate their cultural differences can impact the therapeutic process. Given the

\(^1\) The term “Black” is used to characterize people of African descent regardless of ethnicity (e.g. Cuban, Jamaican, or Nigerian).
ever changing demographics within the United States, it is imperative that psychologists are able to conduct therapy effectively with racially and ethnically diverse groups.

The American Psychological Association has responded to increased diversity within the United States through (1) encouraging graduate training programs to address and integrate issues of race into the curriculum (APA Committee on Accreditation, 2002), (2) creating cultural competency guidelines for conducting psychotherapy with culturally diverse populations, (APA, 1993), and (3) supporting professional meetings focused on developing strategies to promote cultural sensitivity within psychology (McGuire, 1999). In addition, scholars have suggested that culturally adapting treatments (CATs) to meet the need of specific cultural groups may be one way to address culture within the therapeutic process (Domenech-Rodríguez & Wieling, 2005; Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Whaley & Davis, 2007). Culturally adapted treatment is defined as “any modification to an evidence-based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components in the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population” (Whaley & Davis, 2007 p. 570-571). Although research concerning CATs is relatively new, findings indicate that cultural adaptations are effective in the treatment of racial and ethnic minorities (REMs) with mental health concerns (Griner & Smith; 2006). Unfortunately the majority of CAT studies examine treatment within a mono-racial context (Carrington, 2006). Consequently there is no evidence regarding the effectiveness of CAT delivered within a cross-cultural context.

Despite the attention to cultural sensitivity within psychotherapy, for many REMs, particularly African Americans, there remains a preference for experiencing therapy with a clinician who is of the same race (Helms & Carter, 1991; Morten & Atkinson 1983; Thompson,
Bazile, & Akbar, 2004; Townes, Chavez-Korrell, & Cunningham, 2009; Want, Parham, Baker, & Sherman, 2004). Scholars have suggested that historical and present experiences with racism, have contributed to some African Americans developing a mistrust of working with European American health professionals (Terrell & Terrell, 1984; Whaley, 2001). Although strides within professional psychology have been made through integrating and addressing cultural competency of clinicians within training and adapting treatment to meet the needs of specific cultural groups, little research addresses the subjective experience of cross-racial therapy for African Americans. Thus there is limited empirical evidence which describes that actual experience of African Americans in cross-racial therapy. Receiving even less attention is the experience of psychotherapy for African American women, a group highly underserved within the mental health system and at risk for developing depression (Carrington, 2006; Barbee, 1992; Jackson & Williams, 2006).

Gender is an important variable to address with regards to the development of depression. Research findings have consistently concluded that in adulthood women are twice as likely as men to develop depression (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1992; Luct et al., 2003; Piccinelli & Wilkinson, 2000). An in depth review of literature regarding gender differences for depression for the general population is beyond the scope of this literature review. However possible explanations for gender differences in the development of depression include higher ruminative coping among women (Holen-Hoeksema & Girgus, 1994), genetic factors (Kendler, Gardner, Neale & Prescott, 2001; Zubenko, Hughes, Maher, et al. 2002), experiences of rape or child sexual abuse (Kendler, Gardner, & Prescott, 2002), adherence to traditional gender roles (Aube, Fichman, Saltaris, & Koestner, 2000), and greater cognitive vulnerability (Hankin & Abramson, 2001). Hyde, Mezulis, and Abramson (2008) were one of the first
scholars to design an integrative model addressing affective, biological and cognitive factors in the emergence of gender differences in depression. The authors postulated that affective, biological, and cognitive factors that interact with negative life events (e.g. sexual abuse) increase rates of depression for adolescent girls and may account for gender difference in depression.

The California Women’s Health Project indicated that approximately 60% of African American women experience symptoms of major depressive disorder (MDD) at some point in their life (California Women’s Health Project; CAWHP, 2010). For example, in a study of depression, African American women reported experiencing depression at rates twice that of their White counterparts (Kessler, 1995). Similarly, in a study of prevalence rates of depressive symptoms in a national sample of middle-aged women, African American and Hispanic women reported the highest rates of depression (Bromberger, et al., 2004). Sociocultural factors unique to African American women are believed to place them at a high risk for developing depression. According to Satcher (2001), women of color encounter similar health concerns as European American women; however, since women of color encounter cultural, social, and economic barriers “they are in poorer health, use fewer health services, and continue to suffer disproportionately from premature death, disease, and disabilities,” (p. 199). Clearly MDD is a challenge that influences African American women at alarming rates. It is crucial that more research focus on the treatment of depression for this population.

Complicating the fact that African American women are at risk for developing MDD is the low utilization of mental health services by this group. Use of mental health services by African Americans is low compared to European Americans (U.S. Department of Health and Human Services, 2001), with these low rates consistent across the lifespan for African American
women (Barbee, 1992). Barriers to treatment for African Americans in general include lack of access to resources (Chow, Jaffe, & Snowden, 2003), cultural mistrust of the health care system and providers (Nickerson, Helms, & Terrell, 1994) and negative attitudes toward seeking professional psychological help, or stigma (USDHHS, 2001). Even when such barriers are addressed, African Americans are still twice as likely to drop out of therapy after one session (Sue, 1990; Sue 1999; Wierzbicki & Pekarik, 1993). As aforementioned, some scholars have postulated that cultural insensitivity within the therapeutic process may create an uncomfortable experience which prevents African Americans from returning to therapy (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Whaley & Davis, 2007; Sue, 1999). Consequently, developing culturally-adapted treatments (CATs) can address the cultural needs of clients and create a positive therapeutic experience.

Research findings have evidenced that culturally adapted treatments are effective and preferred for African American women with depression (Carrington, 2006; Kohn et al., 2002). Kohn and colleagues (2002) examined treatment preferences of 12 depressed African American women. The participants were given a choice to participate in a traditional (non-adapted) group or a culturally adapted group. Ten of the 12 (83%) participants preferred the culturally adapted group to the traditional group, and outcomes indicated a significant decline in symptoms. The culturally adapted treatment was grounded in theories related to African American culture/identity and addressed issues specifically related to African American women (e.g. African American female stereotypes and African American family structure). However, since this study focused more on the acceptability and outcomes of a CAT, the authors did not provide data on the race and ethnicity of the therapists used for the study. Therefore it is unknown whether the women in this study experienced the CAT within a cross-racial context.
As aforementioned, the rate of cross-racial therapeutic contexts is increasing. Undeniably addressing race and culture may become a highly integral component of the therapeutic process. Culturally adapted treatments are designed to address the cultural needs of clients and tend to integrate theories grounded in a particular culture. In addition, in the lead researcher’s review of CATs specifically designed for African Americans, treatment tend to address issues related to racism, discrimination, and stereotypes (e.g. Kohn, Oden, Munoz & Robinson, 2002).

Historically, race and racism within the United States has been a highly controversial and emotionally-charged topic, particularly when discussed within cross-racial contexts. Given the difficulty that comes with discussing race, it is possible that African American women’s experiences of addressing race in therapy may be impacted by the race of the therapist. Therefore it is important that we not only examine the effectiveness of CATs, but also the experience of CATs delivered within a cross-racial context.

Understanding African American women’s experience of a CAT within the context of cross-racial therapy is warranted to improve services for underserved groups. African American women are highly underserved and at risk for developing depression. Studies examining CATs tend to utilize therapists who are racially-similar to participants. Racial matching as a key component of CAT is unlikely to occur because only 2% of psychologists are self-identified as clinicians of color. Since empirical evidence suggests that CATs are effective in treating African American women, it is important that CATs can be effectively delivered by European American clinicians. Therefore it is important to examine the experiences of African American women receiving a CAT delivered by European American clinicians.

Virtually no research to date has examined the experience of depressed African American women receiving a CAT delivered by European American clinicians. Furthermore, no research
to date has examined the clinical outcomes of a CAT delivered by European American clinicians. Therefore the purpose of this current study is to examine the subjective experiences and clinical outcomes of depressed African American women engaged in a culturally adapted group counseling treatment that is delivered by European American clinicians.
CHAPTER II

Literature Review

The goal of this chapter is to provide an in-depth analysis of relevant literature pertaining to the experiences of depressed African American women in cross-racial therapy with European American therapists. This chapter is organized into two primary topic areas. The first part orients the reader to depression through a discussion of definition, etiology, and treatment of depression. In particular, literature is reviewed and critiqued on its applicability to African American women. Specifically, it is argued that traditional etiological models of depression limit the understanding of the development of depression for African American women. A biopsychosocial approach is discussed as the framework which best addresses the unique risk factors that are specific to African American women in developing depression. In addition, a review and critique of traditional treatment models and their applicability to African American women is provided. In the second part of this chapter, the focus shifts to the therapeutic process and factors that contribute to the experience of therapy. Given the current study’s focus on African American women in cross-racial therapy, the review of the therapeutic process will specifically address how race influences the experience of therapy this group.

Historical and Contemporary Descriptors of Depression

Within a Western context, scholars have described the term depression as an emotion, a fleeting frame of mind, a mood, a symptom, and a disease (Jackson, 1985). The experience of sadness or dejectedness in one’s life and its impact on an individual’s health has been an area of interest for scholars dating back to ancient Greece. Melancholia is perhaps the most well-documented early Western conceptualization of what modern science would classify as “clinical
depression” (Jackson 1985). Hippocrates in the 5th and 4th century B.C. described melancholia as “an aversion to food, despondency, sleeplessness, restlessness, and irritability” (Hippocrates [Jones and Wirthington, trans.] 1923-31 p.185 as cited in Jackson, 1985). In the years to follow melancholia was understood as a chronic illness that was unassociated with a fever, in which those afflicted would experience fear, failure to thrive, sadness, guilt, and at times delusions (Jackson 1985). In fact melancholia was believed to be “a partial insanity with sound mental functioning outside the limits of a single circumscribed delusion” (Jackson, 1985, p. 44). Over the years, the nonpsychotic and manic-like symptoms of the illness became more isolated and the term “depression” came into use to describe the remaining cluster of symptoms (Jackson, 1986).

Depression as it is known today is described as a chronic and at times a debilitating mental illness that is classified as a mood or affective disorder (American Psychiatric Association [APA], 2000). A mood disorder refers to a group of psychiatric disorders that are marked by a pervasive disturbance of mood (or prolonged experience of emotion), which cannot be attributed to a physical or other mental or substance abuse disorder (Gayle Encyclopedia of Medicine, 2008). According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), which is the nosology used by mental health professionals to diagnose mental illness, symptoms of depression cluster into emotional, behavioral, physiological, motivational and cognitive realms (APA, 2000). Some specific symptoms include: feelings of sadness, guilt, hopelessness, anhedonia (lack in pleasurable activities), sleep disturbance, sexual dysfunction, reduced social interaction, lack of motivation, trouble concentrating, and memory loss. According to the DSM-IV-TR, for an individual to be diagnosed with major depressive disorder (MDD), at least five (or more) symptoms need to be
present during a 2-week period of time and at least one of the symptoms has to be depressed mood or loss of interest or pleasure.

Major depressive disorder is the mental health concern that this current study will focus, however it important to note that there are other types of commonly-experienced depression. Dysthymia is characterized a low grade depression, in which symptoms must be present for at least two years to be diagnosed (APA, 2000). The symptoms are similar to those present in MDD; however they may be experienced at a lower severity. Depression in general can be experienced at different levels of severity. Mild depression is typically categorized when experiencing some of the symptoms of MDD while remaining fairly functional in one’s life. Moderate depression includes experiencing more symptoms and at a more intense level. Individuals experiencing moderate depression may still be functional but have days where they find it difficult to get out of bed, begin to isolate themselves from others, or have fleeting suicidal thoughts. Severe depression is marked by experiencing many symptoms at an intense level, disruption or challenges with completing day to day tasks (e.g. bathing, working, getting out of bed), and concrete and persistent suicidal thoughts, plans or possible attempts (APA, 2000).

It is important to note that not all cultural groups experience depression or other mental illnesses in the same manner. In fact the most recent publication of the DSM-IV-TR includes a section on “culturally bound syndromes,” which address how mental illness symptoms may manifest for different cultural groups. For example, scholars acknowledge the role of culture in how depression is conceptualized, experienced, and treated (Bernal & Schorron-Del-Rio, 2001; Kleinman & Good, 1985; Miranda, et al., 2006; Sue, 1999). Kleinman and Good (1985) contended that the cultural construction of depression depends on how a culture constructs
everyday feelings, such that “affect comes into consciousness when a state of psychobiological arousal is given shape by cultural judgment (the process of assigning an emotion label) made by individuals who suffer the arousal” (p. 103).

In using a framework that accounts for culture, symptoms of depression may be experienced differently by other groups. Specific to African American women, scholars reported that the expression of nontraditional symptoms of depression (Greene, 1994; Pickering, 2000). For example, Jones and Shorter Gooden (2003) described depression for African American women as the “sisterella complex,” which is a cluster of depression symptoms that includes an inability to relax, inability to attend to one’s needs, an over emphasis on working very hard (job tasks, child care), feeling unworthy, and suffering quietly. The “sisterella complex” differs from “traditional” conceptualizations of depression in that it is marked by an unhealthy increase in activity whereas traditional notions of depression are indicated by a decrease in activity and withdrawal from engaging in day to day functions. Increased activity when in the face of life challenges is a culturally prescribed response in that within African American culture, women are socialized to be “psychologically strong” and to “keep on keeping on” despite challenges or setbacks in life (Greene, 1994). There is currently no empirical data supporting the existence of a “sisterella complex;” however Greene and other scholars (e.g. Jones & Shorter Gooding, 2003; Pickering, 2000) contend that cultural manifestations of mental health concerns must be addressed within therapy, particularly in regards to depression.

Depression can have a devastating impact on an individual’s life and her or his loved ones. Left untreated, depression has been associated with lower quality of life (Frank, Matza, Revicki, & Chung, 2005), relational and family problems (Boyd, Henderson, Ross-Durow, & Aspen, 1997), increased risk for substance abuse (Najavits, Weiss, & Shaw, 1999), poor
compliance with medical treatment (Kim et al., 2003), and increased risk for suicide (Coryell & Young, 2005). For African American women, untreated depression can lead to increased prevalence and incidents of psychiatric and medical conditions (Pickering, 2000). Given the effects that depression can have on one’s life, accurate understanding of how it develops and how to treat it merits exploration. The following section explores how scholars understand the development of depression.

**Etiology of Depression**

How depression develops is a question which has plagued scholars for centuries. The Greek physician Hippocrates believed that melancholia (depression) resulted from an imbalance in bodily fluids or humors, which consisted of blood, yellow bile, black bile, and phlegm (Jackson, 1986). Today, there remains no clear understanding of how depression develops and scholars continue to grapple with fully understanding how individuals develop depression. Within the literature there are three primary models of understanding depression: (1) the medical model, (2) the psychological model, and (3) the biopsychosocial. Although the medical model, psychological model, and biopsychosocial model of depression are presented separately, it is important to highlight that in clinical practice integrating these models is not uncommon. However, these frameworks were conceptualized independently of one another, and thus are presented separately.

The following sections will review the three models to provide a foundational understanding of how the etiology of depression is viewed within the field of psychology. Understandably, how depression is conceptualized directly influences the approach to treating it. However, for the purposes of this section of the literature review, the distinction between etiological models and treatment models is necessary to discuss. For the purposes of this review,
etiological models are conceptualized as theoretical frameworks that are used to understand the development of depression. In contrast, treatment models are conceptualized as actual clinical interventions or psychotherapies that are used to treat depression. Therefore this section will focus exclusively on the development of depression and not the efficacy of treatment models. The treatment of depression is addressed in another section of this review. The following section will specifically provide critiques of the three primary models, with special attention to cultural factors, and provide support for the biopsychosocial model as a means to understand the development of depression for African American women.

*The Medical Model:*

The primary notion of the medical or biological model for depression is that it is a medical illness (Rusch, Kanter, & Brodino, 2009). The medical model focuses on the genetic nature of depression and posits that genetic or biological deficits lead to an individual developing the illness (Rusch, Kanter, & Brodino, 2009). More specifically, hypotheses grounded in the medical model focus on dysfunction in the brain, primarily neurotransmitters, leading to depression. Neurotransmitters are chemicals in the brain that serve as messengers which carry signals from one neuron to another cell. The neurotransmitters of serotonin, dopamine, and norepinephrine, are believed to play a role in the development of depression. Specifically, it is the activity of these chemicals (either being too high or too low) which are thought to cause depression (McAllister-Williams & Young, 1998; National Alliance on Mental Health; NAMI, 2000). McAllister-Williams and Young (1998) reviewed the pathophysiology of depression focusing on the role of serotonin and corticosteroids. In their analysis of literature regarding serotonin, they concluded that scholars know the pharmacology of selective serotonin reuptake inhibitor (SSRIs) medication, however the development of depression remains unclear.
McAllister-Williams and Young (1998) ultimately concluded that it is still unknown what causes neurotransmitters to work improperly in understanding depression. Despite continued limited knowledge, the medical model perspective has been useful in the promotion of developing effective medications to treat depression (Parish & Peden, 2009; Wells, Tang, Miranda, Benjamin, Duan, & Sherbourne, 2008; Papakostas, Shelton, Smith, & Fava, 2007).

Another strength of the medical model is that this approach to labeling depression as a medical illness may possibly decrease stigma. For example, on the National Alliance on Mental Health’s (NAMI, 2000) website depression is described as a “medical illness,” much like diabetes. Similarly, mental illness is described as a “brain disease.” By utilizing more medical friendly terms, traditionally stigmatized descriptors and derogatory labels may be reduced.

Despite the strengths of the medical model, its primary focus addresses the biochemistry of individuals and does not address how psychological processes may account for the development of depression. As Engle (1980) classically argued, “the crippling flaw of that [medical] model is that it does not include the patient and his attributes as person, a human being” (p. 536). What Engle is alluding to is that fact that one’s psychology, personality or environment is not addressed. In not addressing a person within her or his context, social and cultural variables that may be important factors that may not be addressed. Depression is conceptualized as a disease of the brain within the medical model framework and therefore does not address the psychological and social influence of depression.

The Psychological Models: Interpersonal and Cognitive/Behavioral

While the medical model focuses on the individual from a biological perspective, psychological models of depression focus on how one’s interpersonal, cognitive, and behavioral patterns can influence the development and maintenance of depression. Psychological models
for understanding depression are grounded in psychological theory such as interpersonal theory (Sullivan, 1968) and cognitive-behavioral theory (Beck, 1976). Before discussing specific psychological models of depression, it is first important to make a distinction between psychological models of depression and psychological theory. Psychological models of depression are frameworks designed to address specifically the development of depression. In contrast, psychological theories are paradigms designed to understand healthy human functioning and how psychopathology, in general, can emerge. There are numerous psychological theories such as Psychodynamic theory (Freud, 1964), Gestalt theory (Perls, 1969), and Family Systems theory (Satir, 1967); each individual theory can influence how a particular model for depression is conceptualized. Given the high correlation between models and theories, the explanation and critiques of the psychological models for depression will indirectly reflect the theory for which it is based.

In performing a literature search for psychological models of depression, interpersonal theory and cognitive-behavioral theory emerged as the most prevalent frameworks influencing specific models for understanding depression (Hass & Fitzgibbons, 1989; Klerman, 1989; Murphy, Sahakian, & Carroll, 1998). The lead researcher of this present study determined that these approaches were the most prevalent given that: (1) they have a long history of use in influencing psychological models of depression and are considered classical approaches to treating depression (Klerman, 1989), (2) they were the most frequently used psychological theories that scholars explicitly published theoretical models focused on how depression develops (Beck, 1976; Driessen, & Hollon, 2010; Stuart & Robertson, 2003; Teyber, 2000; Weissman, Markowitz, & Klerman, 2000; Westbrook, Kennerley, Kirk, 2007) and (3) current literature examining the effectiveness of treatment for depression frequently tests cognitive-
behavioral and interpersonal treatments (Elkin et al. 1989; Kellett, Clarke, & Mathews, 2007; Luty, Carter, McKenzie, Rae, Frampton, Mulder, & Joyce, 2007; Rossello, Bernal, & Riviera-Medina, 2008; White, 2000).

The classic understanding of the interpersonal psychological model of depression focuses on the importance of attachment and social bonds to human functioning (Arieti, & Bemporad, 1978; Becker, 1974; Fromm-Reichmann, 1960; Klerman, 1989; Sullivan, 1953). Specifically, Attachment theory is based on the seminal work of John Bowlby (1969). According to the Attachment theory, people have a natural and innate tendency to seek attachments from others to survive and receive individual satisfaction. Attachments are made early in life through social bonds or connections with their primary caregivers. From an interpersonal psychological model, depression is an emotional response to a disruption in attachment, which leads to challenges in making connections and forming health relationships with others (Arieti, & Bemporad, 1978; Fromm-Reichmann, 1960; Stuart & Robertson, 2003; Teyber, 2000; Weissman, Markowitz, & Klerman, 2000). Ultimately attachment theory suggests that the ability to navigate life stressors is heavily influenced by how individuals utilize relationships to navigate challenges.

One challenge with interpersonal and cognitive models, however, is the lack of attention to the social and cultural contexts wherein relationships are formed. Although interpersonal models for depression focus on how relationships are formed and one’s network of relationships, there remains an emphasis on one’s interpersonal behavior; the assumption that one must be flexible in using relationships to navigate challenges assumes that the individual must change and pays little attention to sociocultural systems (e.g. racial discrimination) that may need to change (Murdock, 2004; Sue & Sue, 2003). As Murdock (2004) stated in her critique of interpersonal approaches “these approaches may neglect the influence of oppression and
discrimination in people’s lives” (p. 348). Not addressing how the context of oppression and discrimination may influence relationships could significantly impact how we understand the development of depression from an interpersonal perspective for groups who experience discrimination, such as persons with disabilities, gay, lesbians, transgendered, and queer individuals, women, or racial and ethnic minorities, such as African American women.

Another psychological model for depression is the cognitive/behavioral model. The model focuses on the ways in which one’s behavior and mental representations influence depression (Beck, 1976; Driessen, & Hollon, 2010; Westbrook, Kennerley, & Kirk, 2007; Wright & Beck, 1996). The premise of cognitive models assumes that cognitions or thoughts are the primary determinant of emotional and behavioral aspects of depression (Beck, 1976; Beck, Shaw, Rush, et al., 1979; Westbrook, Kennerley, Kirk, 2007; Wright & Beck, 1996). Aaron Beck is historically the most associated with cognitive behavioral approaches and his classic theory of depression posits that depression results when there are errors in processing information, which in turn impede one’s ability to problem solve due to erring on the side of negative schemas and negative views about self, others, and the future (1967). Over the course of several decades a myriad of theory and data-based research identifies how one’s thoughts impacts behavior, and ultimately results in how one feels.

In a seminal review of cognitive psychological models of depression, Hass and Fitzgibbon (1989) identified four hypothetical constructs which impact depressed mood: (1) cognitive schemas, or an abstract, internal, and experienced based representations that organizes, guides, and stores incoming information, (2) cognitive-diathesis-stress mechanisms, which suggests that schemas are activated by environmental stressors, (3) cognitive attributions, which are patterns of cause-effect thinking that are conditioned and internally consistent, and (4) covert
behavior, which are cognitive events that conform to classical conditioning and operant models of learning. These four components are found in some variation in most cognitive-behavioral models of depression (Driessen, & Hollon, 2010; Hass & Fitzgibbon, 1989; Westbrook, Kennerley, Kirk, 2007). The consistency of these components of Cognitive Behavioral models suggests that they are important ingredients to understand depression.

Like the interpersonal model for depression, cognitive behavioral models have also been critiqued based on the lack of addressing culture (Davis & Padesky, 1989; Mudock, 2004; Scorzelli & Reinke-Scorzelli, 1994; Sue & Sue, 2003). Similar to the interpersonal model, the cognitive-behavioral model is based on Western European beliefs, which assume that an individual is responsible for her or his fate; again, such value does not account for how one’s culture or social contexts may influence one’s thought process. In applying this theory for an African American woman the following scenario raises questions regarding the factors that contribute to the development of depression. For example, consider an African American woman who is employed in a predominantly European American and male dominated company experiences gender and racial discrimination, which influences her feeling uncomfortable and stressed in her environment. According to the cognitive behavioral models, she may engage in a cognitive pattern that reflects negative schemas and negative views about self, others, and the future. However, for this woman is her thinking maladaptive or is her environment maladaptive? This question reflects the challenge that can occur when culture and social context are not addressed. Without understanding the individual in context, the risk of missing important factors that may contribute the developing depression increases.

Summary
Medical and psychological models are conceptual frameworks for how depression is formed and maintained for individuals. Both models have advanced the field of psychology in treating depression. Specifically, the medical model has lead to the advancement in developing psychotropic medication for depression (Mann & Kupfer, 1993; Parish & Peden, 2009; Papakostas, Shelton, Smith, & Fava, 2007; Wells, Tang, Miranda, Benjamin, Duan, & Sherbourne, 2008). In addition, interpersonal and cognitive behavioral psychological models for depression have been influential in advancing specific interpersonal and cognitive behavioral interventions for depression (Elkin et al. 1989; Kellett, Clarke, & Mathews, 2007; Luty, Carter, McKenzie, Rae, Frampton, Mulder, & Joyce, 2007; Rossello, Bernal, & Riviera-Medina, 2008; White, 2000). The medical model provides a great conceptualization for how one’s biochemistry can influence depression, whereas psychological models provide an excellent framework for understanding how individual factors influence depression. However, these approaches examined separately do not address the role of culture and social contexts in developing depression (Engle, 1989; Murdock, 2004; Sue & Sue, 2003). The biopsychosocial model is an approach that integrates biological (medical), psychological, and environmental factors which contribute to depression. The biopsychosocial model is discussed in the next section.

The Biopsychosocial Model

One of the first scholars to examine disorders through considering the interaction among biological, psychological and sociological factors was George Engle. Engel (1977, 1980) posited that illness results from the simultaneous interaction among systems at the cellular, tissue, organismal, interpersonal, and environmental levels. His conceptualization of the biopsychosocial approach is grounded in systems or ecological models which posit that to understand human development one has to understand the social, psychological, and
environmental systems in which people dwell (Bronfenbrenner, 1979). Engle’s biopsychosocial model was the first to address how genetic, individual, and psychosocial factors can account for illness and outcome. In Engle’s seminal theoretical paper in 1980 he purposefully applied the biopsychosocial model with a patient experiencing a medical condition to illustrate the importance attending to a patient holistically, rather than just attending the physical symptoms. Since his initial 1980 paper, the biospsychosocial model has been applied to psychological issues, including depression. The biopsychosocial model represents a clear shift and break from the reductionistic nature of the medical model (Drossman, 1998).

The biopsychosocial model has been utilized specifically to conceptualize the development of depression. Most notably, Schotte and colleagues (2006) applied the biopsychosocial model as a guide for understanding depression. From the research findings over the past 30 years, these scholars created a conceptual model which posited that individuals have biological and psychological vulnerabilities, which are influenced by both risk and protective factors, to developing depression. Protective factors are qualities that buffer against vulnerability to depression. Examples of protective factors include a strong supportive social network, being raised in a warm and safe family, being in good physical health, and having well-developed social skills. Schotte and colleagues (2006) postulated that protective factors help individuals to navigate challenging situations and cope with day to day life stressors. In fact, they also suggest that protective factors may play a preventative role in buffering one from developing depression. According to Schotte et al. (2006) depression arises when there is high vulnerability and low protective factors. That is, if individuals have multiple vulnerabilities and limited protective factors, coping with life stressors becomes more challenging and depression is likely to develop.
According to Schotte et al.’s (2006) model the risk factors include: (1) biological risk factors such as having depression run in the family and temperamental predispositions, (2) psychological risk factors such as experiencing trauma, maladaptive schemas and coping styles, and intergenerational factors, (3) somatic risk factors such as somatic diseases and substance misuse, and (4) social and cultural risk factors such as instability and insecurity within Western societies, poverty, and racism.

Attention to the stressors within one’s sociocultural environment is a unique feature of the biopsychosocial model that differentiates it from purely biological or psychological models for understanding depression. Sociocultural factors refer to aspects of one’s social and cultural environment that influence daily life. These aspects include how society is organized, the beliefs, values, and attitudes that shape how people form and create social networks, and the cultural factors that shape how people are socialized (Schott, et al., 2006). The authors posit that changes and instability within the structure of society can influence vulnerability to depression. Scholars have suggested that there are sociocultural experiences unique to African American women that may impact the development of depression (Buchanan & Fitzgerald, 2008; de Groot, Auslander, Williams, Sherradend, & Haire-Joshu, 2003; Jones, Cross, DeFour, 2007; Williams & Mohammed, 2009). Specifically, within the literature the intersection of racism and sexism, and poverty has been identified as challenges that African American women encounter.

Interesting, Schotte and colleagues also identify gender is considered a risk factor across all four categories as it is considered an all-encompassing risk factor due to the high prevalence of women experiencing depression as compared to men. According to this model, the greater incidence of depression among women can be attributed to biological, psychological and sociocultural factors. In regards to this current study, the explicit attention to gender differences
within a sociocultural context (i.e. taking into account how culture, social norms, environment, and social forces) and how it influences human functioning is highly applicable to African American women, who are the focus of the current project. Unlike medical or psychological models, Schotte et al.’s (2006) conceptualization of developing depression specifically address gender and culture, two important factors that will be later addressed in detail throughout this literature review.

Within the biopsychosocial model, biological risk factors (genetics), psychological risk factors (personality), somatic (chronic illness) risk factors and sociocultural risk factors (environmental stressors) all play a role in the development of depression. The degree to which these factors interact with one another explain the variability in the development of depression. That is, Schotte and colleagues posited that it is unlikely that one of these factors alone can lead to depression, but rather the combination and interaction among them can place one at risk. Attention to stressors in the environment does provide a unique variability of experience for African American women in comparison to other groups.

**Sociocultural Risk Factors for Depressed African American Women**

The following section addresses the context of sociocultural risk factors and their relationship to mental health and depression for African American women. First this section will review perceived race based discrimination experienced by African Americans in general in order to set the context of the type and frequency of discrimination. Throughout the literature the majority of studies examining African Americans tend to address the group as whole with fewer studies attending to specific gender groups. Next a review the specific sociocultural risk factors (racism, intersection of sexism and racism, and poverty) and their relationship to mental health and depression are provided.
Racism in the United States targeted towards African Americans dates back to the early 17th century when West Africans were kidnapped and brought into the United States to serve as slaves for European farmers. During the period of slavery in the United States, racism was used to justify captivity, physical and mental brutality, and denial of the most basic of rights (e.g. education, housing, legal marriage). For African American women, the experience of slavery was particularly traumatic in that they were frequently subjected to rape, experienced children being sold away, and were also subjected to frequent physical and emotional abuse of slave owners and overseers (Lowe, 2006). Even after the abolishment of slavery in 1965, African Americans continued to live within a context of legalized racism (e.g. Jim Crow segregation laws) until the Civil Rights Bill of 1965, which sought to curb *de jure* racism (Lowe, 2006).

**Types of Discrimination**

In today’s post-slavery and Jim Crow society, race-based discrimination is classified on multiple levels. Forman, Williams, and Jackson (1997) were one of the first to examine multi-levels of discrimination within a study. Based on a review of empirical studies examining experiences with discrimination, these authors postulated that there are two primary levels of discrimination. First, “everyday” discrimination refers to daily experiences of discrimination that is embedded into day-to-day encounters and represents subtle experiences of racism.

“Everyday discrimination” is similar to what scholars currently label as *microaggressions*, which is described as everyday encounters that result in unconscious displays of racial bias (Essed, 1991; Harrell, 2000; Sue et al., 2007). Examples of such daily encounters of discrimination include African Americans being overlooked when seeking services, being frequently followed...
in stores on suspicion of theft (racial profiling), and being treated as through others are afraid of them.

The second level is “major experiences with discrimination” (Forman, Williams, & Jackson 1997). Major experiences with discrimination refer to discrimination that is experienced in institutions such as work, school, and applying for housing. According to the literature examining discrimination, African Americans continue to experience frequent race-based discrimination (Broman, Mavaddat, & Hsu, 2000; Forman, Williams, & Jackson, 1997; Hunt, Wise, Jipguep, Cozier, & Rosenberg, 2007; Kessler, Mickelson, & Williams, 1999). Within the literature, the classification of discrimination typically describes everyday and lifetime experiences. However there is variation in the degree to which “place” variables or the system where the discrimination takes place (e.g. work, school, legal, housing) and frequency of discrimination is assessed.

The literature examining the frequency or distribution of perceived race-based discrimination are typically epidemiological studies on large national data sets that focus on how individual demographic traits (e.g. race, age, socioeconomic status, and gender) impact the frequency of perceived experience of racism (Broman, Mavaddat, & Hsu, 2000, Forman, Williams, & Jackson, 1997; Hunt, Wise, Jipguep, Cozier, & Rosenberg, 2007; Kessler, Mickelson, & Williams, 1999; Thomas, Bardwell, Malcarne, & Dimsdale, 2004; Welch, Sigleman, Bledsoe, & Combs, 2001). The following section will review literature examining the sociodemographic variables of race, age, SES, and gender and how they account for the variation in the experience of discrimination for African Americans.

Sociodemographic Variations
Within the literature sociodemographic variables are often examined to understand the frequency patterns of the experience of depression among different groups and subgroups. In identifying literature for this current study, race appeared to receive the most attention and had more number of studies. Research findings with regards to race and the frequency of perceived discrimination has consistently demonstrated that African Americans report more experiences with race based discrimination than their European American counterparts (Broman, Mavaddat, & Hsu, 2000; Forman, Williams, & Jackson, 1997; Hunt, Wise, Jipguep, Cozier, & Rosenberg, 2007; Kessler, Mickelson, & Williams, 1999; Thomas, Bardwell, Malcarne, &Dimsdale, 2004; Welch, Sigleman, Bledsoe, & Combs, 2001). For example Forman, Williams, and Jackson (1997) examined data from the 1995 Detroit Area Study to examine frequency of perceived discrimination. The Detroit Area Study was a multistage sample of the individuals 18 years and older residing in the Detroit area. Participants were given the Major Experiences of Discrimination Index, which assessed lifetime and recent discrimination and the Everyday Discrimination Index, which measured frequency of everyday discrimination. Based on a sample of 520 European Americans and 586 African Americans, results indicated that 70% of African Americans reported at least one incident of a major discrimination within their life time as opposed to 36% of European Americans. In addition, 41% of African Americans as opposed to 17% of European Americans reported experiencing everyday discrimination. These findings were consistent with a more recent research study which examined differences among demographic variables (e.g. gender, age, race, SES) and one’s ethnic experience (e.g. ethnic identity and perceived discrimination). Specifically, Thomas et al. (2004) sampled a smaller group of African Americans (n = 37) and European Americans (n = 45) and concluded that perceptions of discrimination was higher among African Americans than their European
counterparts. Similar findings were yielded despite the smaller sample and use of a different measure of perceived discrimination. That the results were similar in spite of the differences provides continued evidence that there exists a high frequency of African Americans experiencing racism.

Research findings examining other individual demographic traits such as age, socioeconomic status and gender, and the frequency of perceived discrimination have been less studied yielding equivocal results. Regarding age, there are relatively few studies examining age differences. No study was identified which specifically examined or predicted age to be significant in perceiving discrimination. Generally these studies tend to look at multiple demographic variables at one time to determine correlates of perceived discrimination. Research findings generally suggest that younger African Americans tend to report higher frequency of discrimination on experience of discrimination oriented measures; the outcomes hold regardless of instrumentation used or context of study (Thomas, Bardwell, Malcarne, & Dismdale, 2004; Kessler, Williams, & Jackson, 1999; Gary, 1995; Williams & Chung in press). Some scholars postulate that younger people have higher perceptions of racism due to challenges with navigating predominantly European American colleges and universities (Thomas, Bardwell, Malcarne, & Dismdale, 2004) and having more encounters with the legal system which can be perceived as racial motivated (Broman, Mavaddat, & Hsu, 2000).

In regards to socioeconomic status (SES), the majority of literature uses education level or type of employment (e.g., professional, trade, income level), and income as proxy variable for social class (Gary, 1995; Hunt, Wise, Jipguep, Cozier, & Rosenberg, 2007; Kessler, Williams, & Jackson 1999; Thomas, Bardwell, Malcarne, & Dimsdale, 2004). Generally, research has demonstrated complex patterns between SES and perceived discrimination. Sigelman and Welch
(1991) published a book which examined African Americans’ views on racial inequality. In it they analyzed data from the Chilton Research Services, which conducted telephone poll surveys with African Americans (n = 1462) and European Americans (n = 1358). Findings in regards to SES suggested that working class participants, those receiving government assistance, and those who indicated difficulties in their finances were more likely to report experiencing discrimination. These authors speculated that higher SES African Americans may share similar values as middle class European Americans and therefore report lower perceptions of discrimination.

In contrast research has also indicated a positive relationship between education and perceptions of discrimination for African Americans (Bobo and Suh, 1995; Kessler, Williams, & Jackson, 1999; Thomas, Bardwell, Malcarne, & Dismdale, 2004). Kessler, Williams and Jackson (1999) theorized that well-educated people may be more likely to attribute shortcomings to discrimination rather than personal challenges. Other scholars such as Forman, Williams, and Jackson (1997) and Sigelman and Welch (1991) pointed out that higher SES African Americans may pose a higher threat to the status quo due to associating more with European Americans and viewed more as equals and therefore be susceptible to discrimination.

Gender difference with regards to discrimination is an important variable to examine. Regarding African Americans, research has been mixed as to whether African American men or women perceive more discrimination. Specifically, it appears that men report higher incidences of discrimination while women report stronger associations between discrimination and mental health outcomes. For example Borrell, Keife, Williams, Diez-Roux, and Gordon-Larsen, (2006) examined perceived discrimination among young African American men (n = 706) and women (n = 1116) ages 18 to 30 who were part of the coronary artery risk development in young adults
study (CARDIA), a 15-year longitudinal study. Participants were asked about their experiences of racial discrimination on seven domains: at school, getting a job, getting housing, at work, at home, getting clinical care, on the street or in a public setting. If participants answered “yes” to having experienced racial discrimination a follow-up question assessing the frequency (“rarely, sometimes, and often”) was asked. The data was analyzed based on composite scores of both the domain and frequency of experience, which ranged from 0 to 21. Results indicated that men reported a higher frequency of perceived discrimination. In addition, the findings demonstrated that perceived racial discrimination was associated with poorer physical and mental health outcomes for both men and women. However, the relationship among self-reported measures of physical health, mental health, and depressive symptoms to perceived racial discrimination, was stronger for women than men. Borrell et al. did not provide an explanation for why men reported higher frequency of discrimination than women. Interestingly, the authors focused attention on the finding that women had stronger associations with racial discrimination and health outcomes. Borrell and colleagues posited that the gender difference could be explained by the intersection of race and gender. According to the authors, African American women experienced both racial and gender discrimination; underscoring how the intersection of both racism and sexism can result in increased psychological distress.

In another study, Thomas, Bardwell, Malcarne, and Dimsdale (2004) examined the effects of demographic variables on the ethnic experiences of African Americans and European Americans. Within the study, “ethnic experience” was conceptualized to include perceived discrimination in addition to social affiliation/intimacy, and mainstream comfort. Thirty-seven African Americans (20 males, 17 females) completed measures on ethnic experience, and social position and results found that women reported higher incidents of perceived racial
discrimination than men. This finding supported previous findings in which African American women were more susceptible to discrimination than men (Gardner, 1995; Sigelman & Welch 1991). Similar to Borrell and colleagues, Thomas et al. concluded that the intersection of gender and race may account for the gender differences within the findings.

Similar to Borrell et al.’s (2006) finding that men reported higher frequency of discrimination, Broman, Mavaddat, and Hsu (2000) found that gender accounted for frequency of experienced discrimination. These authors examined the experiences and consequences of perceived racial discrimination for African American men (n = 276) and women (n = 531) via telephone-based structured interviews regarding discrimination in specific domains (e.g. work, legal system, and education). Results indicated that 60% of the sample experienced racial discrimination; however, men reported higher racial discrimination in dealing with the police or within the legal system than women. Discrimination with police was the only domain that had a significant gender difference. The authors suggested that racial profiling, stereotyping for African American men, and historical mistreatment of African American men by police may explain the finding. This study suggests that the domain or context wherein the discrimination occurs may account for gender differences in frequency of perceived racism.

Gender differences may lie in methodological approaches. Unlike Borrell and colleagues (2006) and Broman et al. (2000), Thomas et al. (2004) used a global scale for measuring perceived discrimination while others explored the types of discrimination (everyday and lifetime) and setting (place) of the discrimination (e.g., work, legal system, school). Thomas et al. (2004) suggested that studies that account for the system in which discrimination takes place, particularly the legal system, may result in men having higher perceptions of discrimination.
Other scholars contend that women are discriminated against more than men but are less likely to report it due to the African American men and women having different referent groups of comparison (Crosby, 1984; Gardner 1995; Sigleman & Welch 1991). That is, scholars postulated that African American women are more likely to compare themselves to the experiences of European American women. Since African American and European American women are more similar on characteristics such as employment and education than African American men are to European American men, African American men would report higher perceptions of discrimination.

Summary

Overall, the literature indicates that African Americans experience higher perceptions of racial discrimination than European Americans and that younger and lower SES African Americans report more discrimination. In regards to gender, there is some evidence to suggest the context or system in which the discrimination occurs (e.g. legal system) influences the perceptions of men. However, there is contrasting evidence which indicates that globally African American women may have higher perceptions of discrimination than men. Furthermore, there is evidence which suggests that for African American women there is stronger relationship between perception of discrimination and mental health. A stronger relationship between discrimination and mental health for women provides support for the current study’s aim to improve mental health treatment for this group. African American women have unique sociocultural risk factors that can impact their mental health. Specifically, scholars (e.g. Borrell et al. 2006, Sigleman & Welch 1991) posit that African American women’s mental health may be more impacted by the experience of discrimination because they are coping with both racism and sexism. As will be reviewed in the next section, a growing body of research suggests that the experience of racism
is linked to a decline in mental health, and specifically developing depression. The following section with also address the intersection of racism and sexism and its relationship to mental health for African American women.

**Racism and Mental Health**

As presented in the previous section, research evidences the prevalence of perceived racism among African Americans a problem that still plagues social context of the United States. According to the biopsychosocial model of depression, hostile social contexts, such as racism, can contribute to developing depression (Clark, Anderson, Clark, & Williams, 1999; Schotte et al., 2006). Clark, Anderson, Clark and Williams (1999) developed a theoretical model to explain the conceptual link between exposure to racism and mental health concerns for African Americans. The authors postulated that the experience of a racist event serves as an environmental stimulus which results in both psychological and physiological stress responses. These stress responses are influenced by sociodemographic factors (e.g. gender), psychological and behavioral factors, and coping responses. Over time, the responses to the stress begin to influence health outcomes. For example, Franklin and Boyd-Franklin (2000) asserted that stress resulting from experiences with racism is a consequence of frequently feeling overlooked and mistreated. Clark et al. (1999) concluded that “the combined effects of acute and chronic [racism] perceptions have the potential to contribute to psychological and physiological sequelae [pathological condition] that may be toxic” (p.807).

The conceptual model presented by Clark and colleagues (1999) are in alignment with other contextual models which link environmental stimuli (the social context) to health outcomes (Andersen, Kiecolt-Glaser, Glaser, 1996; Jorgensen, Johnson, Kolodiej, & Scheer, 1996; Schotte et al., 2006). However unlike others, Clark et al.’s (1999) model is unique in that it provides a
conceptual understanding of how racism specifically impacts the psychological well-being of African Americans. Although the model has not been directly tested, there is empirical evidence supporting the link between race-based discrimination and mental health.

A growing body of research has emerged providing empirical evidence to support the link between prolonged exposures to experiences of racism and developing mental health concerns, for African Americans (Williams & Mohammed, 2009). The majority of research focuses on African Americans in general with fewer studies focusing on women. Williams and Williams-Morris (2000) provided a comprehensive review of literature examining racism and mental health for African Americans. Their examination of literature suggested that racism can negatively impact mental health in three ways: (1) racism that is embedded in societal institutions such as school and work can lead to stunted socioeconomic mobility, which leads to differential access to resources and poor living conditions, (2) exposure to racism can lead to psychological and physiological reactions that are unhealthy and (3) societal acceptance of negative racial stereotypes can result in African American internalizing negative self-evaluations that ultimately impact psychological well-being.

The impact of racism on mental health for African Americans has been well-documented (Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Karlsen & Nazroo, 2002; Outlaw, 1993; Sellers, Harrell, 2000; Utsey & Constantine, 2008 Utsey & Ponterotto, 1996; Williams & Williams-Morris, 2000). Scholars have examined race-based discrimination and mental on multiple outcome measures and generally results indicated positive associations between exposure to racism to psychological distress (Banks, Kohn-Woods, & Spencer, 2006; Meyer, 1995; Ren et al, 1999; Williams, 2000), an inverse relationship to life satisfaction (Williams & Chung (forthcoming); William et al., 1997), and inversely related to psychological well-being.
These studies have ranged from large national adult samples (Kessler et al. 1999) to college students (Bynum, 2007; Utsey & Hook, 2007) to adolescents (Brody et al., 2006; Simmons et al., 2006). Despite the different populations under investigation, and difference in outcome measures used, the trends in outcomes have held.

There has been growing body of research linking experiences with race-based discrimination to specific mental health concerns such as depression (Comas-Diaz & Greene, 1994; Kessler et al. 1999; Karlsen, & Nazroo, 2002). For example, Kessler, Mickelson, and Williams (1999) examined the prevalence and distribution of mental health correlates of perceived discrimination. The authors utilized the Mac Arthur Foundation Midlife Development in the US (MIDUS) national telephone-mail survey to recruit 3,032 individuals (2,485 European American, 339 African American, 141 Other). The sample consisted of individuals 25 to 74 years of age and of various racial backgrounds. In addition to demographic questions, participants were asked 11 yes-no questions related to exposure to discrimination (e.g. discrimination in housing) and 9 questions related to the frequency of exposure to chronic daily discrimination (e.g. being called racial slurs). To assess depression symptoms the World Health Organization’s (WHO) “Composite International Diagnostic Interview,” Version 1.0 (WHO, 1990 as cited in Kessler et al., 1999) was used. In addition, the researchers developed a six-item measure that assessed how often during the past month individuals experienced depressive symptoms (e.g. hopelessness, sadness, worthlessness, anhedonia). Results indicated that there was positive association between endorsed depressive symptoms and perceived discrimination. Kessler et al. (1999) suggested their findings supported previous studies findings linking perceived discrimination to symptoms of depression. They postulated that stress related to the
experience of discrimination may be an explanation for the connection between racism and depressive symptoms.

A positive association between racism and depressive symptoms were also concluded in Borrell, Keife, Williams, Diez-Roux, and Gordon-Larsen’s, (2006) examination of perceived discrimination and self-reported help among young African American men \((n = 706)\) and women \((n = 1116)\) ages 18 to 30 who were part of the coronary artery risk development in young adults study (CARDIA), a 15 year longitudinal study. Participants were asked about their experiences of racial discrimination on seven domains: at school, getting a job, getting housing, at work, at home, getting clinical care, on the street or in a public setting. If participants answered “yes” to any of these domains a follow-up question assessing the frequency (“rarely, sometimes, and often”) was asked. The data was analyzed based on composite scores of both the domain and frequency, which ranged from 0 to 21. Mental health was measured using the Medical Outcomes Study Short Form (SF-12; Ware Kosinski, & Keller as cited in Borrell et al., 2006). Findings supported a relationship between perceived discrimination and mental health wherein experiencing discrimination was associated with poorer mental health outcomes.

However, Borrell et al.’s (2006) study differed from Kessler et al.’s (1999) study in that a stronger association between perceived racial discrimination and depressive symptoms for women than men was evidenced. Kessler and colleagues found the opposite. The difference in findings between these two studies were similar to the gender differences found in literature pertaining to gender and frequency of perceived discrimination. Some scholars (e.g. Thomas et al., 2007) suggest that measurements of discrimination may explain the variability of findings. These scholars suggest that place specific (e.g. work place, legal system) measures may be more sensitive to men. No study in this literature review was located which specifically focused on
gender differences for perceived discrimination and mental health was located. Gender differences are often examined in a post-hoc manner and authors provide little to no explanation for gender differences when observed. More research examining gender differences in the frequency of perceived discrimination and the correlates to mental health is needed.

Although the majority of studies examining perceived discrimination and mental health consisted of African American male and female samples, there are some studies which specifically examine African American women. Research in this area has found that racism negatively impacts mental health for African American women (Hunn & Craig, 2009; Jones, Cross, DeFour, 2007; Schulz, Gravlee, Williams, Israel, Mentz, & Rowe, 2006). For example, Kwate, Valdimarsdoittir, Guevarra, and Bovbjerg (2003) examined experiences with racist events and heal health outcomes for 71 African American women. Participants were administered the Schedule of Racist Events (SRE; Broman, Mavaddat, & Hsu as cited in Kwate et al. 2003), which is an 18-item self-report inventory that measures the frequency of racist events experienced by African Americans. Participants were also given the Brief Symptom inventory (BSI), which is a 53-item standardized measure of psychological distress; in addition participants were given measures of physical health. Participants completed the measures three times, approximately one month apart. Results indicated that the experience of racism was positively related to psychological distress. The findings of Kwate et al.’s (2003) study were consistent with other studies which concluded that racism has deleterious effects on mental health for African Americans (e.g. Borrell, Keife, Williams, Diez-Roux, & Gordon-Larsen, 2006).

Similarly Schultz, Gravlee, William, Israel, Mentz, and Rowe (2006) examined discrimination, symptoms of depression, and self-rated health among 343 African American
women from Detroit. The longitudinal data was collected in 1996 and again in 2001. The authors tested the degree to which a change in everyday discrimination over time would impact self-reported symptoms of depression and general health. Participants completed the Center for Epidemiological Studies Depression Scale (CES-D) and Everyday Perceived Discrimination measure specifically constructed for this study. Results indicated a positive relationship between change in perceived discrimination and symptoms for depression. This finding held regardless of age, income, and education, which suggests a very strong relationship between experiencing race-based discrimination and mental health.

Although, the influence of racism on the psychological well-being of African Americans is well-documented, the relationship should be interpreted with caution and attention to cultural variability. Racial identity is an important cultural factors to consider when understanding how African American women develop symptoms of depression. Sellers and colleagues defined African American racial identity as “the significance and qualitative meaning that individuals attribute to their membership within the Black racial group within their self-concepts” (p. 23). Some research concludes that the impact of racism on mental health is influenced by racial identity (Jones, Cross, DeFour, 2007; Sellers & Shelton, 2003. For example, Jones, Cross, and DeFour (2007) examined race-related stress, racial identity attitudes and mental health among 262 African American female college students. Participants completed the Schedule or Racist Events (SRE; Landrine & Klonoff, as cited in Jones et al., 2007), the Cross Racial Identity Scale (CRIS; Cross & Vandiver as cited in Jones et al. 2007), Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1997), and a self-esteem and demographic measure. The findings indicated that the relationship between race-related stress and depression symptoms were moderated by racial identity. Specifically, the results concluded that individuals with more
multicultural attitudes toward race had lower symptoms of depression. That is, individuals who have an appreciation for both their race and the races of others, are less nationalistic/ethnocentric in their racial identity, and do not endorse self-hatred identity attitudes were less likely to endorse depression symptoms.

Understanding the relationship of racial identity to the perception of racist events and the function of racial identity as a buffer to negative life stressors may be important in understanding the outcome differences for African Americans, particularly among men and women. As aforementioned, research suggests that African American men and women view discrimination differently. The degree to which racial identity differs for men and women may partially explain differential outcomes in perceptions of race-based discrimination. To date no studies have been located which examine gender differences in racial identity, racism, and mental health.

Summary

Research indicates that racism negatively impacts both African American men and women’s mental health. Specifically, experiences of racism have been found to be correlated with symptoms of depression. Gender differences in the perceptions of racist events may explain why gender differences sometimes exist in the strength of the correlation between racism and mental health for African American men and women (e.g. Thomas et al., 2007). The experience of racism for African American women is unique in that their gender may be simultaneously a target for sexism. There is a paucity of research examining the intersection of racism and sexism for African American women and mental health outcomes (Croteau, Talbot, Lance, & Evans, 2002; Harley, Jolivette, McCormick, & Tice, 2002; Williams & Wiggins, 2010). However, scholars (e.g. Buchanan & Fitzgerald, 2008; Comas-Diaz & Greene, 1994; Greene, 1994; Hunn & Craig, 2009) contend that it is important to address this unique intersection and how it may
impact mental health for African American women. The following section will review the research that examines this phenomenon.

**Intersection of Racism, Sexism, and Depression**

According to recent conceptual papers on racism and sexism, African American women are “stigmatized by race and gender and may be targets of additional discrimination on the basis of sexual orientation, class, age, and other social variables” (Williams & Wiggins, 2010, p.175). In the previous review of literature it is clear that racism is still an experience that African American women go through. A limited but growing body of literature also suggests that African American women are the targets of gender discrimination or sexism as well (Miville & Ferguson, 2006; Moradi & Subich, 2003; Shorter-Gooden, 2004; Williams, 2005; Williams & Wiggins, 2010). In addition, similar to the effects of racism, research suggests that gender discrimination can negatively impact mental health, particularly the development of depression (Klonoff & Landrine, 1995; Klonoff, Landrine, & Campbell, 2000; Moradi & Funderburk, 2006; Schultz, Gravelle, Williams, Israel, Mentz, & Row, 2006) In their conceptual paper examining feminist-focused spirituality as a response to racism and sexism for African American women, Williams and Wiggins (2010) observed that racism and gender continue to be analyzed separately. As other scholars have noted, when these identities are studied separately it limits our understanding of individuals with multiple stigmatized identities (Constantine, 2002; Croteau, Talbot, Lance, & Evans, 2002; Harley, Jolivette, McCormick, & Tice, 2002; Williams & Wiggins, 2010). In this review of literature, the majority of studies examined racism and sexism separately, despite the call to examine the intersection of these experiences. Consequently, the following section highlights research focused primarily on sexism and then reviews the limited research examining the intersection of racism and sexism.
Sexism: Definition and Impact on Mental Health

Like race-based discrimination, gender- or sex-based discrimination is described as having multiple forms. The framework most frequently used to understand the multiple experiences of sexism was developed by Klonoff and Landrine (1995). These authors described gender discrimination as “gender-specific, negative life events or stressors” (p.441) and examples include being discriminated against at work in salaries, promotion, and tenure, being sexually harassed, being called sexist names, and being discriminated by strangers who ignore one’s presence or behave in a hostile manner. Similar to theoretical models linking racism to the experience of stress (e.g. Clark, Anderson, Clark, & Williams, 1999), these authors place the theoretical link between gender discrimination and mental health through stress. Klonoff and Landrine (1995) postulated that sexism can be acute (recent) or chronic (lifetime) and that there are many forms or contexts for sexism to occur (e.g. work, personal relationships, institutions).

Similar to research examining the impact of racism, sexism has also been found to be linked to mental health (Landrine et al., 1995; Landrine & Klonoff, 1997; Moradi & Subich, 2002; Moradi, Dirks, & Matterson, 2005; Swim et al., 2001). For example, Landrine et al. (1995) examined physical and psychiatric correlates of gender discrimination revealing that gender discrimination was highly correlated with a host of psychiatric symptoms, including depression. In addition, Moradi and Funderburk (2006) examined the roles of perceived sexist events and social support in the mental health of 157 female college students of various racial and ethnic backgrounds who were seeking counseling. The majority of the sample was European American (64%), with some African American women included in the study (11%). Participants completed the Brief Symptom inventory to measure psychological distress, the Schedule of Sexist Events, and other measures pertaining to self-esteem, social support, and empowerment. Results
indicated that the frequency of sexist events had a positive direct relationship to psychological distress. The authors suggested that their findings provided more support for the link between perceived gender discrimination and psychological distress. In addition, the authors found no link between the experience of sexist events and social support or self esteem; this study further supported the inconsistency in explain how perceived sexism negatively impacts mental health.

Emerging research examining sexism has also suggested that gender-based discrimination impacts women more than men (Klonoff, Landrine, & Campbell, 2002; Miville & Ferguson, 2006). For example, Klonoff, Landrine, and Campbell (2002) examined gender differences in psychiatric symptoms with a mixed-gendered sample of 255 college students (180 females, 75 males). The number of African Americans included in the sample was not reported, however 120 participants were described as “minorities.” The students completed measures related to psychological challenges, including depression, and the frequency of sexist events (Schedule of Sexist events, Klonoff & Landrine, 1995). The findings indicated that women who encountered gender discrimination frequently had significantly more symptoms than men on all symptom measures. In addition, women who reported fewer experiences of gender discrimination did not differ from men on the symptom measures. These findings provide evidence that sexism influences psychological functioning for women, and also that the frequency of psychological symptoms may be attributed to women’s experiences of sexism.

The experience of gender discrimination may impact mental health through negatively impacting aspects of well-being such as self-appraisal and self-esteem; however research has consistently concluded that no link between the experience of sexist events and self-esteem or self-appraisal (Cassidy, Howe, & Warden, 2004; Fischer & Shaw, 1999; Lee, 2003; Moradi & Funderburk, 2006; Moradi & Hasan, 2004). No literature was found providing empirical
evidence linking gender discrimination to other variables of well-being. The most comprehensive conceptual understanding of the relationship between sexism and mental health was provided by Klonoff and Landrine (1995), who postulated that the experience of sexism is related to stress.

There is limited research examining the impact of sexism on African American women despite the fact that this group experiences discrimination based on gender. Sexism and gender stereotyping seems to be common across most racial groups. For example, Hansen, Gama, and Harkins (2002) provided a critical review of literature regarding gender issues in counseling. These authors found that research consistently concludes that characteristics associated with men (e.g. active, rational, and inventive) and those associated with women (e.g. gentle, affections, and weak) are similar across many cultures. Despite the fact that African American women experience gender discrimination, the vast majority of literature focuses on the impact of racism on mental health outcomes, and ignores how gender may impact the experience of racism, and ultimately psychological well-being. Literature examining sexism tends to focus on European American women and when multiethnic samples are collected, ethnic differences are rarely explored. The intersection between sexism and racism as experienced by African American women is complex; however research suggests that both sexism and racism studied separately can have negative impacts on psychological well-being (Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Fisher & Holtz, 2007; Karlsen & Nazroo, 2002; Landrine et al., 1995; Outlaw, 1993; Sellers, Harrell, 2000; Shorter-Gooden, 2004; Swim, Hyers, Cohen, & Ferguson, 2001, 2001; Utsey & Constantine, 2008; Utsey & Ponterotto, 1996; Williams & Williams-Morris, 2000).
Intersection of Sexism and Racism

The environmental context for African American women is unique because it is possible to experience gender and racial discrimination simultaneously. Beal (1970) discussed the reality of African American woman experiencing both sexism and racism, and described this process as “double jeopardy.” She postulated that sexism and racism have separate impacts on African American women’s lives, but ultimately in combination produce aversive experiences. Contemporary scholars assert that for African American women, sexism and racism intertwine and produce gendered racism, based on racially influenced stereotypes of gender roles (Essed, 1991; Miville & Ferguson, 2006). Even though research supports that African American women’s mental health is negatively impacted by sexism and racism, when studied separately, there is a paucity of literature that examines the interaction of race and gender on psychological well-being. The majority of literature related to the intersection of racism and sexism tends to be theoretical or conceptual in nature. The goal of these authors tends to focus on raising awareness around the importance of empirically examining the intersection of racism and sexism (e.g. Greene, 1994; Hunn, 2009; Miville & Ferguson, 2006; Williams & Wiggins, 2010). To date, there remain limited empirical studies in this area.

The notion of experiencing double jeopardy or gendered racism for women of color (including African Americans) has been examined within multiple contexts (e.g. work, college, and the military). Studies have supported the thesis of double jeopardy with findings that
suggest that ethnic minority women have elevated rates of harassment (Bergman & Drasgow, 2003; Cortina, Swan, Fitzgerald, & Waldo, 1998; Hughes & Dodge, 1997; Mecca & Rubin, 1999). For example, Berdahl and Moore (2006) examined double jeopardy for minority women in workplace settings. Two hundred and thirty-eight participants (158 women and 80 men) were included for the study. Of those who participated in the study, over half (52%) identified as an ethnic minority (10% identified as Black). Unfortunately the authors did not report the exact number of women of color who were included in the sample. Participants completed the Sexual Experiences Questionnaire (SEQ; Fitzgerald, Gelfand, & Drasgow as cited in Berdahl & Moore, 2006) in addition to five items that measured masculine notions of harassment, the Sexual Harassment of Men Questionnaire (SHOM; Wald et al. as cited in Berdahl & Moore, 2006), and the Ethnic Harassment Experience scale (EHE; Schnieder et al. as cited in Berdahl & Moore 2006). Results indicated that women experienced more sexual harassment than men, minorities experienced more ethnic harassment than European Americans, and minority women experienced more harassment overall than European American men and women and ethnic minority men. This finding was meaningful because it was one of the first to examine how gender and ethnicity impact harassment at work. The authors suggested that their findings provided support for double jeopardy because those vulnerable to both gender and racial discrimination reported the most harassment.

Berdahl and Moore’s (2006) finding that ethnic minority women experience higher rates of harassment than other groups have been supported in other studies. Bergman and Drasgow (2003) surveyed 22,846 women in military (27% African American) and they completed measures on gender issues, the sexual harassment, employment satisfaction and climate, and perceptions of physical and psychological health. Findings indicated that ethnic minority women
reported having a higher level of harassment than their European American counterparts. Additionally, the findings revealed that ethnic minority women tend to have lower job satisfaction and commitment. Interestingly, in contrast to Bedahl and Moore (2006), Bergman and Drasgow (2003) did not use measures of ethnic or racial harassment. Consequently, it appears that ethnic minority women report higher levels of sexual harassment even in the absence of measuring racial or ethnic harassment directly. This possibly suggests more support of the double jeopardy thesis in that the experience of sexual harassment is intertwined with racial harassment.

Some scholars (e.g. Baker-Fletcher, 1994; Bergman & Drasgow 2006; West & Fenstermaker, 1995) postulate that ethnic minority women report a higher level of harassment not because there is accumulation of risk factors attributed to gender and race, but because the combination of racial and sexual harassment is so intersected that it creates a qualitatively distinctive experience. Bergman and Drasgow’s (2006) posited that one of the distinct experiences of ethnic minority women might be an increased vulnerability to sexual harassment. These authors also pointed out that research examining the factors that might lead ethnic minority women to report more sexual harassment than European American women warrants further research attention and investigation.

The experience of sexual harassment does appear to be unique when compared to their European American counterparts. Mecca and Rubin (1999) examined female college students’ experiences with sexual harassment. The women in the study completed the Sexual Experiences Questionnaire in addition to an open-ended question assessing their experiences of sexual harassment. Interestingly, the authors reported that women of color reported receiving unwanted sexual comments or attention based on racial stereotypes or racially based physical features.
Mecca and Rubin pointed out that these findings had never been made evidenced in studies that focused primarily on European American women’s experience of sexual harassment. This finding was similar to Buchanan and Ormerod (2002) qualitative study of racialized sexual harassment for African American women. Based on focus groups, participants reported that unwanted sexualized comments reflected sexualized images of African American women and that harassment frequently combined both race and gender. For example women reported that they felt European Americans believed Black women were more sexually aggressive and open with candid discussion of sex. Buchanan and Ormerod concluded that these racial stereotypes were grounded in the justification for sexual exploitation of African American during slavery.

These studies serve as examples of how racism and sexism can influence the experience of discrimination for women of color in general and specifically African American women within workplace settings. Research findings suggest that double jeopardy may account for experiencing harassment more often and experiencing harassment that is unique to the intersection of racism and sexism. A limited but growing body of literature is investigating the psychological impact of double jeopardy.

Moradi and Subich (2003) conducted one of the few studies which examined both racism and sexism on psychological distress for African American women. Women from university and community settings ($n = 133$) completed self-reports on perceived racist and sexist events, and psychological distress. Findings indicated that both sexism and racism had equal impacts on increasing psychological distress. Interestingly, when examined concomitantly, only sexism uniquely predicted psychological distress. The constructs of sexism and racism were highly correlated, but did not produce a significant interaction. Because these constructs were so highly correlated, the authors posited that African American women may not experience these
constructs as separate but as fused. The conjecture of a combined effect of sexism and racism is supported by the belief that African American women experience gendered racism (Essed, 1991; King, 1988). Moradi and Subich’s conclusion is similar to Bergman and Drasgow (2003), who postulated that ethnic minority women report a higher level of harassment not because there is accumulation of risk factors attributed to gender and race, but because the combination of racial and sexual harassment is so intersected that it creates a qualitatively distinctive experience.

In another study the effects of racial and sexual harassment within an employment context was examined for 91 African American women who were involved sexual harassment employment lawsuits (Buchanan & Fitzgerald, 2008). The participants completed measures on sexual harassment, racial harassment, supervisor and co-worker satisfaction, measures related to the climate of their employment, a posttraumatic stress disorder (PTSD) checklist, life satisfaction scale, and a negative affectivity scale, which has been used as a proxy for psychological well-being. Similar to other studies this study also found that sexual and racial harassment was highly correlated. This supports the notion that double jeopardy that there are multiple forms of harassment experienced by African American women due to their status as a multiple minority (race and gender). Both sexual and racial harassment was found to be positively correlated with the psychological well-being variables (e.g. PTSD symptoms). The authors concluded that this finding implied that experiencing racial and sexual harassment combined can exacerbate psychological harm. Interestingly, an interaction between racial and sexual harassment was found in relation to some of work related variables (e.g. supervisor satisfaction) but did not predict psychological well-being outcomes. Again, part of the challenge with these variables may lie in the fact that racial and sexual harassment are very highly
correlated. This may be attributing to not finding significant interactions in relation to psychological well-being variables.

In contrast there was one study located which provided some evidence of a significant interaction, however an interaction was not directly analyzed. Woods, Settles, and Buchanan (2008) examined 105 African American women’s experiences of sexual harassment in racially similar and cross-racial contexts. After completing the Sexual Experience Questionnaire, participants were asked to choose an example of sexual harassment that affected them greatly. Participants were also asked to identify the race of the male perpetrator of the harassment. The women also completed measures on status of the perpetrator, subjective appraisal, the Racialized Sexual Harassment scale, and a PTSD checklist. The results indicated that respondents appraised cross-racial experiences as more negative than intraracial ones. In addition, the women reported that cross-racial harassment was more likely to include racialized sexual harassment. Finally, the results also indicated that cross-racial harassment had an indirect mediated effect on posttraumatic stress through the participants’ appraisal of their harassment. That is, negative appraisal was more associated with cross-racial sexual harassment and was associated with increased PTSD symptoms. This finding suggests that experiences of sexual harassment that have components of racial discrimination can increase psychological distress.

Summary

Ultimately, research evidences that both gender and race are important factors to consider in understanding stress and mental health for African American women (Greene, 1994; Kohn, & Hudson, 2002; Williams, 2005; Adkison-Bradley, Bradshaw, Lipford Sanders, 2007). Racism and sexism are important sociocultural factors to consider in the development of depression and other mental health concerns for African American women (Caldwell, Schmeelk-Cone,
Zimmerman, 2003; Fisher & Holtz, 2007; Karlsen & Nazroo, 2002; Landrine et al., 1995; Outlaw, 1993; Sellers & Harrell, 2000; Shorter-Gooden, 2004; Swim, Hyers, Cohen, & Ferguson, 2001, 2001; Utsey & Constantine, 2008; Utsey & Ponterotto, 1996; Williams & Williams-Morris, 2000). In addition, double jeopardy, or the experience of racism and sexism simultaneously, is very unique to women of color. African American women often report that their experience of gender discrimination incorporates elements of racism (Baker-Fletcher, 1994; Bergman & Drasgow, 2006; West & Fenstermaker, 1995). There is limited research on the interaction between racism and sexism, but it appears that these constructs are highly correlated, which may result in African American women struggling to differentiate these two constructs, consequently making it difficult to empirically detect an interaction. Despite the limited research regarding interaction between racism and sexism for African American women, racism and sexism are experiences that African American women face which may impact the quality of their mental health. These sociocultural variables are unique to African American women.

Poverty and Depression

Poverty has consistently been a correlate of depression (Bell & Doucet, 2003; Cutrona et al., 2005; Duncan, 1996; Frank, Matza, Revicki, & Chung, 2005; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Hans-Ulrich Wittchen, & Kendler, 1994; Simmons, Braun, Charnigo, Havens, & Wright, 2008). In addition, poverty as a correlate of depression is particularly high among women and women of color. The following section will examine literature related to the context of poverty, and poverty as sociocultural risk factor of depression for African American women.

Prevalence and Context of Poverty
There are more than 30 million people living below the poverty line in the United States at a rate of 12.6% (DeNavas-Walt, Proctor, & Hill-Lee, 2006; Groh, 2007; U.S. Census Bureau, 2001). It is estimated that 41% of people living in poverty have incomes that is lower than half of the official poverty line (Mishel, et al. 1999). People living in poverty can encounter daily life struggles ranging from obtaining the basic necessities to having challenges in interpersonal relationships (Mickelson & Williams, 2008). The context of poverty is one which individuals and families encounter lack of access to quality health care (Baker & Bell, 1999), poorer physical health (Vaz, 2003), financial stress and burden (de Groot, Auslander, Williams, Sherraden, Haire-Joshu, 2003), being stigmatized (Mickelson & Williams, 2008), and greater exposure to violence (Evans & English, 2003).

Poverty, however, is not evenly distributed within the United States (Barker & Bell, 1999; USDHHS, 2001; Williams & Jackson, 2005). Women are more likely than men to live in poverty and women of color have higher rates of poverty than other groups (Belle & Doucet, 2003; U.S. Census Bureau, 2001). According to the US Census nearly a fourth of African American and Hispanic women live in poverty (U.S. Census Bureau, 2001). A widely-cited statistic within the poverty literature comes from the U.S. Census Bureau’s current population report which suggested that 54% of African American women live in poverty in comparison to 25% of European American women (Lamison-White, 1997).

The disproportion of African American women living in poverty places them at risk for experiencing life challenges often associated with poverty, such as lack of access to quality care (Baker & Bell, 1999), poorer physical health (Vaz, 2003), financial stress and burden (de Groot, Auslander, Williams, Sherraden, Haire-Joshu, 2003), and greater exposure to violence (Evans & English, 2003). In addition, living in poverty is highly correlated with depression, which can
adversely affect African American women. Kessler et al. (1994), in a well-cited study, utilized data from the National Comorbidity Survey (NCS) to examine lifetime and 12-month prevalence of psychiatric disorders in the United States. The NCS was a congressionally-mandated survey that was intended to investigate the co-occurrence of both substance-abuse disorders and psychiatric disorders. A total of 8,098 participants (49% women and 11.5% African American) participated in the study. In addition to completing a demographic questionnaire, participants were interviewed by individuals trained to use the Composite International Diagnostic Interview (CIDI). Findings evidenced that income and education was inversely correlated to the prevalence of affective and anxiety disorders. Interestingly the results also indicated that income and education was larger in predicting 12-month prevalence rather than lifetime prevalence. The authors interpreted this finding as suggesting that socioeconomic status is associated with both the onset and the course of a disorder.

Living in poverty has also been well-established as having an impact on mental health for women, particularly depression (Bell & Doucet, 2003; Cutrona et al.2005; Duncan, 1996; Frank, Matza, Revicki, & Chung, 2005; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Hans-Ulrich Wittchen, & Kendler, 1994; Simmons, Braun, Charnigo, Havens, & Wright, 2008). Given that African American women disproportionately live in poverty, examining depression in relation to poverty for this group has begun to gain attention within the literature. The following section will address poverty and depression for African American women.

**Poverty and Depression for African American Women**

Examining the relationship between poverty and depression has been investigated with women in various life circumstances and across the life span (Groh, 2007). Consistently research findings conclude depression is high among low-income mothers with young children (Chung,
Poverty serves a sociocultural risk factor of depression among low-income African American women. For example, Frank, Matza, Rvicki, and Chung (2005) examined depression and health-related quality of life low-income African American women. A sample of 124 depressed low-income African American women and 44 non-depressed low-income women completed measures related to health-related quality of life, which refers to how physical and mental health interferes with a person’s day-to-day life. Findings suggested that the depressed sample experienced significantly more challenges in managing day-to-day functions (e.g. eating, bathing, and getting around one’s home). This study is significant in that it provides evidence to support the debilitation in which depression can cause for low-income African American women. In another study, Coiro (2001) examined depressive symptoms among low-income, single, African American mothers receiving welfare. A sample of 173 women completed the Center for Epidemiological Studies Depression Scale (CES-D), a demographic questionnaire, and measures on social support and welfare-to-work activities. Of the sample, 40% reported symptom levels that would warrant a diagnosis of depression. This study is similar to previous studies that conclude that low-income mothers with children are at risk for depression (Chung, McCollum, Elo, Lee, & Culhane, 2004; McLennan, Kotelchuck, & Cho, 2001; Siefert,
Finalayson, Williams, & Delva, 2007). Interestingly, association between low-income mothers and depression holds regardless of instrumentation used or context of study.

Miranda, Azocar, Komaromy, and Golding (1998) examined the unmet mental health needs of women in public-sector gynecologic clinics. Two-hundred and five low-income ethnically diverse women (30% of which were African American) completed the PRIME-MD, which is an 18-item instrument used to assess current mental disorders in medical settings. However, since there was a high rate of illiteracy among the participants, all questions were asked in an interview format. The participants also provided a history of sexual and other physical assault in addition to asked questions about the quality of their primary care services. Results indicated that nearly 22% of the women met the criteria for depression. This finding is particularly alarming given that only 6% of women in the general public meet criteria for depression (Blazer, Kessler, McGonagle, et al., 1994) and suggests that there are high rates of depression for women with low-income.

The reasons why African American women living in poverty report a high frequency of depression seem to lie in the social context of poverty and the stress associated with negative life experiences. The context of poverty for women is unhealthy. Women living in poverty encounter more frequent, more threatening, and more uncontrollable life events than the general population (Bell & Doucet, 2003) and the context can often include ongoing chronic deprivation (Ennis, Hobfoll & Schroder, 2000). A widely-cited study by Bassuk et al. (1998) examining mental illness among low-income and homeless mothers found that 83% of women (n = 220), had reported being physically or sexually assaulted in her lifetime. Research evidences that the social context of living in poverty results in an increase of exposure to environmental stressors (Bassuk et al., 1998).
Living in disadvantaged neighborhoods has often been cited as a general contextual factor in explaining the relationship between poverty and depression for women (Curtrona, Russell, Brown, Clark, Hessling, & Gardner, 2005; Groh, 2007; Shultz et al., 2006). Within the literature two dimension of neighborhood context is often referenced in relation to its impact on the psychological well-being of African American women, neighborhood disadvantage and social disorder (Curtrona, Russell, Brown, Clark, Hessling, & Gardner, 2005; Massey, & Shibuya, 1995; Wilson, 1996; Woody 1992). Neighborhood economic disadvantage is identified by variables such as the percentage of people who live below the poverty line, unemployment rates, and percentage of single-parent households. It is believed that neighborhoods that are economically disadvantaged provide limited opportunities for employment and tend to have low-quality schools, low-quality housing, and services that are not available, such as food delivery, taxi service, and credit application (Curtrona, Russell, Brown, Clark, Hessling, & Gardner, 2005; Sooman & Macintrye, 1995; Troutt, 1993). In contrast, social disorder within a neighborhood context refers to “the breakdown of process and structures that maintain order, civility, and safety” (Curtrona, Russell, Brown, Clark, Hessling, & Gardner, 2005, p. 4). Markers of social disorder include public intoxication, drug use and sales, poorly marinated and vacant buildings, and high rates of youth delinquency (Curtrona, Russell, Brown, Clark, Hessling, & Gardner, 2005). Scholars have postulated that the stress of negotiating daily life in such environments may trigger feelings of hopelessness and depression (Aneshensel & Sucoff, 1996; Ross, 2000).

Curtrona, Russell, Brown, Clark, Hessling, and Gardner (2005) examined neighborhood context in relation to personality and stressful life events as predictors of depression among 6311 low income African American women. The authors constructed the Community Dilapidation and Community Deviance measures for this study to assess neighborhood context. Both scales
yielded high alphas of .89. In addition, participants completed a demographic questionnaire, the Composite International Diagnostic Instrument (which is an interview used to assess psychiatric disorders), and measures on personality and stressful life events. Findings indicated that neighborhood-level economic disadvantage and social disorder predicted that onset of depression when controlling for demographic characteristics. These findings were significant because this was one of the first known studies to quantify the context of neighborhoods in poverty to assess depression directly. The authors suggest that their finding was in alignment with theoretical notions of impoverished contexts influencing depression. Ultimately, life in poverty is a context in which depression can develop, this is particularly important to understand for African American women given they are disproportionately represented in poverty. Consequently, poverty is a risk factor for depression that cannot be ignored.

Summary

In summary the sociocultural context in which African American women reside, can be a risk factor for developing depression (Buchanan & Fitzgerald, 2008; de Groot, Auslander, Williams, Sherradend, & Haire-Joshu, 2003; Jones, Cross, DeFour, 2007; Williams & Mohammed, 2009). Specifically, sexism and racism are two social problems which unfortunately affect African American women’s psychological well being, self-esteem, and mental health (Cassidy, Howe, & Warden, 2004; Fisher & Shaw, 1999; Lee, 2003; Moradi & Funderburk, 2006; Moradi & Hasan, 2004). These issues, coupled with the disproportionate number of African American women living in poverty can create a context in which mental health concerns such as depression occur. Understanding the sociocultural context in which depression may occur for African American women is important in order to further understand and critique how depression is treated for this group.
The following section will explore how depression is generally treated, with particularly attention to how psychotherapy is used to treat depression. In addition, the next section provides an on-going critical examination of literature pertaining to treating depression for African American women.

**Treatment for Depression**

According to the National Alliance on Mental Illness (NAMI), depression is most responsive to treatment in comparison to other mental health concerns. (NAMI, 2010). Frequently-identified effective treatments within the literature include medication (Anderson, 2001; Parish & Peden, 2009; Papakostas, Shelton, Smith, & Fava, 2007; Wells, Tang, Miranda, Benjamin, Duan, & Sherbourne, 2008), psychotherapy (Churchill, Hunot, Corney, et al., 2001; Cuijpers, van Straten, & Smit, 2006; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998), or a combination of both (Cuijpers, van Straten, Warmerdam, Andersson, 2009; Hirschfeld, Dunner, Keitner, Klein, Korna, et al., 2002; Keller, McCullough, Klein, Arnow, et al., 2000; Ravindran, Anisman, Merali, Charbonneau, Telner, Bialik, et al., 2000). To set the context of different treatment of depression the following section briefly reviews the effectiveness of psychotropic medication but emphasizes psychotherapeutic approaches for treating depression, given that this study focuses on the subjective experience of therapy. Throughout this section attention to treatment for African Americans in general, and African American women specifically, is addressed.

*Effectiveness of Psychotropic Medication*

As aforementioned, the medical model approach posits that depression can develop through dysfunctions in the brain, primarily neurotransmitters (McAllister-Williams & Young, 1998; NAMI, 2000; Rusch, Kanter, Brodino, 2009). Use of psychotropic medication for the
treatment of depression is consistent with the medical model approach (NAMI, 2000), with antidepressants the most commonly used for treatment (Fournier, DeRubeis, & Hollon, 2010; Hollon, Thase, & Markowitz, 2002). The two primary categories are tricyclic antidepressants (TCAs), and newer antidepressants known as selective serotonin reuptake inhibitors (SSRIs). Both TCAs and SSRIs work by inhibiting the reuptake of serotonin and norepinephrine (neurotransmitters) by brain cells; they also slightly assist in blocking the reabsorption of dopamine (Mayo Clinic, 2000).

Examining the effectiveness of antidepressants for treating depression is primarily conducted in randomized clinical trials. Randomized clinical trials are designed to evaluate the benefits of treatment within controlled settings (Leon, Solomon, Mueller, Endicott, et al., 2005). For example, one of the largest, highly studied, and frequently cited clinical trial databases is the sequenced treatment alternative to relieve depression (SRAR*D; Rush, et al., 2004). The STAR*D was a multisite, prospective, randomized, multistep clinical trial for individuals with major depressive disorder. This trial included 4,000 adults enrolled from primary and specialty care practices. The study compared various treatment options for individuals who did not respond satisfactorily to citalopram, which is selective serotonin, reuptake inhibitor (SSRI) antidepressant (Rush, et al., 2004). Treatments in the study included both psychotherapy and medication. Outcome measures were typically measured using the clinician-rated version of the Hamilton Depression Scale and the Quick Inventory of Depressive Symptomatology. According to Rush’s (2007) report on STAR*D data, generally results indicated that the usage of combination treatment (i.e., two antidepressants) may be more effective than augmentation (i.e., one antidepressant and another agent). This finding has implications for the way in which antidepressants are used with other medications to produce reductions in depression symptoms.
A comprehensive review of all studies utilizing the STAR*D data is far beyond the scope of this current literature review, however the STAR*D database serves an example of how medication is examined for the treatment of depression.

Within the literature, research utilizing data from randomized clinical trials typically examine the efficacy of psychotropic medication when compared to other psychotropic medications (Anderson, 2000; Barbui & Hotopf, 2001; Rush, 2004; Trindade & Menon, 1997), placebos (Barrett, Williams, Oxman, Frank, et al., 2001; Beasely et al., 1991; Mulrow, Williams, Trivedi, et al., 1999; USDHHS, 1993) or psychotherapy (Cuijpers, Straten, Warmerdam, & Andersson, 2009; Hirschfeld, Dunner, Keitner, Klein, et al., 2002; Keller, McCullough, Klein, Arnow, et al., 2000) for the treatment for depression. For example, Bech, Ciadella, Haugh, Birkett, et al. (2000) conducted a meta-analysis of randomized controlled trials of fluoxetine versus a placebo, and tricyclic antidepressants in short-term treatment of major depression. For their analysis 69 studies across 6,633 participants were included; data indicating the race and ethnicity of individuals in the trial were not included. The results indicated that Fluoxetine was superior to the placebo. Overall, there is significant evidence to support that medication is an effective treatment for depression; however, specific to African American women, treatment outcomes are less clear.

Psychotropic Medication and African American Women

As aforementioned, psychotropic medication has been found to be highly effective in treating depression (Anderson, 2001; Parish & Peden, 2009; Papakostas, Shelton, Smith, & Fava, 2007; Wells, Tang, Miranda, Benjamin, Duan, & Sherbourne, 2008). Specific to African American women, however, there is little data to support the efficacy of medication for the treatment of depression. A challenge to understanding the effectiveness of
psychopharmaceuticals for African American women can in part be explained by the lack of African American women sampled for clinical trials (Carrington, 2006; Jackson, 2006, Sue, 1999). Racial demographics are often not reported in clinical trial and meta-analysis studies (Jackson, 2006; Sue & Sue, 2003). The failure to report demographic information makes generalizing the findings to African Americans difficult (Jackson, 2006).

Jackson (2006) reviewed literature, which examined the use of psychiatric medication in treating African American women with depression. She posited that literature focuses on issues of access to care due to health disparities among African American women; however, she noted that in primarily focusing on issues of access, there remains little understanding about optimal treatment once African American women have gained access. In addition, she questioned the degree to which there are racial differences in response and remission rates for medications. Jackson’s questions reflect the limited knowledge regarding the effectiveness of medication for the treatment of depression for African American women.

There are few studies examining racial differences in outcome for medication treatment for depression. Findings examining race yield conflicting results in that sometime race can be significant and in other instances there is no relationship (Jackson, 2006). In addition, no studies were located which focused on medication treatment outcome for African American women with depression. In one of the few studies in which African Americans were included, Steinberg, Munro, Samus, Rabins, et al. (2004) examined 44 elderly patients with Alzheimer’s disease and their response to an SSRI (sertraline) for the treatment depression via a 12-week clinical trial (either sertraline or placebo). The study controlled for placebo effects and the doses were flexible. Completing baseline and posttest measures of the Hamilton Depression Rating Scales (HDRS) and the Cornell Scale for Depression in Dementia (CSCD), findings indicated that
African American patients tended to respond better to treatment than European American participants. Steinberg et al. (2004) did not have an a priori hypothesis regarding race as a significant predictor of treatment outcome, however, they speculated the finding was due to chance, given their small sample size. Unfortunately, the authors did not report the number of African American who participated in the study. Similar to assertions made in Jackson’s (2006) critique of literature pertaining to African Americans and psychotropic medication, this study serves as an example of how ethnic/racial variable are not always attended to in clinical trials.

In another study, Trivedi, Rush, Wisniewski, Nierenberg et al. (2006) examined outcomes with citalopram for depression using data from STAR*D study. The study specifically focused on remission, which was defined as a score less than or equal to seven on the Hamilton Depression Rating Scale (HDRS; primary outcome) or a score greater than or equal to five on the Quick Inventory of Depressive Symptomology-Self-Report (QIDS-SR; secondary outcome). The sample consisted of 2,180 European Americans, 506 African Americans and 190 who identified as “other.” The sample also consisted of an even distribution of males ($n = 1,043$) and females ($n = 1,833$). Unfortunately, no information was provided regarding the racial breakdown of gender. The participants were all outpatient individuals diagnosed with depression and receiving treatment from 23 psychiatric and 18 primary care “real world” settings. The participants received flexible doses of citalopram for up to 14 weeks, and their clinicians administered routine measurement of symptoms and side effects. Findings indicated that being European American and female was a significant predictor of positive outcomes. Like Steinberg et al. (2004), the difference in response to treatment based on race was not an anticipated or pre-conceptualized finding. However, unlike Steinberg et al., Trivedi and colleagues found that participants who were not European American did not respond as well to treatment. The authors
did not provide any explanation about their finding regarding the influence of race on treatment outcome. These two studies reflect the inconsistencies in understanding the outcome of medication treatment for African Americans. In addition, both studies provide examples of how race is not included in the conceptualization of clinical trial studies.

In contrast, Lesser, Castro, Gaynes, et al. (2007) also used data from the STAR*D study to examine the impact of race and ethnicity in outcomes for the treatment of depression. Recruited from 18 primary care centers, 495 Blacks/African Americans, 1,853 European Americans, and 327 Hispanics received citalopram for up to 14 weeks, with dosage adjustments based on routine clinical assessments. Participants completed the Hamilton Rating Scale for Depression (HRSD) and the Quick Inventory of Depressive Symptomology-Self Report (QIDS-SR) while clinicians completed the Quick Inventory of Depressive Symptomology -Clinician Rated (QIDS-CR). Findings initially indicated that African Americans had lower remission rates than European Americans, however after adjustments were made to account for demographic, sociocultural and clinical variables (e.g. SES, severity of disorder, access to care), no differences in rate of remission on the HRSD emerged. African Americans, however, had lower rates of remission on the QIDS-SR than other participants. The author’s speculated that the difference in remission for the outcome measures may be attributed to the QIDS-SR being a newer measurement and not having norming data.

Interestingly, Lesser, Castro, Gaynes, et al. (2007) posited that the difference in remission for African Americans might be attributable to sociocultural factors related to depression. On average African American and Hispanic participants in this study had a higher severity of depression at baseline than their European American counterparts. The authors contended that issues related to access to care, lack of insurance, and other sociocultural variables such as
income and racism, may have contributed to the increased severity of depression and differential
treatment outcome. Their conceptualization of this outcome is consistent with the previous
presentation of sociocultural factors influencing the development of depression for African
American women (Bender, 2005; Buchanan & Fitzgerald, 2008; de Groot, Auslander, Williams,
Sherradend, & Haire-Joshu, 2003; Jones, Cross, DeFour, 2007; Williams & Mohammed, 2009).
Unfortunately, the breakdown of gender by race was not reported. Consequently, despite this
study’s attention to race, there is no additional understanding about medication to treat
depression for African American women. In addition, since participants did not complete
measurements specifically examining sociocultural risk factors (e.g. racism) there is no evidence
to support the influence of such factors on medication treatment outcome.

Finally, a recent study conducted by Lesser, Myers, Lin, Mira, et al. (2010) examined
race/ethnicity a variable in treatment outcomes yielding results somewhat different from the
studies previously reviewed. The authors contended that they started their study prior the
STAR*D studies and other studies which indicated that there were differences in treatment
outcome with regards to race or ethnicity (e.g. Lesser et al., 2007; Steinberg et al., 2006; Trivide
et al, 2006). Lesser and colleagues conceptualized this study as examining “bioequivalence” to
determine response differed by ethnicity. In doing so, this study did not control for placebo effect
with 169 African Americans and 132 European Americans experiencing depression in an 8-week
clinical trial comparing the efficacy and side effects of citalopram with dosage escalation.
Similar to other studies examining race, participant gender (112 males, 189 females) was not
broken down by race and thus differential outcomes attributed to gender or gender by race could
not be assessed. Treatment outcomes were measured by the structured interview version of the
Hamilton Rating Scale for Depression (HRSD) and the Beck Depression Inventory (BDI).
Findings indicated that African Americans had more severe depression and differed from European American participants on demographic variables (e.g. income, education, and insurance), remission rates for both groups were approximately 50%. The findings for this study differ from previous studies (e.g. Lesser et al., 2007) which have suggested that there are differences in remission rates by race or ethnicity. The authors suggested that when attention is to symptoms, side effects, and dosage modification, ethnic disparities in treatment outcomes can be reduced.

The conflicting findings of these studies highlight the lack of understanding of how African Americans respond to psychotropic treatment. Although, psychotropic medication has evidenced effective treatment (Anderson, 2000; Barbui & Hotopf, 2001; Rush, 2004; Trindade & Menon, 1997) there is some evidence in literature to suggest that more examination of remission rates as it related to race or ethnicity needs to be addressed (Lesser et al., 2007; Lesser et al., 2010; Jackson, 2006). Specific to African American women, even less known about the effect of psychotropic medication for treating depression (Jackson, 2006). Clinical trial studies rarely focus on treatment differences attributed to gender and even fewer studies report information aggregated by gender and race. Consequently, there is a paucity of literature which provides evidence for effective medication treatment for depression with African American women. This present study will add to the limited literature that specifically examines effective treatment for African American women experiencing depression.

Effectiveness of Psychotherapy

In 1977 Smith and Glass published their seminal meta-analysis examining the outcomes of psychotherapy which revealed the effectiveness of psychotherapy. Since their study, a wealth of knowledge has been generated regarding psychotherapy as an effective treatment for mental
health concerns, specifically depression (Dimijian, Hollon, Dodson, et al., 2006; Duncan, Miller, Wampold, & Hubble, 2010; Ekers, Richards, & Gibody, 2007; Norcross, 2002; Norcross, Beutler, & Levant, 2006; Parrish & Penden, 2009). Similar to studies examining the effectiveness of psychotropic medication, research related to psychotherapy has typically relied on clinical trials to establish effectiveness in addition to the meta-analyses of clinical trials.

Elkin and colleagues (1989) conducted one of the largest and most cited studies examining the effectiveness of psychotherapy for the treatment of the depression. Utilizing a large multisite dataset from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP), the study compared the effectiveness of CBT and interpersonal therapy. Randomly assigned to either a reference standard care (imipramine plus clinical management) or placebo control group, 250 participants completed the Beck Depression Inventory (BDI), the Hopkins Symptom Check List-90 Total Score (HSCL-90TS), and general assessment scale (GAS). In addition, outcomes were also clinician assessed through the 17-items Hamilton Rating Scale for Depression (HRSD) and the GAS. Participants and clinicians completed measures at baseline and at several points throughout the 12-week study. Results indicated that both psychotherapies were equally effective in reducing symptoms of depression and provided more empirical evidence for psychotherapy for treating mental health concerns, and specifically depression.

Since the NIMH-TDCRP study, multiple studies which provide empirical support for the effectiveness of psychotherapy in the treatment for depression have emerged (e.g. Luty, Carter, McKenzie, Rae, et al. 2007; Marina, Foner, & Bogetto, 2005; Milgrom, Negri, Gemmill, McNeil, & Matrin, 2005; Strauman, Veith, Merrill, Kolden, et al., 2006). Generally, psychotherapy reduces symptoms of depression in group counseling settings (e.g. Bright, Baker,
Neimeyer, 1999; Dowrick, Dunn, Ayuso-Mateors, Dalgard, et al., 2000; Evans & Connis, 1995; Gallagher, 1981; Hogg & Deffenbacher, 1988; Kelly, Murphy, Bahr, Kalichman et al., 1993), with community populations (Cullen, 2006; Dimidjian et al., 2006; McKendree & Smith, 1998), and with college populations (Blue, Sanfillipo, & Young, 2007; McNamara, 1989; Whitaker & Cooper, 2007). In addition, as evidenced by the literature, psychotherapies are effective in treating depression regardless of therapeutic approach, such as cognitive behavioral versus interpersonal (Cuijpers, van Straten, Andersson & Oppen, 2008; Elkin, 1989; Luty et al., 2007; Mohr, Boudewyn, Goodkin, Bostrom, et al., 2001; Wampold, 2001).

Another way in which the effectiveness of psychotherapy has been established within the literature is through clinical trial and meta-analytic studies of psychotherapy in comparison to medication, which has a long history of being effective in treating depression. For example, Imel, Malterer, McKay, and Wampold (2008) conducted a meta-analysis comparing psychotherapy and medication as a treatment for depression. Twenty-eight studies across 3,381 participants diagnosed with depression were included in the analysis. Findings indicated that the mean effect size for psychotherapy versus medication was not significant, thus supporting that both treatments are equally efficacious. Similarly, Cuijpers, Straten, Oppen, and Andersson (2008) conducted a meta-analysis comparing the outcomes of psychological and pharmacological treatments for depression. Thirty randomized clinical trials across 3,178 participants diagnosed with depression were included. In contrast to Imel et al.’s findings, Cuijpers and colleagues found that for participants with major depression, SSRIs were significantly more effective than psychological treatments. Similar to the conclusions of Imel et al., however, Cuijpers and colleagues concluded that the effect size was relatively small (-0.07) and that in actual clinical practice the difference was most likely negligible. The findings from these studies are important
because as they lend support for psychotherapy as a viable and effective treatment for depression. Generally, clinical trials comparing psychotherapy to medication (e.g. Dimidjian, et al., 2006; Hermens, van Hout, Terluin, Ader, et al., 2007; Hirshfeld, Dunner, Ketner, Klein, et al., 2002; Keller, McCullough, Klein, Arnow, et al., 2000) and meta-analytic studies comparing psychotherapy to medication (Cuijpers, et al, 2008; Cuijpers, Straten, Warmerdam, & Andersson, 2009; Imel et al., 2008) have concluded that psychotherapy is effective.

Psychotherapy and African American Women

The experience of psychotherapy for African American women is discussed in detail later in this literature review; however a critique of effectiveness of psychotherapy with African American women is warranted. Similar to outcome research on medication treatment for depression, outcome research related to psychotherapy as treatment for depression rarely reports demographics aggregated by both race and gender (Jackson, 2006). For example in the National Institute of Mental Health Treatment of Depression Collaborative research program, a seminal study examining the general effectiveness of treatment, the authors did not report on the racial demographics of the national sample (Elkin, et al., 1989) and thus information on differential responses to treatment by race and gender could not be reported. Similarly, studies examining the effectiveness of therapy in comparison to medication (e.g. Anderson, 2001; Parish & Peden, 2009; Papakostas, Shelton, Smith, & Fava, 2007; Wells, Tang, Miranda, Benjamin, Duan, & Sherbourne, 2008) and other types of therapy (e.g. Luty, Carter, McKenzie, Rae, et al. 2007; Marina, Foner, & Bogetto, 2005; Milgrom, Negri, Gemmill, McNeil, & Matrin, 2005; Strauman, Veith, Merrill, Kolden, et al., 2006) have not considered differential outcomes with regards to race and gender.
The non-reporting or under-recruiting of racial and ethnic minorities in general, and African American women specifically, is a critique of clinical trial research on the effectiveness of therapy (Jackson, 2006; Sue, 1999). Utilizing homogenous samples for outcome research raises issues of cultural validity and generalizability of findings. Quintana, Troyano, and Taylor (2001) posited that cultural validity is the appropriateness of a study’s design, procedures, interpretation, and discussion for cultural groups. Baker and Bell (1999) specifically suggested that clinicians not assume that psychotherapeutic treatments for depression are universal and applicable to all racial and ethnic groups because these groups are rarely represented in clinical trials. Consequently the underrepresentation of African American women in psychotherapy studies for the treatment of depression, raises questions about the generalizability of previous findings to this particular group. For example Ward (2007) specifically examined differential treatment effects for racial and ethnic minority women treated for depression. This systematic review of literature consisted of 10 empirical studies which (1) examined treating depression for racial and ethnic minority women, (2) had data analysis that was separated by race or ethnicity and (3) was conducted in the United States. Although this study focused on minority women in general, conclusions based on African American women demonstrated that this group was more likely to only rely on psychotherapy, as oppose to a combination of psychotherapy and medication, and would benefit from treatment delivered from clinicians who specialize in treating depression. Although, the this study provides important information regarding treatment for African American women experiencing depression, the fact that only 10 studies could be identified highlights, the lack of research in this area.

Like medication research, outcome research specifically related to psychotherapy and African American women is limited (Carrington, 2006; Harmon, Edlund, & Fortney, 2005;
Jackson, 2006; Lincoln, Chatters, & Taylor, 2005). The lack of empirical understanding for treating African American women with depression was the focus of the *Journal of Clinical Psychology* in 2006 (volume 42, issue 7). Contributors (e.g. Carrington 2006; Jackson, 2006) specifically addressed and reviewed literature related to diagnosis, treatment, and research for African American women with depression. Generally, their review of literature highlighted treatment outcome inconsistencies for African American women (Jackson, 2006) and an overall lack of representation (Carrington, 2006).

Despite the lack of representation of African American women in outcome studies, there is some empirical evidence to suggest that they respond positively to psychotherapeutic treatment for depression (Kohn, Oten, Manoz, Robinson, & Leavitt, 2005; Miranda et al., 2003; Miranda et al., 2005). Green, Krupnick, Chung, Siddique, et al. (2006) examined the impact of PTSD comorbidity on one-year outcomes in a depression trial. This study was part of a larger research project called the Women Entering Care study (We Care; Miranda et al., 2003). The We Care study was a large multisite research project comprised of low-income racial and ethnic minority women (117 African American, 134 Latinas, 16 European American) experiencing depression and other mental health concerns. The women were randomized to cognitive-behavioral therapy, antidepressant medication, or community health referral (treatment as usual). Participants completed depression outcomes measures (Hamilton Depression Rating Scale, Primary Care Evaluation of Mental Disorders Patient Health Questionnaire), engaged in depression screening interviews (Composite International Diagnostic Interview), and completed a PTSD measure (Stressful Life Events Screening Questionnaire). Depression symptoms improved for those who had a comorbid diagnosis of PTSD and those diagnosed solely with depression. Participants with PTSD, however, were more impaired throughout the one-year
follow-up than those without PTDS. The authors also did not report differential outcomes by race and ethnicity. The authors highlighted the specific procedure in which the women were provided with participation accommodations such as child care and transportation. In addition, the women were provided with culturally sensitive education and encouragement around issues of mental health. Green and colleagues suggested that the accommodations were a unique feature of their study which differed from “treatment as usual.” Consequently, these authors posited that the issue of access to care is a major challenge in treatment for low-income women of color.

Non-significant findings by ethnicity was similarly found by Miranda and colleagues (2006), who also examined one-year outcomes of a randomized clinical trial of treating depression for low-income women of color using data from the We Care Study and followed similar procedures as Green et al. (2006). Miranda and colleagues stressed the importance of expanding research to examine specifically the treatment of racial and ethnic minority women with mental health concerns. The authors specifically raised issues related to access, and credited the procedures of accommodation of participants with transportation, child care, and culturally sensitive psychoeducation on mental health concerns as critical components of treatment. Again, issues related to treatment effectiveness and treatment access are important factors to consider for racial and ethnic minority women.

Although the findings from Miranda et al. (2006) and Green et al. (2006) are promising, there exist too few studies examining how to treat effectively African American women with depression. Therefore, the current study will address treatment outcomes of African American women experiencing depression.

Summary
Use of psychotropic (Anderson, 2001; Parish & Peden, 2009; Papakostas, Shelton, Smith, & Fava, 2007) and psychotherapeutic treatments (e.g. Dimijian, et al., 2006; Duncan, Miller, Wampold, & Hubble, 2010; Ekers, et al., 2002) for depression have been found to be effective within the literature. Specific to African American women, there is little research examining effective treatment. As evidenced by the medication literature, there is some support that there may be differential outcomes in the remission of depression based on race or ethnicity (Lesser, et al., 2007; Steinberg et al, 2004; Trivedi, et al., 2006). Simultaneously, emerging research suggests that response to treatment is uniform regardless of race (Lesser et al., 2010). Unfortunately, research examining the impact of race on medication treatment of depression is limited and research specific to African American women is virtually non-existent. Similarly, research examining psychotherapeutic treatment for depression is plagued by underrepresentation of racial and ethnic minorities in clinical trials, specifically African American women. In contrast to the medication research, there were no studies located which suggested that African American women respond differently to psychotherapeutic treatment. However, like the medication research, there remains a paucity of literature examining psychotherapy and African American women, despite evidence suggesting this it is an effective treatment.

The process of psychotherapy and how it is effective has yet to be addressed in this literature review. As psychotherapy gains more empirical evidence to support as an effective treatment, scholars debate over identifying the factors that lead to change for clients (e.g. Chambless & Ollendick, 2001; Wampold, 2001). There are two primary perspectives to the debate: 1) specificity of treatment and 2) common factors. Scholars endorsing specificity of treatment argue that there are specific ingredients, skills, or components of treatment that are
necessary to illicit change (e.g. Chambless & Ollendick, 2001). In contrast, a common factors approach focuses on the process of therapy rather than the treatment itself. Identified common factors in therapy include a strong therapeutic alliance between the therapist and the client, a sound rationale for explaining how the client developed her or his problems, and belief in the treatment itself (Lambert, 2004; Spielmans, Pasek, & McFall, 2007).

An in-depth examination of the debate between specificity of treatment and common factors is beyond the scope of this study. The present study will not attempt to argue the importance of common factors versus specificity of treatment. Instead, the common factors literature will be used in the following section to highlight factors important to the therapeutic process. Regardless of which side of the debate one endorses, examining the process of therapy and how individuals experience therapy is important to identify factors that contribute to positive outcomes for clients (Lambert & Ogles, 2003).

In the following section, the process of therapy and how individuals experience therapy will be examined. In addition the following section highlights the process of therapy and experience of treatment as it relates specifically to African American women.

**Factors Influencing the Experience of the Therapeutic Process**

Psychotherapy is a complex and multifaceted process that occurs between therapists and clients. The personal components that make up the client and her/his context, the personal components of the therapist, the relationship that is formed, and the treatment that is delivered all collectively and individually contribute to the therapeutic process. The experience of this process is important because it influences whether or not individuals stay in treatment and can ultimately impact the degree to which a client experiences change (clinical outcome). Lambert (1992) reviewed empirical studies of outcome research (Norcross & Goldfried, 1992) and suggested a
four-factor model of change. He identified extratherapeutic factors (i.e. client and environmental variables), clients’ expectancy of treatment, relationship factors, and treatment mode/techniques as all contributing to therapeutic change. Therapeutic change refers to the degree to which clients experience relief from current life challenges and feel better equip to cope with mental health concerns.

Therapeutic change and the therapeutic process are highly related. The therapeutic process is the context for which change is facilitated. Essentially, the goal of the therapeutic process is to produce clinical change for clients. Within the common factors literature, therapeutic change and the therapeutic process are not explicitly presented together, despite their strong association. For the purposes of this current study, the therapeutic process will be presented in relation to how it can produce an experience that will facilitate change (i.e. promote positive clinical outcomes). In addition, although the current study does not take a stance on the debate on the importance of common factors versus specificity of treatment, the common factors literature will be utilized to provide a framework for understanding factors that contribute to the experience of the therapeutic process.

Finally, in this section the factors that contribute to the therapeutic process are presented slightly modified from Lambert’s (1992) original model. As aforementioned, Lambert identified client expectancy of treatment as a factor contributing to the therapeutic change. Expectancy is often presented in conjunction with placebo effects or the notion that belief alone in the treatment will produce change. Given the focus of the therapeutic process and experience of therapy within this study, expectancy was conceptualized as a client variable (extratherapeutic factor). Expectancy was conceptualized as an extratherapeutic factor because it is believed that clients bring to therapy their own beliefs about the degree to which treatment will be helpful.
Consequently, the experience of therapy can be impacted by this belief. In addition, therapist factors, or the personal characteristics that clinicians bring to therapy, were included as factors that produce change. Therapist effects, or the degree to which therapeutic outcome can be explained by therapist variables, is an area that has been often ignored in outcome literature (Wampold, 2001). Therapist factors were added to the discussion of the therapeutic process because it is believed that clinicians can influence the experience of therapy.

Therefore, the following section briefly highlights factors contributing to the therapeutic process. Specifically, extratherapeutic, therapist, relationship, and treatment model/technique variables will be discussed. In addition, given this current study’s focus on African American women’s experience of cross-cultural therapy, this section will address process variables as they relate to race, the context of cross-cultural therapy, and African American women.

Extratherapeutic Factors

Extratherapeutic factors consist of both client and environmental factors that contribute to the therapeutic process. Client factors are characteristics that are part of the client’s personality such as race/ethnicity, ego strength, interpersonal style, and attitudes toward treatment whereas environmental factors are aspects of the client’s life and environment such as support system, chance events, racism, and persistent trauma (Hubble et al., 1999; Sprenkle & Blow, 2007). Essentially, extratherapeutic factors make up what the client brings to therapy. Understanding these characteristics is valuable in understanding the lens from which the experience of therapy is filtered.

Based on the outcomes of Norcross and Goldfried (1992), Lambert (1992) created a model for change that included contributing factors such as relationship factors, treatment factors, and extratherapeutic factors. He estimated that 40% of change within psychotherapy can
be attributed to extratherapeutic factors. Although it should be noted that Lambert developed estimates based on his review of outcome research and not statistical procedures, scholars agree that the factors he identified greatly contribute to the therapeutic process. Within the literature research tends to focus on role of client characteristics rather than environmental factors in the therapeutic process. However environmental factors such as having social support, has been highly associated with positive treatment outcomes (Duncan et al., 2010; Lambert, 1992). It is beyond the scope of this literature review to examine all client and environmental extratherapeutic factors; however, a few will be highlighted. Given that the current study focuses on the experiences of cross-cultural therapy for African American women, the brief review of some specific extratherapeutic factors will also be examined in relation to race.

Client diagnosis is one such client factor that has been examined in relation to its impact on the therapeutic process. Generally, research indicates that more severe diagnoses lead to challenges with forming strong therapeutic alliances, or the therapeutic relationship, which in turn impacts the overall therapeutic process. Bjorngaard, Rudd, and Friss (2007) conducted a study examining the impact of mental illness on patient satisfaction with the therapeutic relationship. The data was collected from 969 patients in 8 community mental health facilities. The participants completed a measure examining satisfaction within the therapeutic relationship based on dimensions such as clinicians’ ability to listen and understand and sufficient time for contact and dialogue. The results indicated that individuals who had lower GAF scores reported less satisfaction with the therapeutic relationship. This finding suggests that individuals, whose overall level of functioning is low, tend to be less satisfied with their therapist.

Diagnosis can have a far reaching impact on the therapeutic process because severe mental illness ultimately impacts one’s interpersonal style (or how one relates/connects to
others). In turn, one’s interpersonal skills are paramount to forming relationships. Research findings indicate that interpersonal deficits, which are commonly found in personality disorders, indirectly influence the therapeutic process by decreasing motivation and readiness to change (Frieswyk et al., 1986). Similarly, Taft et al. (2005) postulated that individuals who have rigid personality disorder characteristics or interpersonal styles may not possess the openness and flexibility needed to build strong therapeutic alliances. DiGuiseppe, Tafrate, and Eckhardt, (1994) reported that it is difficult to form a strong therapeutic alliance with an individual who cannot take responsibility for her or his own interpersonal problems.

The impact of diagnosis on the therapeutic process is of particular interest in relation to race. African Americans in general have a history of being misdiagnosed, particularly with more severe mental illnesses, such as schizophrenia (Adebimpe, 1981; Garretson, 1993; Baker & Bell, 1999; Neighbors et al., 1999). Research findings have demonstrated that this historical trend has created concern about being misdiagnosed among some African Americans (Baker & Bell, 1999). This concern shapes their expectation and attitudes toward treatment (e.g. fear of being institutionalized, Sussman et al., 1987) and may ultimately lead to challenges within the therapeutic process (e.g. being resistant to treatment).

Attitudes and expectations regarding treatment is another extratherapeutic factor often examined. Therapy expectations has been described as “anticipatory beliefs that clients bring to treatment and can encompass beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery” (Nock, Phil, & Kazdin, 2001, p. 155). Research studies have typically examined expectations in relation to outcomes such as premature termination, client improvement, and therapeutic alliance (Dew & Birkman, 2005). General findings from research have concluded that high expectations of treatment were associated with lower attrition rates
(Nock, Phil, & Kazdin, 2001), keeping appointments (Shuman & Shapiro, 2002), stronger therapeutic alliance (Connolly Gibbons, Crits-Christoph, de la Cruz, Barber, Siqueland, & Gladis; 2003), compliance with treatment (Shuman & Shapiro, 2002), and overall better treatment outcome (Dozois & Westra, 2005). For example one study examined treatment expectations as a predictor for treatment outcome for individuals with a fear of flying (Price, Anderson, Henrich, & Rothbaum, 2008). A clinical sample of 72 individuals completed a pretreatment outcome expectancy fear of flying measures after which they were treated for phobia with either an in vivo exposure or virtual reality exposure therapy. Participants again completed fear of flying measures after completing treatment. Results indicated that higher expectations for treatment outcome yielded higher rates of symptom reduction (Price et al., 2008).

Ultimately expectations of therapy impact the experience of psychotherapy. Seligman, Wuyek, Geers, Hovey, and Motley (2009) examined the effects of inaccurate expectations on experiences with psychotherapy. Utilizing a sample of 63 college students, participants were invited to watch therapy sessions for nonclinical academic problems (e.g. procrastination). The treatment used was either cognitive behavioral therapy or a nondirective therapy. Participants completed pre-treatment measures to assess their expectations, a treatment questionnaire after every session to assess the experience of therapy, and a post-treatment interview regarding their affective reactions to therapy. The authors found that regardless of the type of treatment received, participants’ experience of therapy was more positive when their expectations of treatment were matched.

Expectations of treatment that shape the experience of therapy are important to examine in relation to race. Race is an interesting extratherapeutic factor because it has implication at both
the client and environment levels. Cultural beliefs held by specific racial groups influence how individuals conceptualize mental illness and how it can be treated (Mathews, Corrigan, Smith & Aranda, 2006). These beliefs ultimately can shape expectations of treatment. In contrast, racism is an environmental condition that can influence the onset of mental illness (Williams & Williams, 2000; Karlsen & Nazroo, 2002; Caldwell, Schmeelk-Cone, & Zimmerman, 2003) and also shape the experience of treatment. As aforementioned, the experience of psychotherapy for African Americans will likely be within a cross-cultural context with European American clinicians. Given that the social context of the United States is one in which racism occurs, examining how racism may impact the therapeutic process has to be considered.

Research examining African Americans’ attitudes and expectations of treatment have been generally negative (Obasi & Leong, 2009). Scholars have concluded that there is a strong association between cultural mistrust, or lack of trust in health care providers due to experiences with racism and discrimination (Terrell & Terrell, 1984; Ridley, 1984), and negative expectations of treatment (Nickerson, Helms, & Terrell, 1994; Watkins, & Terrell, 1988; Whaley, 2002; Townes, Chavez-Korell, & Cunningham, 2009). In a qualitative study utilizing focus groups to understand beliefs about mental illness and treatment for mental illness African American participants reported mistrust of doctors and the medical community due to beliefs about racism within the medical field and feeling disregarded by the mental health professionals (Mathews, Corrigan, Smith & Aranda, 2006). It is important to note, however that the majority of the research examining cultural mistrust and attitudes toward treatment rely on nonclinical samples, therefore the beliefs and attitudes do not necessarily reflect the experience of treatment. That is, it is unclear the degree to which the experience of racism in treatment is a reality. The
current study addresses this gap through examining the experiences of African American women in treatment with European American clinicians.

Extratherapeutic factors are important to understand what influences how participants experience therapy. Research findings suggest that what a client brings to the session (e.g. diagnoses and expectations of treatment) can impact how therapy is experienced and ultimately the degree to which this person’s condition can improve. Specific to African Americans, cultural mistrust of providers may shape attitudes toward treatment and ultimately impact the experience of therapy.

Therapist Factors

The experience of therapy is not only attributed to personal qualities of the client, but also the characteristics pertaining to the therapist. Examining the relationship between individual therapists’ characteristics (e.g. race, experience, interpersonal style, theoretical orientation) and clinical outcomes has not historically been a focus of research but has gained more attention in the past 15 years. Research findings have consistently concluded that the outcomes of some therapists are better than others (Luborsky, McLellan, Woody, O’Brien & Auerbach, 1985; Huppert, Bufka, Barlow, Gorman et al. 2010). Significant variance in treatment outcomes among therapists supports the notion that therapist effects are an important component of the therapeutic process.

Although therapist effects are important to examine, scholars have struggled to identify specific external or demographic therapist characteristics that impact treatment outcomes. Age, gender, experience, and theoretical orientation are characteristics of therapists that have been examined in relation to their impact on clinical outcome (Beutler et al., 1994). These particular variables have garnered mixed findings. For example Huppert et al. (2010) examined therapist
variables in assessing the outcomes of a cognitive behavioral treatment for panic disorder.
Within the study, the treatment outcome of 14 therapists treating panic disorder was analyzed.
Results indicated that the number of years spent practicing psychotherapy was positively correlated with overall panic disorder severity. Yielding contrasting findings, in a recent clinical trial examining therapist variable that predict change in chronically depressed clients, Vocisano et al. (2004) found no relationship to outcome and therapist experience, gender, theoretical orientation, and age.

In a classic study addressing differences between more and less effective psychotherapists, Lafferty, Beutler, and Crago (1989) examined 39 therapists who were evenly distributed into an “effective” group and an “ineffective group.” Effectiveness was based on the pre- and post-treatment scores on the Global Severity Index (GSI, as cited in Lafferty, Beutler, & Crago, 1989) of two randomly selected clients of from the therapists. The therapist variables measured included emotional adjustment, relationship skills, eliciting client involvement, credibility, directiveness, and theoretical orientation. The authors suggested that less effective therapists were less understanding and empathetic, overestimated themselves as more supportive, and tended to value intellectual goals. The study’s findings were significant in that it provided evidence for specific therapist internal characteristics that enhance the therapeutic process.

Like extratherapeutic factors, race is also an important therapist characteristic to consider, particularly in relations to cross-racial therapeutic contexts. An overwhelming majority of mental health professionals European American (APA, 2003) and therefore the majority of literature examining therapist variables in relation to race reflect characteristics reflect being European American. Early studies of clinicians’ race and treatment outcome raised questions
regarding potential racial biases within the process of therapy. Jones (1982) conducted a classic study in which 165 African American and European American clients were evenly divided and treated in therapy by African American and European American therapists. Findings evidenced that European American therapists rated their African American clients as more psychologically impaired than their European American clients. Jones’ finding was alarming because it suggested that the racial bias may occur within therapy.

Addressing racism and cultural bias within the therapeutic process has been addressed by the field of counseling psychology. Scholars with the field of psychology have expressed their concern that more attention should focus on discrimination (e.g. racial, sexual orientation, gender) entering therapy (e.g. Sue, Arredondo, McDavis, 1992; Worthington, 2004). Within the counseling psychology literature, strides have been made to develop cultural competencies for graduate training that would assess one’s ability to work with diverse populations (Arredondo & Perez, 2006). Cultural competencies tend to focus the clinicians’ awareness of their own cultural worldview and how that impacts their professional work, awareness and validation of their clients’ cultural worldview, broad knowledge of other cultures, and specific skill need to work with diverse populations (Sue, Arredondo, McDavis, 1992; APA, 2003; Arredondo & Perez, 2006).

Unfortunately there is a paucity of empirical research examining the impact of cultural competency on the therapeutic process. The closest proxy for understanding the importance of cultural competence within the therapeutic process is literature that suggests that clients’ perception of therapists as culturally insensitive lead to negative views of therapy and will discourage individuals from engaging in therapy (Mathews et al. 2006; Sanders Thompson, Bazile, & Akbar, 2004; Williams & Mohammed, 2009. For example, Pope-Davis et al. (2002)
utilized a grounded theory approach to understand client perspectives of multicultural counseling competence. Ten college students of varying ages and racial or ethnic background who had experienced counseling from a therapist who was “cultural different,” were included in the study. Pope-Davis et al (2002) reported that when cultural issues were of concern, clients felt more comfortable disclosing these issues when the therapist did not appear culturally insensitive. This finding suggests that the therapeutic process can be impacted by degree to which therapists project cultural sensitivity.

Examining therapist factors is gaining more attention as evidence suggests variability among therapists and treatment outcome. Concrete or external traits of therapists, such as gender, age, years of experience working, or theoretical orientation seem to have less of an influence on the therapeutic process. However, internal or process-oriented variables such as interpersonal style, ability to demonstrate empathy, and cultural sensitivity may have more barring on the experience of therapy for clients.

*Relationship Factors*

Process-oriented and internal variables related to the therapist appear to have an influence on the therapeutic process. One explanation for this may be the fact that variables such as interpersonal style and ability to demonstrate empathy are factors that greatly contribute to forming relationships. The therapeutic relationship or alliance is the most researched variable in relation to the therapeutic process, experience, and outcome. Norcross (2010) defined client-therapist relationship as “the feelings and attitudes that therapist and client have toward one another and how these are expressed (p.114). Similarly, Bordin (1983) described therapeutic alliance as individuals collaborating towards change through mutual agreement on goals needed
for change, the tasks of each party must engage in for change, and the bonds between all parties
to sustain the change sought.

The therapeutic relationship is an interesting component of the therapeutic process
because it is essentially an abstract manifestation of the interaction between therapist variables
and client variables. Consequently, research highlighting what contributes to strong and weak
alliances rest heavily on therapist and client variables (which were covered earlier in this review
of literature). Some of the identified general components that contribute to a positive therapeutic
relationship include demonstrating empathy (Bohart, Elliot, Greenberg, & Watson, 2002),
genuineness (Norcross, 2001), repairing ruptures in the alliance (Safran, Muran, Wallner
Samstag, & Stevens, 2002), providing feedback (Claiborn, Goodyear, & Horner, 2002), and
having agreed upon goals and mutual collaboration (Shick Tryon & Winograd, 2002).

Generally, the therapeutic alliance has strong association with clinical outcome (Beutler,
et al. 2004; Howgego, Yellowless, Owen, Meldrum, & Dark, 2003). In a study conducted by
Hovarth and Bedi (2002) across 89 studies, the mean correlation between therapeutic working
alliance and therapy outcome around adults was about .21, which corresponds to an moderate
effect size of around .45 (Norcross & Lambert, 2006). This finding suggests that the perception
of having a strong therapeutic relationship with one’s therapist is related to symptom decrease
over the course of therapy.

As with all the factors contributing to the therapeutic process, the discussion of race is
also important. As aforementioned, given the limited number of mental health professional who
are self-identified as racial or ethnic minorities (APA, 2004), African American women will
more likely experience the therapeutic relationship within a cross-racial context. Literature as it
relates to race and therapeutic relationship has generally focused on either racial matching or cross-racial therapy.

Racial matching research has been heavily debated within the field of psychology. Results of racial matching studies have been mixed and virtually no research finding has concluded that racial matching has any impact on clinical outcomes. The argument for matching is rooted in social psychology literature which suggests that people have a tendency to identify with others who are similar to them across some demographic variable (Festinger, 1954). It is believed that racial similarities can lead to similarities in attitudes between clients and therapists (Atkinson, 1983). In addition it has long been believed that matching can lead to increased positive therapeutic change (Fabrinkant, 1974).

One reason why some scholars continue to support racial-matching is that research findings conclude that African Americans prefer to have racially-similar therapists (Helms & Carter, 1991; Morten & Atkinson, 1983; Thompson, Bazile, & Akbar, 2004; Want, Parham, Baker, & Sherman, 2004). Despite this finding, samples utilized for these studies overwhelming include college students and nonclinical populations. As a result, racial-matching research fails to address the experience of African Americans in a monoracial context, does not provide evidence for more positive clinical outcomes within a monoracial context (Maramba & Nagayama Hall, 2002), and does not provide empirical evidence to support stronger therapeutic alliances within monoracial contexts (Wintersteen, Mesinger, & Diamond, 2005). For example Vanders Thompson and Alexander (2006) examined racial matching and treatment outcome with twelve African American college students who were randomly placed in either an African American or European American therapist context. The results indicated that race was not a factor in decreasing symptoms on the Brief Symptom Inventory (BSI; Derogatis as cited in
The authors concluded that for this sample the race of the therapist did not impact the outcome of treatment.

Racial-matching also has little impact on the therapeutic relationship. Wintersteen, Mensinger, and Diamond (2005) conducted a study examining racial-matching with adolescents experiencing cannabis abuse. This study compared a sample of 222 racially-similar client-therapist groups to 122 racially-different groups. The treatment consisted of manualized treatment that was provided in individual, group, and family models ranging from 5 to 21 sessions. Results indicated that racial-matching did not predict higher client-rated alliance. This finding is important because it provides evidence that is contrary to the notion that racial similarity will result in a stronger relational connection.

Complicating the lack of empirical findings in support of racial-matching is the reality that matching is not an option for many African American women seeking treatment. Often African American women and other racial and ethnic minorities will experience treatment within a cross-racial context. Research that examines cross-racial therapy overwhelming focuses on European American clinicians working with a racial or ethnic minority clients. Unfortunately since research addressing cross-racial therapy is in its infancy, there is limited empirical research focused on its association with outcome or the therapeutic relationship. The research tends to: (1) provide the conceptual assumption that addressing issues of race will strengthen the therapeutic relationship (e.g. Cardemil & Battle, 2003; Dyche & Zayas, 2001; La Roche, 2005), (2) confirm assumptions that unchecked racism can negatively impact the process of therapy (e.g. Constantine, 2007; Jones, 1982; Russell, Fujino, Sue, & Cheng, 1996; Whaley, 1997) and (3) provide conceptually and empirically-based evidence to support strategies for addressing race to enhance the experience of cross cultural research (e.g. Pope Davis et al., 2002; Ward, 2005).
The primary assumption of most cross-racial research is the belief that being open to and actually addressing issues of race and ethnicity within therapy will strengthen the therapeutic relationship, which in turn may lead to better outcomes (Cardemil & Battle, 2003; Dyche & Zayas, 2001; La Roche, 2005). Issues of race may be directly related to the cross-cultural interaction between the client and the therapist, or it may be related to environmental or personal struggles outside of the therapeutic context. One study examined the experiences of addressing race in cross-racial psychotherapy dyads (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). Twelve licensed psychologists, consisting of 5 African Americans and 7 European Americans, were interviewed regarding addressing race with clients. Although the results indicated that African American therapists were more comfortable with addressing race than European American therapists, all clinicians perceived these discussions as beneficial to treatment. Similarly Maxie, Arnold, and Stephenson (2006) surveyed 698 licensed psychologists with experience conducting therapy within a cross-racial context and the majority of those surveyed indicated that addressing issues of race helped to facilitate therapy. The results from this study suggested that within cross-racial contexts, addressing issues of race can aid in facilitating the therapeutic process.

Further support for addressing race in cross-racial therapy, is empirical evidence which suggests that clients who encounter racism negatively impacts the therapeutic relationship. Research findings examining challenges in cross-racial therapy demonstrate that European American clinicians tend to overpathologize racial and ethnic minorities (Jones, 1982; Russell, Fujino, Sue, & Cheng, 1996; Whaley, 1997). Authors from these studies postulated that negative racial stereotypes and racism account for these findings. For example, Constantine (2007) examined racial microaggressions against African American clients in cross-cultural counseling
relationships. A group of 40 African American college students who received counseling within a cross-cultural context and 19 of their European American clinicians completed measures related to therapeutic alliance, racial microaggressions, counselor rating, client satisfaction and cross-cultural counseling. Findings indicated that the therapeutic alliance was perceived as weaker when African Americans perceived high rates of microaggressions (i.e., “commonplace verbal, behavioral, or environmental indignities, that communicate negative racial slights and insults toward people of color;” Sue et al. 2007, p. 271) within therapy. The study’s findings underscore how perceived racism within a cross-racial context can weaken the relationship between therapists and clients.

Given that racism within cross-racial therapy can have negative impacts on the therapeutic relationship, many scholars have provided strategies for addressing race in a positive manner. For example Cardemil and Battle (2003) discussed recommendations for psychotherapists to become more comfortable with talking about race and ethnicity in psychotherapy. The authors made recommendations such as suspending preconceptions about clients’ race/ethnicity and that of their family members, recognizing that clients may be different from other members of their racial or ethnic group, acknowledging that power, privilege and racism might affect interactions with clients, and willingness to take risks with clients. Literature providing strategies for addressing race within cross-cultural counseling have strong implications for graduate training and tend to be associated with multicultural counseling and cultural competence literature.

**Summary**

Research pertaining to the therapeutic relationship is well-documented. Generally positive therapist variables such as empathy, genuineness, and flexibility have been identified as
important factors that strengthen the relationship. In addition, the therapeutic alliance has yielded consistent empirical support for influencing clinical outcome, wherein strong alliances are associated with positive outcomes. Given the diverse makeup of the U.S. attention to the therapeutic relationship as it is experienced within a cross-cultural context has gained more attention. Of the limited research, findings reveal that openness in discussing race and not making racial transgressions against clients can strengthen the relationship within cross-cultural contexts. Although there appears to be some movement toward increased examination of cross-cultural therapy, there remains a paucity of research examining the actual experiences of cross-cultural therapy, particularly among African American women.

Treatment Model/Technique Factors

The final factor that contributes to the therapeutic process is the treatment model/or technique used in therapy. These factors refer to the specific therapies used, tactics implemented, therapeutic methods or strategies employed in order to assist the client in taking action to improve their lives (Wampold, 2001; Thomas, 2006). Lambert (1992) estimated that treatment models and techniques can account for up to 15% of the change that takes place in therapy. The degree to which specific therapeutic models or techniques contribute the therapeutic process has been debated within the field of psychology (Wampold, 2001; Chambless & Ollendick, 2001; Littleell, 2010). As previously mentioned, scholars debate over the degree to which specificity of treatment accounts for more change within the therapeutic process or if common factors across modalities are what contributes to client improvement. Attention to specificity of treatment has greatly influenced a movement within psychology to provide evidence based or empirically supported treatments (EB/ESTs). These treatments are interventions for specific disorders that have demonstrated superiority over a control condition in at least two studies by independent
investigators (Bernal & Schorron-Del-Rio, 2001). Proponents of specificity of treatments argue that evidence based treatment is more effective because of the specific skills or components of the treatment.

Regardless of the debate, scholars do contend that the treatment does influence the therapeutic process and therefore accounts for change. It is beyond the scope of this review to present a comprehensive overview of the treatment specificity debate. However, for the purposes of this current study, the review of literature focuses on generally effective treatment and elements of treatment believed to promote change for depressed individuals. Although there are many treatment modalities for treating depression (e.g. interpersonal therapy, humanistic therapy, solution focused therapy), cognitive behavioral therapy (CBT) is most frequently researched and thus the focus of this review. Finally given the present study’s attention to depressed African American women’s experiences in therapy, treatment as it pertains to race is discussed.

Cognitive behavioral therapy is grounded in the belief that people’s emotional reactions and behaviors are strongly influenced by their thoughts, beliefs, and interpretations about themselves, or the situation in which they find themselves (Beck, 1976, Westbrook, Kennerley, Kirk, 2007). Within CBT, problems in functioning are conceptualized as maladaptive interactions between thoughts emotions, behavior, physiology and the environment from which a person operates. Ultimately this framework addresses the meaning individuals give to themselves and the events in their lives. Cognitive behavioral therapy helps individuals reframe or reconstruct these meaning to promote more positive and self-preservation notions of self (Beck, 1976).
Cognitive behavioral therapy relies heavily on psychoeducation, concrete tasks (usually referred to as “homework”), behavioral activation, structured activities geared toward recognizing ill-patterned thinking, and is usually conducted in a fairly structured manner (Westbrook, Kennerley, & Kirk, 2007). Given the structured and concrete nature of the tasks involved in CBT, this approach is amenable to controlled studies. Consequently there is an abundance of literature examining the effectiveness of CBT treatment for depression. Elkin and colleagues (1989) conducted the largest and most cited study examining the effectiveness of psychotherapy for the treatment of the depression. Utilizing a large multisite dataset from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP), the study compared the effectiveness of CBT and interpersonal therapy with 250 clients were randomly assigned to either those two treatments, a reference standard care (imipramine plus clinical management), or placebo control. Results indicated that both psychotherapies were equally effective in treating depression. Importantly, this study was one of the first to utilize a randomized clinical trial and has contributed to establishing the effectiveness of psychotherapy in treating depression.

Since the success of the NIMH-TDCRP study, research has been conducted providing evidence for the effectiveness of CBT. Research has also examined specific elements of CBT that are believed to assist in the therapeutic process and lead to positive clinical outcomes. Christopher, Jacob, Neuhaus, Neary and Fiola (2009) conducted a study that examined the relationship between cognitive and behavioral changes associated with CBT. The study utilized a pre-posttest treatment design to assess depressive symptoms, psychological distress, negative automatic thoughts, and behavioral activation for 105 clients in private psychiatric outpatient facility. The results indicated that that there was a decrease in depressive symptoms, negative
thoughts, and increased behavioral activation. Interestingly, the decrease in negative thoughts was also predictive of lower psychological distress. This study is significant in that it provided evidence that there are elements to treatment that impact the therapeutic process.

Although research has demonstrated that the treatment is an important factor contributing to the therapeutic process, scholars have criticized studies for ignoring how race or ethnicity may impact the experience of a treatment (Sue, Arredondo, McDavis, 1992; Worthington, 2004). The majority of studies examining the effectiveness of treatment often does not report the demographics of participants or report small sampling of racial and ethnic minorities, particularly African American women (Carrington, 2006). As with all the factors that were identified as contributing to the therapeutic process, cultural considerations must be taken into account when addressing the experience of treatment.

As aforementioned, research findings have indicated that the experience of cultural insensitivity can have deleterious effects on the therapeutic process and ultimately lead to poor outcomes. Parallel to the impact that having a cultural competent therapist on the therapeutic process, a culturally competent treatment may also influence the experience of therapy. One way scholars have proposed to address the issue of culturally competent treatment, is to culturally adapt treatment (CAT) to meet the needs of specified cultural groups.

Whaley and Davis (2007) broadly defined CATs as “any modification to an evidence-based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components in the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population” (p. 570-571). Voss Horrell (2008) conducted a review of literature on the effectiveness of CBT with adult ethnic minority clients. Of the 12 studies included for this review, 8 reported some level of cultural modification.
reported, including utilizing bilingual therapists, holding the intervention at a church, utilizing measures normed on a particular ethnic group, and using culturally appropriate visualizations. The treatment modifications were in alignment with the notion that there are specific elements to treatment assist in the progression the therapeutic process. Such findings lend feasibility that cultural adaptations provide specific elements to treatment that contribute to the therapeutic process.

Research involving CATs have generally reported positive outcomes in decreasing symptoms, increasing well-being, and increasing access and responsiveness to treatment (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; Breland-Noble, Bell, & Nicholas, 2006). Griner and Smith (2006) conducted a meta-analysis of CATs and found they were generally effective. Specifically, the study concluded that patients in culturally adapted treatments were four times as likely to have positive responses to treatment as patients who received an unadapted treatment. Although there exists strong support for the effectiveness of CATs they primarily focus on families and adolescents, therefore providing little information about the treatment with adults, specifically African American women who experience depression.

There currently exist few studies examining CATs with African American women (Carrington, 2006) many of which are in early stages of exploration and are typically pilot studies. For example, Kohn and colleagues (2002) conducted a study examining a culturally adapted group intervention for depressed African American women. This study was in early stages given that it was the first time the particular CAT was tested. One of the goals of study was to explore treatment preferences. The women were given a choice to participate in a traditional (non-adapted) group or a culturally adapted group and 80% preferred the culturally adapted group to the traditional group. This study was unique in that it provided women with a
choice between a CAT and an unadapted treatment. Essentially, the findings suggest that African American women may be more open CATs, which may ultimately lead a more positive experience of the therapeutic process.

In spite of promising findings, a major challenge to CAT studies is the over-utilization of therapists who are culturally-similar to participants in the study. Although many scholars strongly argue that culturally adapting treatment should go beyond racial/ethnic matching and that the treatment should be embedded in the client’s culture (e.g. Coleman & Wampold, 2003), a majority of CAT studies either utilize racial matching or do not report the race of the therapist. In a recent review literature focused on culturally modified CBT treatment, 80% of the studies included therapists who were culturally or demographically similar to the participants. Consequently, it is unclear the degree to which culturally different therapists influenced the subjective experience of a culturally sensitive treatment. Given the potential benefits of CATs for African American women and the limited number of African American psychologists (APA, 2003), research that addresses the subjective experiences of culturally sensitive treatment that is delivered in cross-racial context is the next step of scholarly inquiry.

Summary

The subjective experience of psychotherapy is important to the outcome of therapy. An individual’s experience while engaged in the therapeutic process can influence whether or not she or he wants to continue therapy, which ultimately impacts the degree to which healing can take place. As previously reviewed, scholars have identified extratherapeutic, therapist, relationship, and treatment factors as important elements contributing to the therapeutic process, and ultimately the experience of therapy (Lambert, 1992; Thomas, 2006; Wampold, 2001). Although scholars have described and tested conditions which facilitate the therapeutic process,
research often does not account for the therapeutic process within a cross-cultural context, nor does it reflect the experience of therapy for racial and ethnic minorities, specifically African American women. Given the review of general factors that contribute to the therapeutic process, the following section will specifically focus on the dearth of literature pertaining to African American women’s experience in therapy.

**African American Women’s Experience of Psychotherapy**

Literature examining the subjective experience of racial and ethnic minorities in therapy is limited, while studies specifically examining the experience of African American women in therapy are even more limited. No studies were located which qualitatively examined the subjective experience of African American women. The majority of studies examining the experience of therapy focuses on African Americans or racial and ethnic minorities as a whole and do not account for gender differences. In addition, these studies tend to be quantitative or analogue and focus on college student samples (e.g., Kemp, 1994), attitudes toward treatment and perceptions of counseling (e.g., Sanders Thompson, Bazile, & Akbar, 2004), or racial preferences of counselors (e.g., Want, Parham, Baker, & Sherman, 2004) rather than the experience of therapy itself. Generally, findings from these studies suggest that African American can hold negative views toward therapy, usually reflecting cultural mistrust of providers, and prefer to see racially similar therapists (Mathews et al. 2006).

Although most studies focus on perceptions of therapy there are a few studies that examine the experience. For example, Sanders Thompson, Bazile, and Akbar (2004) examined African Americans’ (134 women ad 66 men) perception of therapy and clinicians through conducting focus groups. Interestingly, about 32% of the sample had received at least one therapy session. Focus group questions addressed psychological problems, therapist image,
race/gender/ethnicity, service center characteristics, therapist characteristics, and therapy goals. Sample questions/probes included: “What kind of characteristics do you look for in a therapist? What goals do you set for therapy? Should therapists of a different race or ethnicity discuss race or ethnicity during the initial phase of therapy?” The participants reported a variety of perceptions and experiences with therapy with the perceptions of a lack of trust, impersonal service, and lack of multicultural awareness about the clinicians. This perception was consistent with previous literature addressing cultural mistrust with mental health professionals. Although the participants indicated that the race of the clinician should impact therapy, they believed that therapists were insensitive to the African American experience.

In regards to the perception of the experience of therapy, the authors reported that the majority of participants described the psychotherapeutic process as “an invasive, impersonal strategy to gain relief from distress” (p. 23). However, the findings also indicated that participants who engaged in long-term therapy reported experiencing empathy, compassion, developed trust and believed that an important relationship was formed with their therapist. This contrast in finding is interesting because it provides evidence that the experience of the therapeutic process can influence the duration of engagement in therapy. However, this study did not collect data addressing factors which encourage or discouraged engagement in the therapeutic process.

Although not specifically identifying factors that contributed the engagement in therapy, Ward (2005), questioned of how African Americans engage in therapy though an examination of individuals who had completed therapy at a community mental health agency. A grounded theory study, Ward (2005) identified the process by which African Americans assessed their therapeutic experience. The sample consisted of 13 women and 8 men with various mental health
concerns (e.g. substance abuse, parenting issues, and coping with bipolar disorder). Although this study did not focus specifically on cross-racial therapy, 12 participants reported having a European American therapist, while one reported having an African American therapist. Therefore the findings of this study are somewhat skewed toward the experiences of African Americans in cross-cultural therapy. The participants were interviewed and asked to share their experiences in counseling.

Findings were consistent with factors that contribute to the development of a strong therapeutic alliance such as agreement on tasks, goals, and trust. Participants indicated that their process of engaging in therapy included assessment of client-therapist match, ideological similarities between the client and therapist, effectiveness of the therapist, and feeling safe with the therapist. Ultimately, the ongoing assessment process influenced the degree to which clients demonstrated openness through self-disclosure.

The study’s findings lend evidence to the important factors that assist African Americans in staying in therapy. Although the cross-racial therapeutic process was not directly examined, given that the majority of participants were currently engaging in cross-cultural therapy, these findings shed light on the process of African Americans engaging in therapy with European American clinicians.

While Ward’s (2005) study focused indirectly on the process of engaging in cross-racial therapy for African Americans, Chang and Berk (2009) focused on the experiences of racial and ethnic minorities who completed cross-racial therapy. Specifically, these authors conducted a phenomenological study in which they examined the experiences of racial and ethnic minority clients who had successful and unsuccessful treatment with European American therapists. The
sample consisted of eight men and eight women of various racial and ethnic backgrounds. Six (3 women and 3 men) of the participants were of African or African American decent.

The authors found that there were both general and context specific (i.e. cross-cultural) factors that influenced the relationship. Participants reported that general therapist characteristics such as being caring, respectful, accepting, willing to self-disclose, and open to discussing and addressing ruptures in the therapeutic relationship were helpful. In contrast, context specific therapist characteristics that assisted in building a strong relationship included taking an active role in therapy and demonstrating cultural knowledge, skill and awareness. These findings are in alignment with the multicultural competence and multicultural counseling literature (Arredondo & Perez, 2006) and support the argument that when treatment is delivered in a culturally sensitive manner, a more positive experience of cross cultural therapy occurs. In regards to treatment, participants reported dissatisfaction with “treatments that were too textbook and not tailored to the client’s specific life contexts” (p. 527). This finding in part supports the need for providing treatment that is culturally sensitive, such as culturally adapted treatment (CAT). It is possible that delivering a CAT for those participants may have improved their experience of therapy within a cross-racial context. Another challenge with this study was that it focused on racial and ethnic minorities as one homogenous group and did not account for ethnic and gender differences. To address such challenges, the current study will examine CATs delivered within a cross-racial context and attend to the unique experience of African American women.

When conducting a search for literature focusing on the experience of African American women in cross cultural therapy only two studies were identified. Aitken and Burman, (1999) examined the experiences of a European American female therapist and her African American
female client. The client and therapist were interviewed four times over an 11-month period. Themes that occurred during the course of the therapeutic process included limitation in self-disclosure and negotiating power. Similar to previous studies, this study provided evidence in support of therapist transparency and honesty in discussing issues related to race. Despite the relevant findings emerging from the in-depth case study, the generalizability of the findings to the process experienced by a group is questionable. In addition, like many studies examining the experience of therapy, there was not attention to treatment itself, and whether the therapeutic model employed was culturally sensitive.

Similar to Aitken and Burman (1999), Cooper and Lesser (1997) utilized a single case approach to describe the therapeutic process between an African American woman and her European American female counselor. Specifically, the in-depth case study provided transcripts and summaries of the initial, middle, and end stage of treatment in addition to the counselor’s reflection of treatment. A description of this process indicated that racial identity development was an issue with which the client often struggled. Interestingly, the counselor reported that she found it difficult to allow the issue of race to enter into her relationship with client. As with most studies, this study did not provide information on treatment modality that was utilized nor the experience of the client. This current study will address the experiences of African American women receiving a culturally sensitive treatment.

**Summary**

A majority of research examines the perceptions and attitudes toward treatment rather than the subjective experience of the therapeutic process. In addition, research tends to focus on experiences of African Americans or racial and ethnic minorities as a whole rather than attending to specific racial groups or gender. Interestingly, much of the research reported findings of
African Americans with European American therapists even if cross-racial therapy was not the focus of the study (e.g. Ward, 2005). Research findings evidence that within a cross-cultural context, African Americans and racial and ethnic minorities often have better experiences in treatment when the therapist is culturally sensitive or the treatment is culturally adapted to meet their specific needs (Chang & Berk, 2009). To date, no studies have examined the experience of African American women who are receiving culturally adapted treatment within a cross-cultural context. It is important to understand what assists in facilitating the therapeutic process when a European American is delivering a culturally adapted treatment because (1) culturally adapted treatment has been found to be effective and (2) cross-cultural therapy is the reality in which the vast majority of African American women will experience treatment.

**Conclusion**

The review of literature indicates that depression among African American women is prevalent, often misdiagnosed due to cultural variations in its symptom presentation, and is often left untreated. Many factors such as lack of access to care, cultural mistrust, and attitudes toward seeking professional help contribute to African American women underutilizing mental health services. Despite an understanding of the factors that contribute to African American women underutilizing services or discontinuing services, little is known about the actual subjective experience of being in therapy, which is often occurs within a cross-racial context. Research suggests that racial and ethnic minorities have positive experiences in therapy when therapists are culturally sensitive and treatment is culturally adapted to meet their needs. To date, no studies have examined the experience of Black women who are receiving culturally adapted treatment within a cross-cultural context. The present study addressed this gap.
Purpose of Study

The current study examined the experiences of depressed Black women engaged in a culturally adapted group counseling treatment that is delivered by European American clinicians. Specifically, this study utilized a phenomenological mixed-method approach to uncover how culturally sensitive care is experienced by African American women when provided by European American clinicians. Given the limited attention to treatment outcomes when focusing on the experiences of cross cultural therapy, a secondary aim of this study was to provide descriptive outcome data on the degree to which symptoms were reduced. It was hypothesized that women will experience a significant reduction in symptoms from pre to post-test.
CHAPTER III

Methodology

The primary purpose of this study was to examine qualitatively the experiences of Black women receiving a culturally adapted treatment for depression from European American clinicians. In addition, the study’s secondary aim was to provide descriptive clinical outcome data regarding symptom improvement. The following chapter provides an overview of the research design and methods for this current study.

Qualitative Methodological Framework: Transcendental/Psychological Phenomenology

This study implemented a phenomenological approach to examine the experiences of Black women receiving a culturally adapted treatment delivered by European American clinicians. Phenomenology is a qualitative approach that seeks to capture the universal essence of the lived account of individuals who have experienced a similar phenomenon (e.g. surviving cancer, experiencing grief, or discrimination). In reducing the lived experience of a phenomenon to its universal essence, phenomenological research attempts to “grasp the very nature of the thing (experience)” (van Manen, 1990, p. 177). In phenomenological studies people who have experienced a similar phenomenon are identified and interviewed about their experiences. From this, descriptions of the experience are identified to address the “what” and the “how” of the phenomenon (Moustakas, 1994).

Phenomenology, as stated by Stewart and Mickunas (1990), is a “reasoned inquiry which discovers the inherent essence of appearances” (p. 4). German mathematician and philosopher Edmund Husserl conceived the phenomenological philosophical movement, which primarily focused on systematically reflecting and analyzing the experience of a phenomenon (Moustakas, 1994). As conceptualized by Husserl, phenomenology seeks to examine objectively the
subjective conscious experiences of judgments, perceptions, and emotions that accompany experiencing a phenomenon (Moutakas, 1994).

There are two primary approaches to phenomenological research: hermeneutical phenomenology and transcendental or psychological phenomenology (Creswell, 2007). Hermeneutical phenomenology (van Manen, 1990), focuses on interpreting the hermeneutics of lived experiences. From this perspective, phenomenology is both a description of a lived experience and an interpretive process by which the researcher “mediates” between the different meanings (van Manen, 1990, p. 26). Transcendental or psychological phenomenology focuses more on the description of lived experiences and less on the interpretation (Moutakas, 1994). Given the lack of attention to interpretation, the approach highlights the philosophical assumption in which presuppositions of what is believed to be real is suspended. The process of suspending presuppositions is called bracketing and is employed by the researcher throughout the research process. In doing so, researchers make an effort to bring an unbiased perspective through suspending their biases and putting aside their prior experiences, values, and beliefs.

Given the exploratory nature of this current study and the limited knowledge of the experiences of Black women who participate in cultural adapted treatment within a cross-racial context, a transcendental/psychological phenomenological approach (as described by Moutakas, 1994) was employed. This specific methodological approach was chosen because of its emphasis on understanding the essence of an experience. When there is limited knowledge of a phenomenon, it is first important to establish a foundational understanding of the phenomenon itself. From this foundational understanding more research can be conducted to address explaining the experience and how to improve the experience. As such a
transcendental/psychological phenomenology approach was chosen because it seeks to uncover the foundational understanding of an experience.

There are four primary philosophical components of transcendental phenomenology (Creswell, 2007; Moustakas, 1994). First, is the notion of intentionality, or the belief that consciousness is purposefully directed toward an object. According to Husserl (1931), intentionality refers to the internal experience of being conscious or aware of something. The *something*, or object, could be real or imagined. Phenomenology inherently rejects the notion of the subject-object dichotomy. Instead, there is an endorsement of a dual Cartesian nature of subjects and objects in which the reality of an object is confined to the subjective experience of it by an individual. Intentionality is comprised of noesis, which is the act of feeling, thinking, remembering (consciousness) and noema, which is the object of consciousness wherein meaning is placed onto the object. Noesis and noema are highly related and ongoing processes that occur when one’s consciousness is directed toward an object. Therefore within the phenomenological framework, the lived experience of an individual is conscious and intentional.

Intuition is another important philosophical component of transcendental phenomenology. Husserl’s notion of intuition is based on the work of Descartes, who postulated intuition is one’s natural inclination to “produce solid and true judgments concerning everything that presents itself” (Husserl, 1977; p. 22). Moustakas (1994) described intuition as “the beginning place in deriving knowledge of human experience, free of everyday sense impressions and the natural attitude” (p. 32). Intuition is an important concept within transcendental phenomenology because through an intuitive-reflective process, in which one senses, imagines, questions, doubts, and understands what is being seen, one can transform what is seen and ultimately meaning to the experience/object.
A third important concept within transcendental phenomenology is intersubjectivity. Intersubjectivity refers to the tapping into the subjectivity of others. In this sense others are seen as subjects and not other objects. Intersubjectivity is highly related to the notion of empathy, in which someone is able understand the subjective experience of someone else thorough applying the experience of the “Other” to one’s own subjective experience. Intersubjectivity allows one to transcend in and out of her or his own experience and in essential provides objectivity. In addition intersubjectivity is important to transcendental phenomenology because this process contributes to one’s understanding of her or his perceptions of what is real (Moustakas, 1994).

Finally, as aforementioned, the philosophical notion of epoche, or the suspension of presuppositions of what is believed to be real, is essential to transcendental phenomenology. Though epoche, the subjective experience of the individual is emphasized and not the interpretation of the researcher. Epoche is achieved through a process of bracketing, which will be further discussed in the data analysis section. The emphasis on sustaining judgments is important to the phenomenological approach because it reflects the goal of capturing the essence of a phenomenon from the perspectives of those who experienced it (Moustakas, 1994).

Design

The current study utilized a mixed-method concurrent-nested design. According to Hanson, Creswell, Plano, Pestka, et al. (2003), “In concurrent nested designs, quantitative and qualitative data are collected and analyzed at the same time—However, priority is usually unequal and given to one of the two forms of data—either to the quantitative or qualitative data” (p. 229). For this study priority was given to the qualitative data to examine primarily the experiences of Black women in therapy, while the quantitative data was used to provide contextual information about the participants’ clinical outcomes as the secondary emphasis of the
study. To examine qualitatively the experiences of Black women receiving a culturally adapted treatment from European American clinicians, a phenomenological approach was used. Using phenomenology as a guiding framework, in depth interviews were conducted with treatment participants.

To address the quantitative component of this study, a one-group pretest-posttest approach was used. An outcome measure was completed at baseline, week 6, and week 12. A mixed-method approach was implemented to contextual the experience of participating in culturally adapted treatment. Both the qualitative and quantitative components of this study served to provide a rich understanding of the participant’s experiences.

**Sample size**

Six Black women experiencing depression and two European American clinicians were recruited for this study. According to Yalom (1995) group counseling can be facilitated by one or two co-facilitators. Two facilitators were specifically chosen for this study due to prior usage of two facilitators for delivering the OHDC (Ward, 2010b). Therefore this current study replicated the approach used by Ward (2010a). Since the culturally adapted treatment is a group counseling intervention, group size was taken into consideration in determining the participant sample size. Findings from group therapy research indicate that the optimal size for groups consists of 7 or 8 members, with a range of 6 to 14 (Yalom, 1995). In addition, phenomenological studies typically consist of about 5 to 25 participants (Polkinghorne, 1989). A treatment group sample size of eight was selected based on both methodological and group dynamics considerations.

**Participants**

Six Black women experiencing depression and two European American clinicians were included in this study. An advanced doctoral student and licensed psychologist who had
significant experience working with the treatment protocol were recruited to supervise the facilitators.

Participant Inclusion and Exclusion Criteria

**Inclusion criteria for sample:** Black women who were between the ages of 25 and 55 and experiencing MDD based on a score on the depression screening measure (i.e., Quick Inventory of Depression Symptomatology, Rush, Trivedi, Ibrahim, et al. 2003) were included in the study. The 25 to 55 age range was selected to prevent stage of life issues from interfering with group cohesion. That is, older adults and adolescents were excluded from the study because it was believed that these groups have specific developmental issues (e.g. for the elderly retirement and role transition, and identity issues for adolescents) that may require more intensive individual treatment or specialized group therapy.

**Exclusion criteria for sample:** Black women were excluded from the study if: (1) they were actively suicidal (a suicidal protocol addressed how to screen and refer), (2) they were abusing alcohol, (3) they had changed psychotropic medication in the past six weeks, or (4) their depression was assessed as “severe” based on the screening measure.

**Personnel**

The personnel for this study consisted of psychology graduate students (facilitators and primary supervisor) and a licensed mental health professional (secondary supervisor).

**Facilitators:**

Two European American graduate students were recruited to serve as group facilitators for this study. The facilitators for this study consisted of one male therapist and one female. The male facilitator was a second year doctoral student, was 29 years old at the time of the intervention, and had never worked with Black clients before. The female facilitator was a
second year master’s student, was 26 years old at the time of the intervention, and had worked with a Black female client before. Utilizing graduate student facilitators seemed appropriate given that literature regarding therapist characteristics influence on treatment concluded that the experience of the therapist does not impact outcome (Beutler et al., 1994; Crits-Cristoph et al., 1991; Okiishi et al., 2006; Stein & Lambert, 1995).

Gender of the therapists was also considered in developing the inclusion criteria for the clinicians. Group dynamics are often shaped by the composition of the group such as the individual personalities or mental health concern of each group member, in addition to demographic dimensions such as race, gender, and age (Yalom, 1995). Under this assumption, group dynamics are inevitably formed because each individual will ultimately influence the group. For example, if all group members (including the therapists) are female, a single gender dynamic is formed. Therefore the dynamics of the group will be shaped regardless of whether the therapists are similar or dissimilar on the dimension of gender. Since research indicates that therapeutic outcomes are not tied to the gender of therapists (Beutler et al. 1994; Okiishi et al., 2006; Huppert et al., 2001) and the therapists’ gender was not specifically examined in this current study, the gender of the therapists was not incorporated into the inclusion criteria. Therefore the criteria for inclusion were: (1) self-identified as European American, (2) had completed a course on group psychotherapy and (3) they had either facilitated or observed at least one psychotherapy group.

**Supervisors:**

There were two supervisors for this study. The primary supervisor was an advanced doctoral student who had significant experience with the treatment protocol. Having a supervisor with experience implementing the protocol was very important given that the protocol is
relatively new and facilitators would more than likely have challenges that were connected to the delivery of the treatment protocol. The primary supervisor was responsible for meeting with the facilitators once a week.

The secondary supervisor was a licensed psychologist with significant experience implementing the treatment. The primary role of the secondary supervisor was to provide weekly supervision and consultation to the primary supervisor and facilitators. The secondary supervisor was an individual who had prior experience facilitating groups post-licensure and supervising student therapists. According to the APA ethical guidelines, psychologists are ethically bound to work within their competency; therefore the supervisor will have to demonstrate competence, as provided by the American Psychological Association code of ethics (APA, 2010). Specifically, supervisors must have had didactic and applied training in providing supervision to trainees (Harrar, VandeCreek, & Knapp, 1990). In addition, given the exploratory nature of this study, the relative newness of the intervention that was used, and the importance of monitoring participants’ well-being, it was important to provide oversight with providing support to the study therapists and supervisor.

Sources of Data

Screening Measures

Quick Inventory of Depressive Symptomatology-Clinician Rated (QIDS-CR16): The Quick Inventory of Depression Symptomatology (Rush, Trivedi, Ibrahim, et al. 2003) is a relatively new 16-item measure of depressive symptoms and severity based on the DSM-IV (APA, 1994). It has both a self-rated and clinician-rated version. For both versions of this measure, the severity of symptoms, over the course of the past 7 days, are rated on a scale from 0 to 3 (See Appendix B). The QIDS was based on the Inventory of Depressive Symptomatology (IDS; Rush et al.
2000), which is 30-item measure that also has self-report and clinician-rated versions, and is based on diagnostic criteria for depression within the DSM-IV. The QIDS was developed to provide a more time effective and accurate measure of depression for both clinical and research settings. Specifically, the QIDS was developed to improve clinician and patient ratings by 1) providing equivalent weightings (0-3) for each symptom item; 2) providing clearly stated anchors that estimate the frequency and severity of symptoms; 3) including all DSM-IV criterion items for diagnosing depression; and 4) providing matched clinician and patient ratings (Rush et al. 1986, 1996, 2003; Gullion and Rush, 1998, Trivedi et al. 2004). The 16 items included on the QIDS were selected from items on the IDS that assessed criterion diagnostic symptoms depression based on the DSM-IV.

The psychometric structure of the QIDS corresponds to nine DSM-IV symptom criterion domains (Rush et al., 2003). These domains include: 1) sad mood, 2) concentration, 3) self-criticism, 4) suicidal ideation, 5) interest, 6) energy/fatigue, 7) sleep disturbance (initial, middle, and hypersomnia), 8) increase/decrease in appetite/weight, and 9) psychomotor agitation/retardation. The insomnia, appetite/weight, and psychomotor domains consist of more than one item; thus for scoring purposes the highest rating within those cluster of questions are used for scoring. Scores are computed by adding up the rated items. The total scores range from 0 to 27, with scores from 6 to 10 indicating mild symptoms, 11 to 15 indicating moderate symptoms, 16 to 20 indicating severe symptoms, and 21 to 27 indicating very severe symptoms.

The clinician-rated version of this measure was specifically chosen over a self-report measure due to its semi-structured interview format. The interview structure of this measure provided more diagnostic assessment of the severity of depression, which was important given that intervention used in this study was not designed for individuals experiencing severe
depression. Consequently, a diagnostic interview provided more insight of severity by thoroughly assessing suicidality, psychoses, and history of depressive symptoms.

In addition to the advantage of having a semi-structured interview format for assessing depression, the research using the QIDS has strong psychometric properties. Rush et al. (2003) examined the QIDS in relation to the IDS and the Hamilton Depression Rating Scale (HDRS). Relying on a sample of 681 individuals diagnosed with depression (demographics were not reported), findings suggested that the QIDS had a strong internal consistency ($\alpha = .86$). Findings also concluded a strong correlation between items on the QIDS and the HDRS ($r = .81$).

**Alcohol Users Disorders Identification Test (AUDIT):** Given evidence that alcoholism and depression have strong comorbidity and the current study’s intervention does not attend to problematic drinking, a screening was used to identify individuals who may be experiencing problems with alcohol. The AUDIT was developed by the World Health Organization and is a 10-item self-report screening measure for harmful alcohol use in the past year (Saunders et al., 1993). According to the World Health Organization, this measure was created over the span of two decades and was developed in response to the high prevalence of undiagnosed alcoholism around the world (Barbor, Higgins-Biddle, Saunders, & Montiero, 2001). The AUDIT was designed to be used in both clinical and research settings.

The structure of the measure includes three items on alcohol consumption (e.g. *How often to do you have a drink containing alcohol?*), three items on alcohol dependence symptoms (e.g. *How often during the last year have you found that you were not able to stop drinking once you had started?*), and four items related to problems due to alcohol use (e.g. *Have you or someone else been injured as a result of your drinking*?). Each item is rated from 0-4, based on frequency
within the past year, and scores ranging from 0-40. Scores ranging between 0 and 7 are indicative of little to no evidence a problematic drinking. However, scores between 8 and 15 are indicative a moderate problematic drinking, and scores 16 and above are indicative of serious problematic drinking.

The AUDIT is a widely-used instrument within clinical and research settings and has been found to be reliable across age, gender, and cultures. Specifically, the AUDIT has been tested with university students (DeMartini & Carey, 2009; Johnsson, Lefman, & Berglund, 2008), African American individuals (Cherpitel, 2002; Cherpitel & Bazargan, 2003; Cherpitel & Clark, 1995), and international populations (Olafsdottir, Raitasalo, Greenfield, & Allamani, 2009) which suggests its reliable usage across demographics. Reinert and Allen (2002) conducted a review of 18 research studies involving the AUDIT. The studies included varied on diversity of population (e.g. college students, racial and ethnic minorities, low-income) and setting (e.g. primary care, university, community). The authors concluded that the AUDIT held strong internal consistency above .80 for all studies. The AUDIT has also has strong correlation with other measures of problematic drinking such as the CAGE (Reinert & Allen, 2002). The AUDIT was specifically chosen for this study because of its wide usage in research.

**Descriptive Measure**

*Demographic Questionnaire (DQ):* The demographic questionnaire was designed to provide descriptive information regarding the participants’ background. The items on the measure were specifically chosen to address descriptive variables that may influence experience of the participants. The DQ consists of 12 items gathering information on the participants’ age, education, marital status, income, and prior mental health treatment. Specifically, there are seven questions on sociodemographic variables (e.g., age, education, income, marital status) and
eight questions on mental health and treatment seeking experiences. Sample questions included “Have you ever sought professional treatment for a mental illness (e.g. depression and anxiety,)” and “What is your annual income?” The DQ was only be collected at baseline.

Clinical Outcome Measure

*Beck Depression Inventory-II:* The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item scale developed to assess the frequency and severity of depression symptoms during a 2-week period, as prescribed by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV, 1994). Each item in the measure is rated on a 0-3 scale. Therefore the summary scores range between 0-63. The cutoff scores include: (1) 0-13 for minimal depression, (2) 14-19 for mild depression, (3) 20-28 for moderate depression and scores of 29 and above are indicative of severe depression (Beck et al., 1996). According to Beck and colleagues depression is composed of an affective-cognitive factor and a somatic factor (Beck, Ward, Mendelson, et al. 1961). This 2-factor model is used to describe the BDI-II, with 16 items loading on to the affective-cognitive factor and five items loading onto the somatic factor. The BDI-II is a revised version of the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, et al. 1961). Despite good internal-consistency, test-retest reliability, construct validity, and factorial validity, the original BDI was criticized for its content validity and compatibility with the DSM-IV (Dozois, Dobson, & Ahnberg, 1998). The BDI-II was created to be more consistent with the DSM criteria (Dozois, Dobson, & Ahnberg, 1998).

The BDI-II has demonstrated high internal consistency (Cronbach $\alpha = .92$) and test-retest reliability ($r = .93$; Beck, Steer, and Brown, 1996). The BDI-II has been found to be a reliable measure for depression for college student populations (Carmody, 2005; Steer & Clark, 1997; Storch, Roberti, & Roth, 2004), adult outpatient populations (Beck et al., 1996; Steer, Ball,
Ranieri, & Beck, 1999; Steer, Ranieri, Kumar, & Beck, 2003), and nonclinical populations (Segal, Coolidge, Cahil, & O’Riley, 2008). In addition, the BDI-II has been found to be equally reliable for use with both men and women (Dozois, Dobson, & Ahnberg, 1998).

The BDI-II was specifically chosen for this study because it has demonstrated consistent reliability with ethnically diverse groups (Carmody, 2005). Specifically to African Americans, research findings form this measurement have consistently yielded high alphas (Grothe, Dutton, Jones, Bondenlos, Acona, et al., 2005; Joe, Woolley, Brown, Ghahramanlou-Holoway, & Beck, 2008). For example, Dutton, Groethe, Jones, Whitehead, et al. (2004) examined the use of the BDI-II with African American primary care patients. Two-hundred and twenty African Americans (115 females, 105 males) were recruited from their primary care physicians and completed the BDI-II. The results indicated high internal consistency coefficient of .90. In addition the authors established diagnostic discrimination with participants previously diagnosed with depression having significantly higher mean scores on the BDI-II than participants without a depression diagnosis. The authors concluded that participants who received a diagnosis of depression following clinical structured interviews had an average BDI-II score that was in the “moderate” range. These findings suggested that the BDI-II has diagnostic properties that are consistent with diagnostics used in clinical settings (i.e. structured interview).

The BDI-II was also chosen for this study because of wide usage in both research and clinical contexts (Beck et al., 1996). Specifically to research, the BDI-II has been used in studies specifically examining the effectiveness of CBT counseling groups for individuals who are depressed (e.g. Kellet, Clarke, & Mathews, 2007; Mohr, Boudewyn, Goodkin, Bostrom et al., 2001). In addition, the BDI-II was used as the outcome measure for the only published study to date which examined a culturally adapted CBT treatment versus treatment as usual for depressed
African American women (Kohn et al., 2002). The BDI-II therefore is an appropriate measure for studies with group counseling.

The BDI-II was also chosen because unlike other self-report measures of depression (e.g., Center for Epidemiological Studies Depression Scale, CES-D; Radloff, 1977), the BDI-II was not created primarily for use in research settings; it is widely used in clinical settings as both a screening and outcome measure of depression (Arnau, Meagher, Norris, Bramson et al., 2001; Beck et al., 1996; Viljoen, Iverson, Griffiths, Woodward, 2003). In addition, as established in the Dutton et al (2004) study, the BDI-II has diagnostic discrimination that is consistent with structured clinical interviews. Given that this study was exploratory, had a small sample size, and was primarily qualitative, the use of multiple outcome measures for depression was inappropriate. The CES-D, for example, was created to be used in studies of relationships between depression and other variables (Radloff, 1977). In contrast, the BDI-II was created to be both a clinical diagnostic and a research measure and therefore was chosen as the best “stand alone” measure of depression.

**In-depth Interviews**

Phenomenological interviews are typically an informal and interactive process that relies heavily on open-ended questions and comments (Moustakas, 1994). The researcher may have pre-developed questions that are geared toward promoting a comprehensive understanding of the participants’ experiences; these questions may be altered, varied, or not used if the participants share their experience fully without need of specific prompts.

Interviews traditionally being social conversation aimed at building rapport, creating a relaxed environment, and promoting trust. Following conversation, the research takes time to orient the participant to the purpose of the interview. Moustakas (1994) suggested that interviews
for phenomenological research broad or general questions - - “What have you experienced in terms of this phenomenon?” and “What contexts or situations have typically influenced or affected your experiences of this phenomenon?” Given the exploratory nature of this study a semi-structured interview protocol (See Appendix) was created to help guide follow-up questions that would be consistent across participants.

The interview protocol consisted of questions that uncovered both the textural and structural level of the experience. Participants were asked 10 general questions with probing follow-up questions to gather depth of answers. Sample questions to uncover the textural description of the phenomenon included: “Please describe for me your experience in the Oh Happy Day Class, stating at the beginning and taking me thought the very end” and “What was it like working with the facilitators?” Sample questions to uncover the structural description included: “Did you feel like this class was culturally sensitive? How so? How not?” and “Reflecting back on your experience in the Oh Happy Day class, how important were racial differences? What influenced this?”

Cultural Adapted Treatment: Oh Happy Day Class (OHDC)

The Oh Happy Day Depression Class (OHDC) is a culturally-adapted version of the Coping with Depression Course (CWD; Lewinsohn et al., 1985) for older African American women (Ward, 2008). However, before specifically discussing the specific components of the OHDC and how it was adapted, the components CWD is first presented to set the context of the OHDC.

Coping with Depression Course

The CWD is a cognitive behavioral counseling intervention that can be delivered in either group or individual formats. As this study is a group intervention, the information provided below will
focus on the group delivery of the CWD. Specific information regarding the individual delivery of the CWD can be found in Lewinsohn et al. (1985). The group delivery of the CWD consists of twelve 2-hour sessions. The primary emphasis of CWD is psychoeducational as it is geared towards educating participants about healthy coping strategies that can be used to prevent depressive symptoms and cope with symptoms during a depressive episode. Unlike “traditional” therapies, the therapist-client dynamic within psychoeducational therapy functions more like an instructor-student dynamic than a counselor-client interaction. Consequently the client has control over the therapy through applying what is being learned to him or herself.

The intervention is based on social learning theory which suggests that depression develops when stressors in one’s environment interrupt normal behavioral patterns which lead to an imbalance in positive and negative experiences (Bandura, 1977). The imbalance may decrease a person’s sense of self-efficacy and result in depressive symptoms. Given the social learning emphasis, the intervention focused on participants learning about depression and developing self-change skills that foster healthier approaches to coping with life stressors. Specifically, the sessions focused on psychoeducation about depression, relaxation techniques, setting realistic goals, controlling negative or irrational thoughts, and developing plans or contracts for new behaviors.

The CWD is a highly-researched intervention (Brown & Lewinsohn, 1984; Hoberman, Lewinsohn, & Tilson, 1988; Clarke et al., 2005) having been implemented with multiple populations including adolescents (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Clarke, Reid, et al., 2002), adolescents of color (Guerda, Arntz, Hirsch, Schmiedigen, 2009; Rossello, Bernal, & Rivera-Medina, 2008), adult alcoholics with depression symptoms (Brown, Evans, Miller, Burgess, and Mueller, 1997), young adults 18 to 24 years of age (Clark et al., 2009),
older adults (Haringsma et al., 2005), and low income minority women (Miranda et al., 2003). In a recent meta-analysis of 18 studies, Cuijpers, Munoz, Clarke, and Lewinsohn (2009) found that the CWD was highly effective in preventing the onset of depression in addition to reducing depression symptoms as a treatment. The studies included for the meta-analysis were diverse in their target population. For example studies focused on adolescents (e.g. Rohde, Clarke, Mace, Jorgensen & Seeley, 2004), low income minority women (Miranda et al., 2003), and chronically ill ethnic minorities (e.g. Munoz et al, 1995). The meta-analysis provided support that the CWD was effective with diverse populations, particularly across age, SES, and ethnicity. Despite the utility of the CWD with diverse populations, the treatment has never been exclusively used with African American women. The majority of studies using the CWD with racial and ethnic minorities have been conducted with Latino populations (Munoz et al., 1995; Munoz et al, 2007; Rossello & Bernal, 1999; Rosello, Bernal, & Rivera-Medina, 2008). Consequently the OHDC protocol was specifically developed to tailor the CWD for use with African American women (for a summary of session content for CWD and OHDC see Appendix A).

**Oh Happy Day Class**

The OHDC protocol has been adapted for use with young adult and middle-aged African American women and men as well as elderly African American women (Ward, 2010a; Ward, 2008). Like the CWD, the OHDC uses a group counseling format that consists of twelve 2-hour sessions. Embedded in the group counseling sessions is psychoeducation with an emphasis on teaching clients about depression, increasing awareness of mental illness, increasing healthy coping behaviors, and reducing perceived stigma associated with mental illness. Like the CWD course, OHDC is theoretically-grounded in social learning theory, but incorporates culturally specific elements to meet the needs of African American women. For example, one culturally
adapted element is the focus on educating participants about group counseling and the therapeutic process in Session 1. The adaptation was developed to address the stigma within the African American community around seeking mental health treatment. In addition, many African American women may be unfamiliar with the process of counseling due to underutilization of services. Other sessions specifically adapted include addressing African American women and depression. For example, Session 3 focuses on the intersection of gender and race as risk factors. Data regarding these risk factors are discussed and the lived experience of depression as an African American female is processed. In Session 6, a focus on community resources to provide psychoeducation around seeking-help is included. In this session community social programs are highlighted.

The OHDC is a relatively new intervention that is currently being evaluated. Despite the exploratory nature of this intervention there are preliminary findings that support its efficacy. In a pilot study, Ward (2008) examined the feasibility and acceptability of the OHDC for elderly African American women experiencing depression. Using a one-group pretest-posttest design, the outcome variables included the CES-D and Hamilton Depression Rating Scale, which were completed at baseline, and weeks 6, 12, and 24. Results indicated that symptoms of depression were significantly reduced \( p = .03 \) from baseline \( (M = 24.50, \, SD = 10.7) \) to week 24 follow-up \( (M = 19.30, \, SD = 11.1) \). In another pilot study examining the efficacy of the OHDC with adult African American women (Ward, 2010a) preliminary findings are consistent with the previous findings with elderly women (Ward, 2008). Using the same measurement and design structure, early data suggests that the trend for symptom reduction is consistent from baseline \( (M = 27, \, SD = 9.15) \) to week 12 \( (M = 15, \, SD = 11.32) \). The findings of this study provide preliminary support for the efficacy of the OHDC intervention.
Procedure

Two European American doctoral level students were recruited and trained to co-facilitate the OHDC group. The training was provided by the lead researcher, a Black counseling psychology doctoral student, who had experience facilitating groups with the ODHC protocol. The group facilitator training consisted of five 3-hour training sessions. Each training session had a specific focus to ensure the facilitators’ understanding and adherence to the protocol. The first session consisted of an orientation and introduction to the OHDC intervention manual. The facilitators were asked to read two resources which addressed the intersection of gender and race for Black women with depression (i.e., Adkison-Bradley, Bradshaw, & Sanders, 2007) and therapeutic factors of group formation (i.e., Yalom, 1995). The resource regarding Black women and depression was used to familiarize the facilitators with some general challenges that Black women with depression face. The lead researcher, however, stressed the variability in Black women’s experiences and that the resource should be viewed as general information. The resource on group counseling served as a reorientation to group counseling.

Training Sessions

The goals of the first training session were to (1) provide general background on the specifics of the study (2) provide general education regarding the population in study, (3) begin to process and discuss comforts and discomforts with addressing cross-racial issues and (4) provide a brief overview/introduction to the manual. The remaining training sessions (2 through 5) consisted of in-depth discussion of the intervention manual with the facilitators. Since the intervention manual is divided into 12 weeks, each training session covered three weeks of the treatment protocol. For example, training Session 2 covered treatment weeks 1 through 3 of the intervention, training Session 3 covered weeks 4 through 6 of the intervention and so forth. The
goals of the remaining training sessions were to: (1) review how the manual is to be used, (2) review each week thoroughly, (3) provide clips of prior group counseling sessions utilizing the intervention to get a feel of what sessions might look like, (4) process video clips and (5) discuss challenges with the material. Once the therapists began to facilitate the actual treatment group, they checked in the lead researcher on an “as needed” basis to discuss logistical and clinical challenges.

**Facilitator Supervision**

Facilitators received weekly supervision from an advanced doctoral student (primary supervisor) and a licensed psychologist (secondary supervisor) who were familiar with the OHDC protocol. The supervisors were recruited through known associates of the lead researcher based on her knowledge of individuals who meet the criteria and were interested in the study. The facilitators met with the primary supervisor once a week, while the primary supervisor met with the secondary supervisor once a week for supervision of supervision. The lead researcher served as a consultant regarding any concerns regarding the treatment manual. The primary role of the supervisors was to provide clinical supervision to the group facilitators to provide support and guidance regarding the treatment protocol, therapeutic process, and monitoring the well-being of the participants.

For supervision and documentation purposes, clinicians took notes after each session. The notes documented the interventions used and the group’s progress. No identifying information was used in the notes. Instead of names, participants’ identification numbers were used. These notes did not constitute mental health records. The notes provided documentation of what happened in the group for supervision and participant monitoring purposes. Notes were
kept in a secure file cabinet and were destroyed after the completion of the 12-week intervention. Participants provided written consent for notes to be taken.

**Recruitment and Study Procedures**

Participants were recruited from a moderate size Midwest community through partnerships made with churches, community centers, community mental health agencies, and community businesses. Recruitment involved posting flyers, placing ads in predominantly Black/African American read local newspapers, and meeting with local organizations regarding the study. A snowball recruitment strategy was utilized to maximize recruitment. Although a snowball recruitment method challenges the random selection of participants, this method is particularly useful for small communities and is a method for groups who have traditionally been mistrustful of research participation (Alvarez, Vasquez, Mayorga, Fester, & Mitrani, 2006). In essence the “word of mouth” approach within the African American community provides credibility to institutions and systems that have traditionally been viewed with mistrust.

Participants interested in the study contacted the lead researcher via phone or email (if responding to the flyer) or in person (if recruited in person) to set up a screening in which they completed the QIDS-CR16 and AUDIT. The screening was held at a community health agency. The community facility was in compliance with the Health Insurance Portability and Accountability Act (HIPAA). The screening process lasted approximately 30 minutes to an hour. Participants were informed beforehand about the purpose of the study. They were also informed that the treatment was designed for individuals with mild to moderate depression. Therefore, they were informed that individuals with severe depression may not be able to get all their needs met through the OHDC. Individuals who do not screen into the study ($n = 4$), had severe
depression, or were not interested in participating were provided with mental health resources and referral numbers.

Participants who met the inclusion criteria were provided with consent forms regarding participating in the study. Participants were informed that the study’s purpose was to understand better the experiences with a culturally adapted treatment. Participants were not told the race of the facilitators as to not further bias the self-selection process. Additionally, not informing the participants of the facilitators’ race was purposely utilized to model how services are provided in the community. However, there was not deception used in this study, therefore the lead researcher was open to letting the participants know the facilitators’ race should they ask. No participants inquired about this during the recruitment process.

Participants were informed that their experience of the group is important even if they do not complete all 12-weeks. Participants were also informed prior to beginning the intervention that each session builds on the previous session therefore they will gain more out the class if they attend the majority of the sessions. However, they were reminded that the study was voluntary and they could discontinue their participation at any time. Participants were informed that they would be asked to discontinue the group if (1) their depression symptoms deteriorated and they were in need of more intensive care, or (2) they violated rules of group member conduct (which was established in Session 1).

Finally, participants were informed that they would receive up to $99 for compensation. Participants were compensated with $50 after completing the 12 sessions of the OHDC. Participants also received $49 after completing the interview. Finally participants without transportation were provided cab coupons and those with transportation were provided with $20 dollar gas cards every three sessions. Given the time commitment involved in this study,
compensation to participants seemed appropriate for transportation, potential work time missed, or arrangement for child care. Thus the $99 and transportation assistance represented reimbursement to participants over the entire three month commitment to the study.

After agreeing to participate in the study, participants completed the baseline measures, which include the demographic questionnaire (See Appendix C) and the BDI-II (See Appendix D). Completing the baseline measures took approximately 15-20 minutes. The clinical outcome measure was completed during the middle of the intervention (week 6) at the end of the intervention (week 12). All data collection occurred after the actual session was completed.

Once all six women were recruited for the study, the 12-week treatment intervention began. The women met weekly for two hours at a community center which was in compliance with HIPPA. There was a 10-15 minute break during the session and participants were provided with dinner.

Prior to each session, the participants received reminder phone calls from the lead researcher regarding attending the session. These calls paralleled the reminder calls that are routinely given to patients prior to medical and mental health appointments.

After the last session was completed, participants scheduled interviews with the lead researcher about their experience receiving a culturally adapted treatment delivered by European American clinicians. Six interviews were completed after two weeks of completing the intervention in order to have current reflections on their experience and maintain retention in the study. Interviews lasted between 60 and 90 minutes and were audiotaped and transcribed.

*Participant Safety*

The safety of participants in this study was important. As aforementioned, individuals who endorsed suicidal ideation during the time of the screening were not eligible for the study.
On *QIDS-CR* question 12 is an assessment of suicidal ideation. Individuals who endorse answers other than “not at all” were administered the suicide prevention protocol (See Appendix F), which provides steps for assessing suicidality and instructions for proper actions to take. Participants who indicated that they are currently suicidal or have had a suicide attempt in the past year were eligible for the study because the current treatment protocol was not designed for individuals with suicidal ideation. These individuals were referred to other mental health resources. In the event that a participant’s depression became more acute and she endorsed suicidal thoughts during the course of the study, the therapists, lead researcher, or both parties jointly were to administer the suicide prevention protocol. Additionally, both the primary and secondary supervisors were to provide consultation and oversight regarding hospitalizing or referring participants who become suicidal. During the course of the study no participant required a suicidal ideation assessment.

*Data Analysis*

*Qualitative Analysis*

The data collected from in-depth interviews were analyzed using the procedures of phenomenological data analysis as presented by Moustakas (1994). The data was managed using the Microsoft Excel program to create a codebook. The codebook allowed the data to be organized to keep track of emerging themes and sub-themes, descriptions of themes, significant line numbers in the transcripts, and questions/reactions regarding the data. The research team conducting the analysis consisted of the lead researcher, a Black female advanced doctoral student in the department of Counseling Psychology, and a co-analyst, who was a Black male advanced doctoral student in the department of Counseling Psychology. Both the lead researcher and the co-analyst had strong training and experience with phenomenological research.
Bracketing. Prior to data analysis, the research team met for two hours to engage in bracketing. Bracketing is a process outlined by Moustakas (1994) which involved setting aside one’s own personal experience with a phenomenon to understand fully the experiences of another. During this meeting both members of the research team acknowledged and addressed their experiences as Black/African American individuals. Both members discussed how they have common beliefs around their sense of “what being Black or African American means” and that they should be mindful about generalizing their experience to understand the participants’ experiences within the group. Additionally, both members discussed their views about perceived general cultural expression, relational style, and worldview that are held with the Black/African American community. They discussed possible “countertransference-like” responses to the participants as if they were aunts, mothers, or grandmothers. Both members acknowledged this bias and agreed to hold one another accountable should they make statements like “generally Black/African American people/women…” or making connections between the participants’ stories and a relative. The members of the research team also discussed knowing Black people (both men and women) who have been in cross-racial therapy. They discussed personal accounts of people who have had this experience and agreed to be mindful not to generalize the experiences of others to the experiences of the participants. Finally, both members of the research team acknowledged that as clinicians, they may bring a bias of trying to understand the women’s experience from a clinical perspective. That is, they may try to make meaning of the women’s experiences through clinical conceptualizations. They both agreed to hold each other accountable through having direct conversations about biases when they appeared present during the analysis process. For example both members attended to one another’s clinical language used during the analysis process.
The members of the research team also discussed their individual biases. The principle researcher discussed biases related to being a Black woman and having multiple roles within the study. She shared with her colleague that as a Black woman she may try to understand the participants’ experiences based on her own lived experience. She invited her colleague to hold her accountable should she make statements around “Black women tend to believe or feel this way...” She also stated that since she recruited and interviewed the participants, she may bring a level of bias regarding how well she knows each individual participant. That is, she may try to make interpretations of the women’s experiences based on interacting with them and believing that she has insights around their personalities. Her colleague agreed to bring this to her attention during the data analysis.

The other member of the research team discussed his bias regarding factors he thought made Black/African Americans more comfortable within cross-racial contexts with European-Americans. He shared beliefs such as, African Americans being able to sense if European-Americans have not had on-going interactions with African Americans. He asked his colleague to verbally identify and have a conversation exploring his bias should these assumptions be used in making meaning of the data. The research team member also acknowledged that as a male he had “male privilege” and that this could present itself during the data analysis process. His colleague agreed to attend to language that seemed to connote a disregard for the participants’ context of being a woman.

During this initial meeting the principle researcher took copious notes which were sent to the other member of the research team. These notes were present during the data analysis research meetings. As such, the notes were utilized as a means of holding the research team accountable to one another and reaching consensus during disagreements regarding the data.
Over the course of analyzing the data, the lead researcher and co-analyst had several differences in interpreting the data and moments where processing the reactions to data was necessary. In order to resolve these disagreements both individuals engaged in the process outlined above in order to reach consensus. At times, this process included taking breaks from the data in order to have a “fresh” perspective in re-analyzing the data. The lead researcher and co-analyst relied heavily on notes taken during the bracketing meeting in order to explore biases and hold one another accountable to their interpretation of the data.

Data Analysis Process. The first step of the phenomenological data analysis was horizontalization. This process involved reading the transcripts and highlighting “significant statements,” or quotes that capture how the participants experienced the phenomenon. During this phase, the members of the research team listened to the audio of the interview while reading and highlighting significant statements. As suggested by Hyncer (1985), listening to audio can help to understand fully the nuance of what participants are saying. For example, by attending to tone of voice, laughter, and so forth, the researcher can make better meaning of what is said through attending to nonverbal communication. Both members of the research team listened to the audio recording of the interview separately as they coded. Through attending to biases and consensus, the research team discussed what each person highlighted and informally kept track of inter-rater reliability of text. After review all 6 interviews, 841 significant statements were highlighted. Next, six clusters of meaning or themes from these statements were generated. Then, textural descriptions of the significant statements and themes were developed to describe fully the experience of the participants. Finally, based on the structural (themes) and textural descriptions (sub-themes) the invariant structure or “essence” of the phenomenon was developed. This consisted of developing a general narrative (several paragraphs) that tied together the
common experience of all participants. According to Polkinghorne (1989) the essence of the participants’ story should provide the reader with a feeling of “I understand better what it is like for someone to experience that” (p. 46).

**Scientific Rigor.** To enhance the rigor of the qualitative data, the themes and descriptions formed from the data were sent to two participants to assess accuracy of capturing the essence of their experiences. This process is known as member checking. Two participants agreed to read through the results and provide feedback. However, only one participant followed through with providing her input about the results. The other participant was not able to be reached via the contact information provided. The participant that was contacted provided feedback via phone and indicated that the results were accurate to her experience.

Additionally, the results were independently reviewed by a professor who was outside the lead researcher’s department and whose area of expertise was phenomenological research within the context of mental health. This individual served as an auditor and provided oversight regarding the accuracy of thematic descriptors in addition to feedback regarding implementation of the phenomenological approach within this study. The auditor provided feedback that the data analysis process was accurate and that the results seemed to “fit” or capture the participants’ quotes. The auditor also made recommendations to the lead research regarding the usage of “clinical language” for thematic descriptors. The auditor suggested that the label of the themes more closely resemble the actual words used by the participants. For example one textural descriptor (subtheme) was changed from “corrective emotional experience” to “release of emotion.” The auditor also provided feedback on the “evaluative” tone of the results that at times seemed to reflect the participant’s evaluation of the treatment itself as oppose to their experiences. Based on the lead researcher’s reflection of the evaluative tone and the lead
researcher’s ownership of inherent bias in some of the interview questions, a paragraph clarifying the purpose of the study and addressing a possible treatment evaluation tone of the results was incorporated into the introduction of the results section.

**Quantitative Analysis**

There were two primary analyses for the quantitative data. First, summary statistics were computed to describe the sample with respect to demographic variables. Second, to examine the pre-test/posttest outcomes of the clinical measure (BDI-II), group mean differences were examined with a *t*-test to assess differences from baseline to Week 6, Week 6 to Week 12, and baseline to Week 12.
CHAPTER IV

Results

After careful analysis of the qualitative data, six distinct themes emerged which captured the essence of the shared experience of the women. These themes included: 1) Preconceptions of the Group and Facilitators, 2) Critical Incident, 3) Process of Healing, 4) Therapeutic Qualities of Facilitators, 5) Cultural Differences Not a Barrier to Connecting to Facilitators and 6) Therapeutic Gains. These themes served as the structural descriptors as described by Moustakas (1994). Each theme was further described by textural descriptions or sub-themes that helped to contextualize and fully describe the essence of the participants’ experiences. In wanting to provide a general description of the universal experience of participants, themes were identified based on at least 50% \((n = 3)\) of the participants endorsing a particular theme. Usage of the word “majority” throughout this study denotes at least four or more participants endorsing a particular theme.

In keeping with the transparent nature of phenomenological research, it was important to provide perspective on the interpretation of the data. As aforementioned, the purpose of this study was to examine the experience of Black women receiving a culturally adapted treatment delivered by European clinicians. The intention of this study was to understand the experiences of the participants and not to evaluate the effectiveness or fidelity of the treatment itself. However, due to the lead researcher’s interest in understanding the participants experience within their context, some of the interview questions utilized may have reflected this bias. Thus it is important to own that some of the themes presented in this study may have an “evaluative” connotation.
The presentation of the data is as follows: first participant demographic information is presented, and then each theme (structural description) is identified and provided with a general description. Below each description of the theme are accompanying textural descriptors, which are briefly described. Direct quotes from participants follow the textural descriptors in order to provide a richer contextual understanding of the women’s experience. Next, based on the structural and textural descriptors, the invariant structure, or “essence” of the phenomenon is presented in a narrative form. Finally, quantitative data regarding symptom reduction is presented.

**Participant Demographic Information**

All six participants who agreed to participate in the study completed the treatment. Descriptive statistics were calculated for the demographic information in order to contextualize the sample. The mean year of birth of the women was 1960 (or about 52 years old) with ages ranging from 1970, or about 41 years old, to 1954, or about 57 years old, ($SD = 5.49$ years). The distribution of financial background distribution was evenly spread with $33\%$ ($n = 2$) of women reporting an annual income of 0-$10,000, 33\%$ ($n = 2$) reporting earning $10,001$-$20,000, and $33\%$ ($n = 2$) reporting earning $20,001$-$30,000. Additionally all of the women self-identified as “working class” and $50\%$ ($n = 3$) reported earning a high school diploma or GED. Half of the women in the study also reported having health insurance. Regarding relational/personal factors, $33\%$ ($n = 2$) of the women reported having never been married or widowed, while one woman was married and one was separated. All of the women reported having children, with the average number of children being almost four ($3.5, SD = 1.87$).

Demographic information was also gathered regarding history of mental health, experience seeking services, quality of seeking services, and experience receiving services
within a cross-racial context. Thirty-three percent \((n = 2)\) of the women indicated that they had been formally diagnosed with mental health concerns. The women disclosed being diagnosed with issues related to substance abuse, anxiety, and depression. Despite only two women indicating having formal diagnoses with mental health concerns, 83\% \((n = 5)\) women reported having sought professional mental health treatment from at least one provider, 66.7\% \((n = 4)\) women reported seeking services from two providers, and 33\% \((n = 2)\) reported seeing three providers. The average number of sessions was almost 18 \((M = 17.58, SD = 35.54)\). However, one participant indicated that she was residential treatment and met with a provider daily for three months, while another participant indicated that she had never had treatment. Given the impact that outliers have on means, once these women’s data was removed the average number of session was reduced to just under four sessions \((M = 3.88, SD = 1.75)\).

With regards to the racial context of therapy, the women reported having therapists of Black/African American, European-American, Latino or Hispanic, and Biracial/Multiracial backgrounds. Four out of the five women who reported prior treatment for mental health concerns, indicated that they had been seen by European-American therapists. Only one participant indicated that she had worked exclusively with a Black/African American clinician. Data was collected on the quality of service received from providers. Participants were asked to rate each provider as providing “poor, fair/adequate, good, and excellent” treatment. Of those who had been in treatment with European-American therapists, the majority (80\%; \(n = 4\)) rated the treatment as “good” or “excellent.”
TABLE 1
Summary of Participant Demographic Information (N = 6)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
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<th>SD</th>
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<tbody>
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<td></td>
</tr>
<tr>
<td>$10,001-$20,000</td>
<td>2</td>
<td></td>
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</tr>
<tr>
<td>$20,001-$30,000</td>
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<tr>
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<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>“No”</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
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<td></td>
<td></td>
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<tr>
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<td>1.87</td>
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<tr>
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<td>Mental Health Variables</td>
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</table>

Theme One: Preconceptions of Group and Facilitators

This theme described preconceived beliefs, feelings, and expectations that group members had regarding what the group experience would be like. These beliefs reflected
preconceptions held prior to the group beginning in addition to beliefs held during the early stages of the group (i.e. first 2-3 sessions). Most members had mixed feelings of both excitement and trepidation while some had feelings that were more grounded in one or the other. The trepidation experienced included worries around what the group experience would be like, how knowing group members outside of group would impact their experience, and wondering if perceived female dynamics (e.g. gossiping/competition) would occur in group. In contrast to concerns about the group, all women reported positive expectations of the group, such as looking forward to group starting and believing that participating would be beneficial to addressing their challenges with depression. Finally, all participants indicated that they expected that the facilitators would be Black females.

This theme also described the group members’ preconceived beliefs about how cultural difference between them and facilitators would be barriers to the therapeutic process. The perceived cultural barriers seemed to center on facilitators not being able to help group members because they cannot relate to the participants' lived experience. That is, the group members described wondering if how the facilitators could be helpful when they do not understand what it like to be a Black woman. Similarly, participants reported believing that they would not be able to connect to the facilitators (or vice versa) because of the differences in lived experiences. Additionally, participants’ awareness of the age differences between themselves and the facilitators also lead to preconceptions around the degree to which facilitators could be helpful. Some participants reported believing that the facilitators were too young (both in age and in being students) to be able to helpful. Participants stated wondering how young students could have enough life and professional experience to understand their challenges or know who to help
them. These preconceived notions were grounded in the belief that similarities are important for connection and being able to provide a positive therapeutic experience.

**Textural Descriptors-Group**

1. *Didn’t know what to expect*: Group members described hesitancy with joining the group, particularly due to unfamiliarity with group counseling and not knowing what to expect. Additionally, they described not knowing what to expect in terms of the group meeting their expectation of being helpful.

   “My experience with the Oh’ Happy Day class turned out to be more than what I was looking for.” (Participant 105)

   “And when I first got into the group, I didn't where I was going. I didn't know where I was going. But I was seeking help with some ideas that was, with some things that was bothering me, on my mind, because I don't want to be a depressed person…” (Participant 105)

   “In the beginning yeah you could say I was still somewhat skeptical.” (Participant 109)

   “I mean we just, you could see everybody was like, okay, huh. And you could tell that they were kind of like okay. [Laughter] And so it was like this whole big mystery at first.” (Participant 111)

2. *Reservation about female dynamics*: Group members described trepidation about joining the group specifically due to preconceived notions of all female dynamics such as competition or gossiping.

   “Well, like I said at the beginning of it when we first started I thought it was wasn't going to be interesting or was going to be bull-mess [gossiping].” (Participant 101)

   “It was a nice choice because if it was all women, everything would be blocked and you know how women look at each other.” (Participant 106)

   “Woman together in the room and not cussing each other out ready to call each other out they name.” (Participant 111)

3. *Anonymity*: Participants were aware of the anonymity in the group. Group members described wonderments around possibly knowing other women in the group because the Black community
is small. They further wondered if knowing someone would affect their experience. Some members knew other group members while some did not.

“Okay, first of all, I didn’t know nobody. Like everybody know somebody in [city name]. Now, far as [group member’s name], [she] knew an associate of mines. It was like that was good. That was like, okay, there’s not going to be no he said that I don’t know nobody, so you tend to like it like that.” (Participant 101)

“The day we started the introduction and seeing the other women come in and I was surprised. Some of them, I know them being here for almost 28 years.” (Participant 106)

“Because of the womens in the group. Some I know, [name]. I've been knowing we used to hang together…. But I was skeptical about opening up and letting other people know certain things about me.” (Participant 109)

4. *Facilitators will be Black:* Group members discussed expecting the group facilitators to be Black, and being shocked or surprised that they were White.

“I was really looking to see Afro-American women such as you facilitate the group or whatever.” (Participant 105).

“Then, when I got there, I thought a Black graduate student would interview me. Then, it was a white man and a white woman…and that got me really, really excited to see their reaction to what I have to say.” (Participant 106)

“I was surprised that our facilitators were White. So I was thinking that the group was gonna be Black with Black facilitators.” (Participant 112).

Textural Descriptors—Facilitators

1. *Facilitators can't relate:* This descriptor connoted participants’ beliefs that the facilitators couldn’t relate to or understand them because of cultural (race, gender, age) differences.

“At first, you do probably kind of look at them because they were young and we were older. Well, I did. I can't speak for nobody else.” (Participant 101)

“Day one I was like, wow, we got two, a young white man, male and a young white female in here teaching us about depression on African American women. So I didn't think that it was quite right, you know, I didn't think that I was going to get nothing out of it.” (Participant 105)
“Because I was thinking they [facilitators] would not know what we are going through. Like I’m going to tell this man that he will understand. What am I going to and in it, I said, ‘They have everything. They don’t understand what the Black people go through every day.’” (Participant 106)

“Oh my goodness, these White people [laughs] - these White people they don't know nothing about us. And I’m like how are they gonna deal with us? And how am I gonna relate to them? Sitting there thinking on my first day - oh my goodness this is not gonna work.” (Participant 109)

“Because they were too young - I was looking at age wise and they probably never dealt with a bunch of Black females in one group.” (Participant 109)

“I guess I was expecting other black people or even other people of color, women, you know, I'm like well somebody that could understand my experience with, that, you know, would be able to maybe kind of relate to the things that maybe we were going through.” (Participant 111)

2. Facilitators don't have enough experience: This descriptor connoted the participants’ beliefs that the facilitators were too young and not experienced enough to be helpful.

“You do look at that because they're younger and you're older. What they going to be able to teach us and stuff.” (Participant 101)

“You know, and the thought that came to my mind was, wow, we have some college people here that really don't know about depression, they're reading from there, they're getting everything they know from books.” (Participant 105)

“Because they was too young - I was looking at age wise and they probably never dealt with a bunch a Black females in one group.” (Participant 109)

Theme Two: Critical Incident

This theme described a critical incident wherein there was conflict within the group regarding interactions with group members and facilitators. Specifically, the incident centered on time management and redirecting participants in order to allow for all group members to have an opportunity to speak, and have time for structured activities. The participants indicated this incident was significant because it demonstrated the openness of the facilitators to discuss conflicts openly and in the moment. Participants described appreciating that the conflict was
handled in group in front of all members and not ignored or addressed in a one on one fashion. They indicated that discussing the conflict openly and in the moment made the issue not grow into an ongoing problem or make it turn into a larger issue. The participants described appreciating the facilitators’ non-defensive and honest communication style during the conflict. They indicated that the transparency in addressing the conflict gave a "real" experience to the group. That is, group members and facilitators were not holding back their true feelings or being unauthentic. Group members reported that the conflict in the group brought the group closer together and they felt more comfortable with the facilitators.

**Textural Descriptors**

1. **Conflicts discussed openly and in the moment:** The group members described appreciating the critical incident being discussed openly in front of other group members. The participants described appreciating that that the critical incident, and all other conflicts, were discussed in the moment and not minimized or ignored.

   “I said, ‘Well, you're not letting me finish off my conversation what I need to be finished.’ Then she understood. Me, her and [male facilitator], we all talked. Plus, we did it in front of the room.” (Participant 101)

   “I think [group member] took offense to what [female facilitator] had said and, or how she said it…I think it was just a perception and misunderstanding of how it was said. And, but it was dealt with right away. [Group member] said, well, you know, I just want to say that I didn't appreciate what you said or did…But, right away [female facilitator] was like, hey, I'm sorry. I apologize. And she appreciated [group member] bringing it to her right away instead of keep coming to class and harboring this feeling. But [group member] really appreciated that it was out in the open and we could deal with it.” (Participant 111)

   “And I told them [the facilitators], I said, I know we not the easy people, easiest group to deal with because, you know, we sometimes, sometimes we go all off on a [sounds like] cuff here and there. But that's just because we, I think we felt so comfortable with doing it. And if there was an issue, it was dealt with right away and it was gone. So it was.” (Participant 111)
“She actually apologized [in the moment] for coming out and saying it like she did and [female facilitator] said well because of time we have to realize that other people have to talk.” (Participant 112)

2. Conflict brought group closer together: Group members reported that the conflict brought the group closer together and reflected the ability to have a reparative experience following interpersonal challenges.

“I didn't get a chance to finish and then I confronted her with it and she understood and stuff and then we got along wonderfully.” (Participant 101)

“…the facilitator apologized and she let her know that she wasn't trying to cut her off, she was trying to stay on track with the time, with our schedule. Which we kind of like got off some every now and then…And after that I think that kind of brought people together a little more. Because the [female facilitator] apologized to her it just kind of like brought all us - it was a very touching moment, I'll say.” (Participant 105)

“I wasn't there for the first 2 but when - I can't remember her name now - but when she bought up that they weren't listening to her - and I think that's an important piece to be in there and that they were cutting her off and she wasn't done - because of time, we had like what 2 hours - and so it seemed like the group got more comfortable and he let people speak for as long as - and they realized that they were taking up a lot a time so they stopped but when everybody came around then they had a chance to go back around and talk so that was good.” (Participant 112)

Theme Three: Process of Healing

This theme described experiences and characteristics of the group counseling process that participants found impactful and/or important to their development, or psychological change. The participants described aspects of the group counseling process that lead to gained insight and healing with respects to their challenges with depression. The participants described the importance of receiving support from other members and the power of others sharing their narratives. The women indicated that their interactions with one another made them feel safe to share their experiences and express their emotions. That is, the group environment was one which was non-judgmental and positively reinforced support and empathy. Therefore participants felt comfortable sharing without fear that they would be judge or not supported. As a
result, the women described the group as feeling like a "family or a sisterhood." Through the support and openness of others sharing their experiences, the women felt a normalization of their challenges and were able to engage in their own process of catharsis.

Textural Descriptors

1. Group support: The participants described a feeling of strong support from other group members and the facilitators when sharing their feelings or discussing challenging aspects of their lives/experience with depression.

   “We were all helpful to one another. By expressing our feelings and talking... just expressing our feelings and talking [helped].” (Participant 101)

   “I do need support. And I felt that "O Happy Days" gave me each other support. That be part of my...probably as far as support for me, so I would do it again if it - for support reasons.” (Participant 101)

   “I could tell the girls, once I have to say the girls were very warm, they were all warm and heartfelt. You could feel they, when you're talking, they can feel you and they care. And that was real touching and loving too that led me to open up that I wasn't scared to say nothing or talk about how I was feeling and stuff like that.” (Participant 105)

   “And so I talked about it in group and they really made me feel better at the group saying, oh, you know, you're not that type of person and so and so. So I, that helped me, lead me to pray more. I got a lot of support.” (Participant 109)

   “I talked about this in the group and stuff and they gave me suggestions, they gave me ideas in a different way - they say just let it go but sometimes you really just can't let it go until you see that they're in a different position to where it'll be okay…” (Participant 109)

2. Normalization of challenges: Group members reported that hearing each others' stories and experiences helped to normalize their own experience. That is, the women felt like they were not alone in their struggles with depression and other life challenges.

   “I begin to understand that depression a lot more in myself than I did than before because myself was fighting myself. It was. I was fighting myself and as we got to look at the tapes and talking about it and was in the book I see that I'm not alone.” (Participant 101)

   “…my peers in the group to open up and see how they were feeling, because a lot of them were feeling the same thing I was feeling…” (Participant 105)
“But after listening and learning, talking to some of the other women who also got health issues that they say stems from that - so it was good to learn you are not by yourself and that somebody else is going through some of the same issues that you go through.” (Participant 109)

“Over the weeks we got really comfortable with each other, more people started bringing out more things and we found out that we had a common thread, everybody had something that they were going through exactly like the people in the group. And so that was a good thing, yeah.” (Participant 112).

3. Release of emotion: Group members described the importance of sharing stories and expressing their emotions and releasing negative feelings while in group. They indicated that this process was healing.

“I think I kind of opened up some feelings one day when we was at group. I don't think people really talk about their relationship. But I know my relationship was a very big part of me feeling depressed. So when I opened up to the relationship part about me and my significant other, then a couple of more of the ladies opened up too.” (Participant 109)

“I think everybody got a chance to let something out that they was hiding inside that was kind of fearful or worry to them. The other, one or the other ladies, I think she got off her chest a lot about how she think that people change.” (Participant 105)

“And you can feel the honestly that was going around, and you can feel when they [group members] uplift somebody. Say like if you worried about something and you want to talk about it but you don't know if you should, if you're around the right people to talk about it, you talk about it and then the release. Yeah, you could feel the release that people were getting when they speak and they talk.” (Participant 105)

“And that's one thing that I realize about this whole process, it's holding on to all of this stuff that causes the other stuff. You know, all this negative baggage and the garbage that we hold on to based upon other people's perceptions, what has happened to us in our life, everything. As long as we hold on to it, that's what causes the other negative feelings. And so the more that we got it out and it was like, okay, I'm letting this all out.” (Participant 111)

4. Group felt like a Family/Sisterhood: The women in the group described feeling so connected to each other and the facilitators that the group itself felt like a family or a sisterhood.

“…it [the group] was about each other. We just - just - it's like we knew each other as - and then during the 12 weeks went by so fast. Gosh. It was like, huh-uh, this ain't the last
of it. And then we just got to know one another. And we'll come in and we'll talk and exercise the stuff in our book…” (Participant 101)

“So everybody got in there. A little, some of them a little slower than the other, but before, I say by week nine, we all were like, you know, new friends. We all were like new friends and it was great.” (Participant 105)

“It was just kind of like just sitting down with your girlfriend's, just having an evening over some food and letting it out, and laughing, and shedding some tears, and supporting each other, lots of hugs, and really healing. And I have to say, I am better because of it. I'm in such, more of a better place.” (Participant 111)

“And so I was okay with that. I was, I felt like, okay, well, you know what, if you want to learn from me, I definitely feel like I can learn from you. And I did. It was just like we was just all one big family. Everybody was like, you too [male facilitator; laughter].” (Participant 111)

5. Group was safe: The participants described the group as a safe place to discuss their challenges.

“You could feel they [group members], when you're talking, they can feel you and they care. And that was real touching and loving too that led me to open up that I wasn't scared to say nothing or talk about how I was feeling and stuff like that.” (Participant 105)

“It seemed like that little room was over there was our release, release and our comfort every Thursday we knew we had somewhere to go that feel comfortable and just, you know, like say if you had to go somewhere and scream, that was it.” (Participant 105)

“It's a scary process to bring up stuff that has caused you pain. But when you know that you're in a safe place, that you're safe and that nothing's going to harm you, you're just like, here you go, you want this, there you go, take it.” (Participant 111)

6. Investment in group: The participants described having a personal investment in the group process. They described looking forward to coming to group, taking the group seriously, and the group being a reflection of them taking time out for themselves.

“I'd leave work all stressed with a headache because of things that was going on and I could come to my group and talk to the facilitators.” (Participant 105)

“Remember I told you I am excited to be coming to the class and then I really didn't want to miss anything. I didn't want to miss the experiences.” (Participant 106)
“And it was an experience that I actually end up really loving and looking forward to. I was like, oh, it's Thursday, you know, [Laughter] you start anticipating Thursday. And then after that, that following week when we didn't have group, I was like, oh, hum.” (Participant 111)

“I was enjoying it. Like I told her, I was doing something for myself and so I was looking forward to Thursdays coming in. And they seemed just as pleased. It wasn't like another - and everybody when we went around the group everybody said this is Thursday and we're tired but we went on, the group was active and strong; it wasn't like - we never had a day where what am I gonna say and what are you gonna do and I don't wanna say anything - we didn't have anything like that.” (Participant 112)

**Theme Four: Therapeutic Qualities of the Facilitators**

This theme described group members experience and perception of the facilitators' attributions that they believe contributed to a positive therapeutic experience within the group. During the interviews participants described personal qualities of the facilitators that they believed help them to not only address their challenges with depression but also connect to the facilitators. Their ability to connect to the facilitators through these personal attributes made cultural differences less salient. That is cultural difference were no longer associated with barriers to connection or treatment and the personal characteristics of the facilitators were more important that their cultural differences. Generally the participants described facilitators as being empathic, transparent, caring and non-judgmental. The participants indicated that these qualities were more important the facilitator’s race, age, and gender.

**Textural Descriptors**

1. **Empathetic/Caring**: Group members described facilitators as being empathetic and understanding of their experiences. Additionally, they indicated that facilitators seemed to genuinely care for their well-being.

   “And you can feel the concern from the facilitators. And they was, they were very concerned about what we had to say, they were very interested in what was going on with us. And they gave, they made sure everybody got a turn to, even though the one that was
mighty, a little quiet and all, they still made sure that everybody got a turn to speak, to be heard.” (Participant 105)

“And then they were so hurt that one day that we didn't get food. [Male facilitator] even pulled a bowl of beans out of his bag and shared with us.” (Participant 105)

“But then to, you know, in the, midway of the group, I started to realize that they actually generally had a concern and they really, really wanted to know our experience and how our experience has caused depression, or has caused anxiety or different things like that. And so that's why I was trying to open up as much as I can, as much as you can allow somebody to experience what you've experienced and let them understand what you're going through. And I really felt like they really, honestly, genuinely was trying to understand. And, which helped me become more comfortable.” (Participant 111)

“And they were a lot understanding to be 2 young students. They said they couldn't actually relate but they understood, which was good. And then he said I can't imagine—I can feel that but I can't feel that as a Black woman. But as a human being.” (Participant 112)

2. Facilitators are real: The participants indicated that the facilitators were transparent and open to sharing their experiences and feelings within group. Group members described this transparency as making it easier to connect to the facilitators and were helpful for their therapeutic process.

“You do look at that because they're younger and you're older. What they going to be able to teach us and stuff. It wasn't a question at all about that neither because they also, like I said, expressed their feelings when we went around talking. Everybody expressed their feelings. So it wasn't as different.” (Participant 101)

“They [facilitators] were all real. You know how a real family interacts? They eat with us. They drink with us. They cried with us and they had sympathy because these people are women that are really depressed.” (Participant 106)

“…we shared our experiences. …they [facilitators] also include themselves in sharing their emotions and sharing their feelings. That makes me more comfortable because they are sharing their own. I felt really good that they are equally sharing so that I can actually reflect.” (Participant 106)

“So that was a good thing. And they told us about their feelings and the different things that was happening with them that day and stuff like then how did they deal with it. So it was helpful to know that hey they was doing those same exercises we was doing so that was good. It was nice.” (Participant 109)
3. Invested in Group: Group members described the facilitators being highly invested in the group through making their weekly commitment and being prepared for group. They also described knowing that as students the facilitators had numerous commitments, which made group members feel more appreciative of the facilitators' time.

“They [facilitators] were very nice. ...it seemed like they were studying, they was, it seemed like they were trying to make sure they make that ‘A’…They was going to follow these rules in this book, they was gonna get down to the point of it, they was gonna make sure that we got through with that lesson by 7:30, and they was gonna make sure that, you know, they were on target, they were on target with what they were doing. They made a commitment. And when I see how they were so [committed] ...And I think that helped me to get here too every Thursday, you know, I saw how committed they was to this.” (Participant 105)

“And they took their time out a their schedule to work with us and I thought that man you all got school, you all busy time set aside you all time for us, least we could do was be there and just show that we appreciate that you coming out. Because I know I really appreciated them because some nights I just wanted to get away, just snap and they were so helpful.” (Participant 109)

“I know with my children, when they're learning something new they're really engaged and that's how they were, they were really present with everyone, with everything that everybody was saying. And you just, you could see that they really was concerned.” (Participant 111)

4. Non-Judgmental: Group members indicated that the facilitators' non-judgmental approach to counseling and trying to understand their stories was helpful and made them feel more connected to them.

“Right to the end I said by them expressing their feelings to us as we expressed our feelings to them, it wasn't a judgmental thing.” (Participant 101)

“And the facilitators were our friends too. So no, there was no more shame, shame there, I don't think after about week nine, we were able to open up and say anything, you know, how we feel.” (Participant 105)

“Because they are very open, and didn't have any bad stereotype, but if they had attitude, I would take my bag and leave because I can't deal with that. If they exhibited any
tension or looking down on me, I'll just take my bag and leave because they can't do anything for me.” (Participant 106)

“And we started feeling very comfortable with everyone and so it was just the ability to just express ourselves without judge, being judged or anybody saying, I don't understand what you mean; although maybe they didn't understand us or understand that particular experience. We never felt that. I never felt like if I explain something to you or say something to you, it's not like, well, that haven't been my experience.” (Participant 111)

5. Active/Facilitative participation: Group members reported that facilitators were active in their group participations, such as engaging in the activities and sharing their opinions/experiences, asking questions, redirecting group members, providing psychoeducation, and pushing them to grow. Group members indicated that this made them feel more comfortable with the facilitators.

“They [Facilitators] took in control like far as asking us questions about like how we feel,” (Participant 101)

“And that was nice to know that they participated in it as well. They weren't just to hear us talking and not participate themselves. So that was a good thing. I think it was much easier for everybody then to open up.” (Participant 109)

“But it was kind of like they forced us to go deeper within ourselves, to even to find that pain, bring it up and get it out. And the coping skills that they gave us, it was kind of like I felt like this is something that I would use, or maybe something that I'm using, and I want to share it with you. This is how I get through what I'm going through.” (Participant 111)

6. Personable: Group members reported appreciating that the facilitators were genuine and authentic in their interactions with them. They also described the facilitators being real in the sense that they were personable and easy to talk to, which increased their ability to form a relationship with them.

“They [facilitators] understood us even far as the speakers, when the speakers came out, and we chitchatted and talked and stuff, both of them was wonderful.” (Participant 101)

“And the sympathy and [male facilitator] relates to everybody he makes you want to come because of the welcomeness. When you come in, he say, ‘Hi, [participant’s name]! How you doing? How was your day?’ But if I am dealing with anything, it just opens up my mind.” (Participant 106)
“The openness is that we were working with family. They didn't say, ‘Oh, I am a graduate student.’ They just interacted, really.” (Participant 106)

“I don't know, I guess after the third group session like I say it was all just the aura about the room, about them, there was just something that was - I guess you could say more of a glow of information - the expression that they gave and how they conducted they self as individuals. They were - how would you say - they were more of one of us. More of one of us. And that's what made it so much easier to accept them by them being themselves.” (Participant 109)

**Theme Five: Cultural Differences Not a Barrier to Connecting to Facilitators**

This theme described the participants' experience of differences (i.e. race, gender, and age) between them and facilitators not being a barrier to the group being beneficial. A dominant theme across the interviews was the belief that cultural differences did not negatively impact the group, despite participants having preconceived notions that these differences would be a barrier to treatment. In addition to highlighting the facilitators' positive personal characteristics, the participants also shared processes within their interactions with the facilitators that made cultural differences less of a barrier to treatment. Specifically, participants described the group process as being a mutually beneficial learning process for both group members and the facilitators. Additionally, they reported openly talking about cultural differences helping with making these differences less of a barrier.

**Textural Descriptors**

1. **Cultural differences did not matter:** Race, gender, and age did not prevent group members from getting needs met or having a therapeutic experience.

   “It wasn't no problem. It wasn't no problem. Once I looked beside, once I looked passed the color of their skin, it was just like it was one of us, they were one of us.” (Participant 105)

   “They were very, you know, they were very very committed to what they were doing. And that showed me that some people, no matter what color of your skin, that they do, they're still concerned. They were concerned about us.” (Participant 105)
“It depends on how open they are. It doesn't mean if he is black or white. It depends on how open they are.” (Participant 106)

“And that's just how it is. That's how my mother always raised me and taught me; it doesn't matter what color a person's skin is, long as they treat you with respect and you give them the same in return then that's what you'll get.” (Participant 109)

“I guess it was; I never thought in my life I would ever say this, but it was not a difference. I mean because, like I said, they just let us go. They let us share what we needed to share, and they gave us strategies and coping skills that I think anybody would have said to try to help. So I mean it was okay, it was fine to me. You know, after I got beyond my perception and my immaturity, it was great.” (Participant 111)

2. Reciprocal learning as a buffer for differences: The group members' experience of the facilitators open to learning from them and the facilitators having something to gain from working with the women made cultural difference less significant.

“Well this is new to [the facilitators] too, this is something they're learning about too. So it was just like we were all in a class together helping each other and learning something. This was all knew to us all. And then they also said that they was doing it to help. They were actually interested in helping somebody find out something while they were helping theirself.” (Participant 105)

“That it was all a learning process for us all. So that was like, okay, well maybe we, maybe we don't need nobody that been through it to learn about it. So it seemed like we was just all in one big class together and sometime learning.” (Participant 105)

“It was a learning experience for them [facilitators] just as well as it was for us knowing that they were learning just like was learning and that was a good thing.” (Participant 109)

“I don't know why he [male facilitator] didn't seem to take offense regarding her calling him White Boy - White Man or whatever. I don't know, I guess they didn't really seem to matter about the color of our skin, it was something different for them to be able to talk and find out things about Black person I guess you could say. Being able to sit and talk and to hear a lot of Black women talk about themselves and each other.” (Participant 109)

“When I first walked in I'm like, oh, goodness, what are [the facilitators] gonna tell me. But as I listened to them and talked to them, and the more they said, we're just here to learn from you. I'm like okay, okay, I can handle that. And so I was okay with that. I was, I felt like, okay, well, you know what, if you want to learn from me, I definitely feel like I can learn from you. And I did.” (Participant 111)
“I felt like, I say again, that they had a genuine concern that they really wanted to be more of a solution and not the problem. Like in later years, as they get older and deal with people, I think they'll be more considerate and more cultural competent in their language and in everything, and dealing with people of color. I really think this has helped them a great deal.” (Participant 111)

3. Discussed cultural differences: Group members described talking about cultural differences between group members and the facilitators and that it was helpful in not making these differences an ongoing issue.

“And that's another thing that they had that we had discussed. We did discuss that [racial differences]. It doesn't matter to me what their nationality was.” (Participant 101)

“Yeah, we talked about a race thing a couple of times, it was a little joke, joke situation. But I don't know, I don't know. To me, to me racial, it really don't have to be, I think it's something that was taught and planted in us from way, way back or from something we saw on TV or something like that. And I, not saying that it don't exist, because I feel like it do, it still exists but not in everyone, not in everyone.” (Participant 105)

“Him and one of the other ladies were talking about it [racial differences]. [Male facilitator] spoke on it some then I was the one that didn't speak on it because to me it wasn't an issue about them being White or about me being Black. We did talk about the first time you could say you was with a bunch of Black women [laughs] but it was just in a joking manner and I don't think anybody took it really serious and they're saying well you White Boy - [laughs] he didn't take offense to it but it was only like in a playing matter when she [another group member] brought it up.” (Participant 109)

“Just really allowing me to say what I needed to say without any judging. We were very comfortable in our speech, and we said what needed to be said, and we just, not that we didn't care, I mean it was very respectful, it wasn't anything vulgar or anything like that, but we dealt with issues, racism, economics, different things like that and without feeling like they would get offended. And they weren't, I mean they were some tough cookies. And they acknowledged that this is true, that this is our experience, and what we've experienced they don't experience, or maybe never experienced. And so that for me, I think, put things into perspective where I'm like, okay, at least you can acknowledge that I'm having this experience and you're not taking and saying I don't understand, or what do you mean, racism, you know, we have a Black President.” (Participant 111)

Theme Six: Therapeutic Gains

This theme referred to the participants' experiences of what they learned and personally gained from being the group. During the interviews participants spontaneously self-reflect on
their personal journey of growth while in the group. Specifically, participants shared personal insights regarding their challenges with depression, identified their psychoeducation understanding of depression, coping strategies they learned and continue to utilize, and how they were able to improve relationships outside of group.

**Textural Descriptors**

1. *Learned about myself:* The group members described gaining personal insight regarding patterns of depression, personal challenges, and recognizing personal growth.

   “I could be slipping into depression just because I'm letting all my activities go that I like to do, and I'm worrying too much about something that I have no control over and stuff like that. So it helped me to see that I still have to take care of me and I can't just lay around because I will get depressed.” (Participant 105)

   “So this [the group experience], it was teaching me to think before I speak or think before I react. Or sometimes just be quiet, no matter how I feel. Because I'm the type will explode sometime if you make me mad or say something I don't like. Especially when I feel like you're not being honest with me, I feel like you're telling a lie on me in my face that really hurts me.” (Participant 105)

   “Some of the things I say I don't think… [they] are just blurted out. I'm not thinking about the consequences [and] if it will hurt someone's feeling or whatever. But since being in the group I've learned to stop jumping the gun. Sitting there thinking about how I should say what it is I'm thinking to say before I just blurt it out.” (Participant 109)

   “So I gotta forgive myself because even though I didn't do anything I still need that forgiveness for something that I might've done to somebody else. And I learned that forgiveness ain't just for the person that done something wrong to you, it's also for yourself. And that was a good thing to know.” (Participant 109)

   “I've learned so much. I really learned a lot about myself and about how I deal with things, and how I've been very good at just not dealing with things. Like if things affect me, I've learned how to just push it down so deep where I just keep going. And then eventually something happens and then, boom, you know, there's that explosion. So now I take that moment and I check in with myself, how are you feeling today, you know, mentally. I don't necessarily talk to myself, but there are some times I do.” (Participant 111)

2. *Learned about Depression:* Participants reported learning more about depression, medication, and mental health through the psychoeducation provided in the group.
“There's so many different depressions, too. I can't remember all of them, but it was - it was something else.” (Participant 101)

“I enjoyed the meditation. I enjoyed us going back after we do the exercise in the book and I enjoy us talking about it more so after where we had finished and after the people - the guest speakers came out and then we still went and talked more about it.” (Participant 101)

“And further on down the line as we got to the people coming in to visit us, that was, I liked that part. And we got to know about some resources that can help. And then they showed us some things…” (Participant 105)

“I learned the meditation and I took it home and then I tried it on my daughter. Get on the boat. We all lighted the candle and then we all meditated for at least 20 minutes and it was a quiet time to get into my mind and see the light and reflect the light and saying it's going to be okay because the training of the meditation.” (Participant 106).

“But then I also learned we had some speakers that came in [inaudible] and was talking about the health issues you could get from that which was surprising to me because I never knew that these could cause so many illness in a person.” (Participant 109)

3. *Coping Strategies*: Group members reported learning specific techniques for coping with depression in addition to developing/nurturing strategies that they already had.

“So that [the session] helped me to, after that, when I left here that day, I started writing and praying about my thinking.” (Participant 105)

“And from learning some things in the group and some ways to do things like exercise, take a walk, do something you like that brings, that makes you happy, that is to bring your joy back.” (Participant 105)

“And this was an opportunity for me to find a different way to do it instead of just jumping up walking I can sit and meditate or listen to music and whatnot.” (Participant 109)

“I have a lot of different strategies and coping things that I could do now. I still have my candle that they gave us, and I often look at it and just think back to that night that we did the whole meditating, relaxing, that was awesome, taking the trip.” (Participant 111)

4. *Improved Relationships*: Group members described applying what they learned to their personal relationships and having better interactions with loved ones as a result.

“I do have two kids there's a lot that I couldn't talk to them because I'm their strong. And I want them to know that they - when I finally let my kids know - let them know that I was coming here and stuff… I called my son because I never thought I was going to live
this long... You know, like Sunday me, him and his sister, we all went out just us three and stuff. And he always wants to do everything and we just had a beautiful time and stuff.” (Participant 101)

“My grandbaby, she doesn't even want to come stay with me because she say, all you do is sleep grandma, I don't want to come to your house, that's no fun there. And I told her, just yesterday I said, I'm going to take you skating, I'm going to take you to the movies, we're going to do something if you come to granny house, I'm not, granny not gonna just lay around.” (Participant 105)

“I learned the meditation and I took it home and then I tried it on my daughter. While she is talking about that, she is laughing and it made me happy that she is actually taking a quiet time for herself and then she is using it and then she brought the video. I showed it to her brothers and they just laughed. They just busted into laughter when I was commanding her to go into the boat.” (Participant 106)
## TABLE 2.
Summary of Themes and Textural Descriptors

<table>
<thead>
<tr>
<th>Theme</th>
<th>Textural Descriptors</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preconceptions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>1. Didn’t know what to expect</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2. Reservation about female dynamics</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3. Anonymity</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4. Facilitators will be Black</td>
<td>6</td>
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<tr>
<td>Facilitators</td>
<td>1. Facilitators can’t relate</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2. Facilitators don’t have enough experience</td>
<td>3</td>
</tr>
<tr>
<td>2. Critical Incident</td>
<td>1. Conflicts discussed openly</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2. Conflict brought group together</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2. Normalization of challenges</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3. Release of emotion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4. Group felt like a family/sisterhood</td>
<td>3</td>
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<td></td>
<td>5. Group was safe</td>
<td>3</td>
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<td></td>
<td>6. Investment in group</td>
<td>4</td>
</tr>
<tr>
<td>4. Therapeutic quality of the facilitators</td>
<td>1. Empathetic/caring</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2. Facilitators are real</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3. Invested in group</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4. Non-judgmental</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5. Active/facilitative participation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6. Personable</td>
<td>3</td>
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<td>5. Cultural differences not a barrier to connecting to facilitators</td>
<td>1. Cultural difference did not matter</td>
<td>5</td>
</tr>
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<td></td>
<td>2. Reciprocal learning</td>
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<td></td>
<td>3. Discussed cultural differences</td>
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<tr>
<td>6. Therapeutic gains</td>
<td>1. Learned about myself</td>
<td>4</td>
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<td></td>
<td>2. Learned about depression</td>
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<td></td>
<td>3. Coping strategies</td>
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<tr>
<td></td>
<td>4. Improved relationships</td>
<td>3</td>
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**Invariant Structure: “Essence” of Phenomenon**

The participants’ experience in receiving culturally-sensitive care from European American clinicians appeared marked by a process of moving away from an awareness of cultural (e.g. race, gender, age) differences, based on preconceptions of what the group and facilitators would be like, and toward engaging in a therapeutically healing process that transcended culture difference. The participants described entering this experience with preconceived notions of what the group would be like and having expectation about who the facilitators would be. Specifically, the women described having mixed feelings about beginning the group. They expressed excitement and were hopeful that group counseling would be beneficial to cope with depression. However, the women also described entering the group with trepidation because they did not know what to expect, were unsure if having amenity would be a problem, or if challenges would arise regarding perceived negative dynamics among women. Specifically the women described being worried that competition or gossiping would prevent the experience from being a positive one. Additionally, participants described having an expectation that the facilitators would be Black and female. Despite mixed feelings regarding starting the group and expectations of facilitators, all women entered group with a curiosity about what the experience would be like.

All participants described varying levels of feeling surprised when arriving to the first group meeting and seeing a European American male and female introducing themselves as the co-facilitators. The women indicated that this unexpected situation made them more curious about what the experience in group would be like. Participants also expressed discomfort in wondering if they would be able to get their needs met from co-facilitators that were culturally different. The women indicated that they had concerns around the degree to which two young
and European American counselors-in-training could relate to them as Black women with more lived experience. They wondered if they would be able to learn from the facilitators or feel comfortable sharing personal details of their lives with them. Women also noted the differences in having a male group leader, and if this too would create distance between group members and facilitators. During the early group meetings, the women described believing that relatedness was paramount to achieving understanding and promoting comfort. Upon meeting the facilitators they expressed feeling doubtful that the European American counselors could be helpful and if they could understand their experiences.

The participants described initially feeling nervous in the group because they did not know one another and felt unsure about how personal they could be in sharing their lived experiences. Upon meeting one another, they expressed feeling immediately connected to one another due to perceiving other group members as personable, nice, and respectful. They also described an incident that occurred early on in the group meetings that helped bring the group members and facilitators closer together. All participants discussed a challenge that arose around facilitators redirecting vocal group members in order to give quieter group members an opportunity to speak and have time to address the psychoeducational component of the session. The challenge occurred when one group member seemed unhappy with being redirected and expressed her feelings to the facilitators. During this moment the facilitators and group member openly discussed the challenge and were able to navigate and resolve a tenuous situation. Participants described the incident as somewhat tenuous but that it brought group members and the facilitators closer together because they were able to discuss conflict openly; thus making the group feel “more real.”
After this critical incident the women described how the group came together to form what felt to them like a family or a sisterhood. They described feeling supported by one another and feeling safe to open up about personal matters because the group was not judgmental. The women indicated that coming to group each week was a special time where they could release their feelings, get advice, and not feel like they were alone in their struggles. Many participants expressed having limited spaces in their lives where they can safely experience their emotions and receive validation from others. Consequently the women felt a sense of ownership or strong investment in the group. They took the meetings seriously and it was important to hold one another accountable in using the group for personal growth and support.

In conjunction to the women deepening their relationship with one another was the deepening of their relationship with the facilitators. The women described the facilitators as being empathic, understanding, caring, and transparent. Many women recalled the instance when food was not provided during the session and one of the facilitators shared food with them. They found this gesture to be a reflection of the facilitators’ deep care for them and made the group feel more like family. The women experienced the facilitators as people who were “real” or genuine. This realness was reflected not only in their honest interactions/discussions but also the moments of lightheartedness and interjection of humor. The women describe feeling comfortable “giving it to the facilitators,” in terms of their cultural difference (race, age, gender). The jovial exchanges and non-defensive reactions of the facilitators helped the women to feel closer to them and made their differences less of an issue.

The facilitators were also experienced as active in sharing their reactions, challenging group member thinking, pushing them to experience their emotions, taking a facilitative role in redirecting group members as needed and “keeping the group on track.” They identified these
personal qualities as being important to feeling understood and connected to the facilitators. Additionally, the participants described experiencing the facilitators as individuals who were equally willing to learn from them and their experiences. That is, the participants did not get the sense that the facilitators were trying to be the “experts of Black women” or that they were trying to project wisdom beyond their lived experience. The women attributed this reciprocal learning environment and the facilitators’ positive personal attributes to their ability to look beyond preconceptions regarding the facilitators’ ability to help them. They also indicated that these factors attributed to race not being a barrier to healing.

Contrary to preconceptions that cultural difference would prevent the facilitators from understanding or being able to help the participants, all the women described an experience in which race was not a barrier or an issue preventing the group from being a healing experience. Each participant described how their experience of the facilitators as caring, attentive, and willing to “be with them” during moments of difficulty transcended issues such as race, age, or gender. Participants described the experience like a family and that everyone was “real” with one another, including the facilitators. They stated that facilitators validated the fact that racism exists and were open to discussing the cultural difference between themselves and the participants. The women indicated that early on in the group the racial difference in the group were addressed and was the women shared that they were expecting Black facilitators. Discussing cultural differences early on in the group put the women at ease that the group was going to be a genuine experience. This “realness” was exemplified by the critical incident, which proved to the women that even conflicts were going to be discussed and approached in an honest and open manner. Additionally, the women stated that talking about race helped to prevent racial differences from being an ongoing issue. It seemed as though it was something
that needed to be discussed but not on an ongoing basis. For the women, the process of healing did not include race, age, or gender. With regards to this, some of the women described wanting to recommend the group to others and that the group would be useful to anyone, regardless of race.

The overarching experience for these women was the process of healing through opening up and forming a sisterhood with other group members and the facilitators. The women described having a transformative experience in which they gained insight regarding their symptoms of depression and the patterns in their lives that help to sustain their depression. Additionally, the women described the experience as one of discovery, wherein they were able to discover and re-discover tools for coping with their depression. They expressed gratitude for the psychoeducational aspects to the program and speakers that were able to provide them with tools and knowledge for managing depression. They also described the group as a transformative process in that they were able to apply what they learned to relationships with family and friends.

The participants described the end of group as a bittersweet process. The women felt touched by the 12 weeks of support they received from one another and the facilitators. While they were proud of their personal growth, they were saddened not to have a weekly space to support one another. They indicated that they had learned much about themselves and each other. All women described thinking about the difficult transition of not having their “Thursday meetings.” However, they expressed gratitude for having been able to take this journey with one another.

Quantitative Data

In order to further contextualize the findings, participants completed the Beck Depression Inventory (BDI) at baseline (pre-intervention), week 6 (midway through intervention), and week
12 (end of intervention). This data was collected to further understand the experience of cross-racial therapy within the context of symptom reduction. Furthermore this data was collected to understand better the participants’ symptoms throughout the course of treatment.

For the first step of analysis, a repeated measures within-subject analysis of variance (ANOVA) was conducted to assess whether differences existed in symptoms of depression (as measured by the BDI) by data collection time period (baseline vs. week 6 vs. week 12). The Mauchly's Test of Sphericity, which determines whether the variances among different combinations of groups are equal, yielded non-significant results \( \chi^2(2, N = 6) = 0.25, p = .88 \). This finding indicated that the variances among the different combinations of groups were equal, thus ANOVA calculations were based on the assumption that sphericity existed within the data. Results for the data collection time period were significant on the BDI \( F(2, 10) = 4.281, p = .045 \). Post hoc analyses were conducted utilizing paired sample t-tests to assess the impact of treatment across time and identify specific group differences. However, when performing multiple t-tests, an increased risk for committing a Type I error (i.e., rejecting a true null hypothesis). To buffer against the possibility of Type I error, Cronk (2006) suggested conducting ‘‘protected depended t-tests’’ where the alpha level (\( \alpha = .05 \)) is divided by the total number of t-tests in order to implement a more rigorous alpha level. Since for this study there is one independent variable with 3 levels, 3 separate paired t-tests were conducted. Therefore, the modified alpha level used to test significance was .05/3 or .017.

Measures for the BDI-II (Beck, Steer, & Brown, 1996) from baseline through week 12 did not reveal significant differences. Baseline scores (\( M = 20.67, SD = 5.75 \)) were not significantly different from week 6 scores (\( M = 17.17, SD = 11.92 \)), \( t(5) = .787, p = .467 \). Scores from week 6 (\( M = 17.17, SD = 11.92 \)) were also not significantly different from week 12 (\( M = 14.67, SD = 11.92 \)).
9.17, \( SD = 7.28 \), \( t(5) = 2.230, p = .076 \). Finally, no significant difference was found from baseline scores (\( M = 20.67, SD = 5.75 \)) to week 12 (\( M = 9.17, SD = 7.28 \), \( t(5) = 2.87, p = .035 \) (see table 3). Despite the lack to statistical significant difference among the scores, the trend of decreasing BDI scores seems to suggest strong clinical significance, with the general trend of symptom reduction for the participants throughout the course of their participation in the group intervention. Furthermore, when an effect size was calculated the results yielded \( d = 2.19 \), an effect size consistent with benchmark effect sizes for treatment of depression of approximately 1.92 (Minami, Wampold, Serlin, et al. 2007), see table 4.

TABLE 3.
Symptom Reduction Results

<table>
<thead>
<tr>
<th>Week Comparison</th>
<th>( df )</th>
<th>Mean Difference of scores</th>
<th>( SD )</th>
<th>( t )</th>
<th>( p )</th>
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</thead>
<tbody>
<tr>
<td>Baseline to Wk 6</td>
<td>5</td>
<td>3.5</td>
<td>10.89</td>
<td>.79</td>
<td>.467</td>
</tr>
<tr>
<td>Wk 6 to Wk 12</td>
<td>5</td>
<td>8.0</td>
<td>8.78</td>
<td>2.23</td>
<td>.076</td>
</tr>
<tr>
<td>Baseline to Wk 12</td>
<td>5</td>
<td>11.5</td>
<td>9.81</td>
<td>2.87</td>
<td>.035</td>
</tr>
</tbody>
</table>
TABLE 4.

Graph of Symptom Reduction Trend
CHAPTER V

Discussion

The purpose of this study was to examine the experiences of depressed Black women engaged in a culturally-adapted group counseling treatment that was delivered by European American clinicians. Specifically, this study utilized a phenomenological mixed-method approach to uncover the experiences of six Black women who were engaged in a culturally-sensitive counseling group for depression that was facilitated by two European-American clinicians. Given the limited attention to treatment outcomes when focusing on the experiences of cross-racial therapy, a secondary aim of this study was to provide descriptive outcome data on the degree to which depression symptoms were reduced. Regarding the quantitative data, it was hypothesized that women would experience a significant reduction in symptoms from pre to post-test.

The findings of this study make a unique contribution to the literature examining cross-racial therapy in that it provides a narrative of the therapeutic process as experienced by a group of women working within a cross-racial context. The narratives provided by the six women regarding their experience of therapy provided a window of opportunity to examine closely the process of culturally sensitive cross-racial therapy. Consistent with literature regarding factors impacting the process of therapy (e.g. extratherapeutic factors, therapist factors, relationship factors, and treatment factors), the organization and function of the discussion is to place the findings of this study within the context of what is known about the process of therapy. Therapeutic alliance will not be directly discussed as it is assumed that client and therapist variables contributed to the therapeutic alliance. The discussion is organized to explore factors that contributed to the experience of therapy rather than discuss the alliance directly.
Implications for the role of race and culture within the women’s experience of treatment are highlighted. Additionally, implications for clinical practice are embedded throughout the discussion while future research is discussed separately.

*Extratherapeutic Factors: Importance of Open/Flexible Attitudes and an Affirming Environment*

Extratherapeutic factors consist of both client and environmental factors that contribute to the therapeutic process. Client factors are characteristics that are part of the client’s personality such as race/ethnicity, ego strength, interpersonal style, and attitudes toward treatment whereas environmental factors are aspects of the client’s life and environment such as support system, chance events, racism, and persistent trauma (Hubble et al., 1999; Sprenkle & Blow, 2007). Essentially, extratherapeutic factors make up what the client brings to therapy. Therapy expectations have been described as “anticipatory beliefs that clients bring to treatment and can encompass beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery” (Nock, Phil, & Kazdin, 2001, p. 155). Research studies have typically examined expectations in relation to outcomes such as premature termination, client improvement, and therapeutic alliance (Dew & Birkman, 2005). General findings from research have concluded that high expectations of treatment are associated with lower attrition rates (Nock, Phil, & Kazdin, 2001), keeping appointments (Shuman & Shapiro, 2002), stronger therapeutic alliance (Connolly Gibbons, Crits-Christoph, de la Cruz, Barber, Siqueland, & Gladis; 2003), compliance with treatment (Shuman & Shapiro, 2002), and overall better treatment outcome (Dozois & Westra, 2005).

With regards to Black Americans’ attitudes toward psychological treatment, the trend tends to be negative or skeptical (Obasi & Leong, 2009). Scholars have concluded that there is a strong association between cultural mistrust, or lack of trust in health care providers due to
experiences with racism and discrimination (Terrell & Terrell, 1984; Ridley, 1984), and negative expectations of treatment (Nickerson, Helms, & Terrell, 1994; Watkins, & Terrell, 1988; Whaley, 2002; Townes, Chavez-Korell, & Cunningham, 2009). Specific to Black women, research examining their perceptions also confirms a negative bias (Sanders Thompson, Bazile, and Akbar, 2004). Contrary to literature that suggests that Black women tend to be skeptical, the findings of this current study described a process in which the women were open to treatment and had positive attitudes toward receiving counseling; however consistent with research regarding cultural mistrust, upon meeting the European-American clinicians, participants developed negative expectations toward the usefulness of the therapeutic experience.

The women in this current study described having neutral to positive expectations prior to the treatment beginning and having a general openness to therapy. Some of the women even described looking forward to the intervention prior to it beginning, having excitement around the group starting, and being curious about who would be in the group. The majority of trepidation around starting group counseling was wondering what the experience would be like and how to navigate dual relationships, should they know other group members outside of group. One possible explanation for the initial openness could be that the women were unaware of the racial background of their therapists. During the recruitment and screening procedures of this study the women were told that that they would be engaging in culturally sensitive group counseling that was developed for Black/African American women with depression. In order to parallel the experience of therapist assignments in real-world settings, in addition to not further biasing the self-selection process within research, the race the therapist was not disclosed to the participants. The procedure, however, did stipulate that if a participant were to ask about the therapists’ race, the lead researcher would disclose this, as the study did not utilize deception. Interestingly none
of the participants or potential participants inquired about the therapists’ race. This may have been due to the women being subtly primed to expect having Black therapists.

The participants may have been primed to believe they were working with Black or African American facilitators because of the extensive contact (e.g. screening, baseline, interview, weekly courtesy phone calls, and the lead research being the primary contact person) they had with the lead researcher (a self-identified Black woman). One of the participants indicated that they thought the lead researcher might be leading the group. The women had also been looking forward to the group beginning due to the opportunity to receive help. As a self-selected group, to some degree there is built-in investment for participating in the study. The women’s interest starting the group may have also been a reflection of the nature of self-selection and their being open to receiving help to cope with depression.

Despite initial positive attitudes toward treatment, the women were unsure about the utility of counseling upon observing that the therapists were European American. As mentioned in the results, a majority of women expressed being shocked to see European American therapists and expected them to be at least Black/African American if not both Black/African American and female. Most participants indicated that they assumed racial (or racial and gender) matching would occur because the group was developed for Black/African American women with depression. Upon meeting the facilitators, the women reported having concern about the usefulness of treatment. Specifically, most women reported wondering if the clinicians would be able to understand their experience, relate to them, or provide a healing experience.

This process of the participants assessing the counselors was consistent with Ward’s (2005) grounded theory study which examined how African Americans assess their experiences in therapy. Ward’s (2005) sample consisted of 13 women and 8 men with various mental health
concerns (e.g. substance abuse, parenting issues, and coping with bipolar disorder). Although this study did not focus specifically on cross-racial therapy, 12 participants reported having a European American therapist, while one reported having an African American therapist. Ward reported that participants assessed for client-therapist match along multiple dimensions including race, gender, age, and ideology (i.e. belief system). Interestingly, participants in Ward’s study identified assessing the counselor’s race and ethnicity first, which seems consistent with the process of the current study’s participants. Ward reported that if there was a mismatch in race, participants would then assess safety, counselor effectiveness, and other factors such as gender and age. Ward concluded that the function of this assessment process was to help participants determine whether the counselors could relate to the participants along dimensions of race, gender, age, or ideology. Similarly, the women in the current study initially held the belief that it was important for counselors to be able to relate to their clients. Consequently, the women were initially concerned that the difference in race would prevent the facilitators from being able to relate to them.

The belief that some people of color believe racial difference may prevent therapist from understanding them is similar to other studies examining cross-racial therapy (Aitken & Burmen, 1999; Chang & Berk, 2009; Chang & Yoon, 2011). For example Chang and Yoon (2011) conducted a qualitative study in which they interviewed 23 racial and ethnic minorities (nine of which were Black and five of whom were female) participating in therapy with a European American therapist. Nineteen of 23 participants reported that the mismatch in race would be a significant barrier to treatment and that the European American clinicians would not be able to understand their experience. Additionally, the participants in the current study indicated possibly feelings disconnected and distanced from their counselors.
Similar to Chang and Yoon’s (2011) study, the initial reactions of the women in this current study to the clinicians were consistent with literature regarding Black or African American’s cultural mistrust of European American within the context of mental health treatment (e.g. Nickerson, Helms, & Terrell, 1994; Townes, Chavez-Korell, & Cunningham, 2009; Watkins, & Terrell, 1988; Whaley, 2002). Scholars have concluded that there is a strong association between cultural mistrust, or lack of trust in health care providers due to experiences with racism and discrimination (Terrell & Terrell, 1984; Ridley, 1984), and negative expectations of treatment (Nickerson, Helms, & Terrell, 1994; Watkins, & Terrell, 1988; Whaley, 2002; Townes, Chavez-Korell, & Cunningham, 2009). In a qualitative study utilizing focus groups to understand beliefs about mental illness and treatment for mental illness, African American participants reported mistrust of doctors and the medical community due to beliefs about racism within the medical field and feeling disregarded by the mental health professionals (Mathews, Corrigan, Smith & Aranda, 2006).

Contextually, it is interesting that the women in this current study had trepidations to work with the facilitators despite the majority of participants having had previous experience working with European American clinicians. Four of the five women who reported having been in treatment for mental health concerns prior to study participation indicated that they had been seen by European American therapists. Only one participant indicated that she had worked exclusively with a Black/African American clinician. Based on the data collected on the quality of service received from providers, the majority of participants (80%; n = 4) rated the treatment as “good” or “excellent.” It is interesting that participants had reservations about working with the clinicians in this study given the history of having positive therapy experiences with European American providers. It is possible that the participants’ reactions were reflective of a
socialization process of cultural mistrust within healthcare, a process that is not uncommon among people of color. Some scholars suggest that when interacting within the health care system some Black/African American individuals develop “healthy paranoia.” Healthy paranoia is described as a self-protective cultural response to the experiences of racism wherein one displays hyper-vigilant, cautious, and distrustful beliefs or behaviors regarding interacting with European Americans (Sims, 2010; Sue et al, 2008; Thomas & Quinn, 1991). Sims (2010) conducted a longitudinal qualitative study examining the healthy paranoia among older Black women interacting within the healthcare. The study focused on eight women who were over the age of 40 and reported believing that the disparities in Black women’s health were attributed to cultural differences (i.e. being provided with less quality care because they are Black and female). It is possible that the initial reactions of the participants in this current study similarly reflected a self-protective strategy that some Black women develop when interacting with European Americans in the health field.

Although the analysis of the interviews did not yield enough consistency to code for factors that may have contributed to developing preconceived notions that European American clinicians were unhelpful, two women did express this concern. Specifically two participants indicated that not trusting European Americans might have been something learned or was a belief they were supposed to endorse, stating:

“I thought [European American people] were against me. I don't know where I learned it from. Maybe TV or my dad taught it to me…it's just thing that we hear.” (Participant 105)
“I don't know, I guess because of [my] ethnic background I'm supposed to dislike White [people]. To feel like they won't do nothing for you, they White, they prejudice.

(Participant 109)

With regards to the clinical implications of this study, it is important to consider that the participants held skeptical preconceived notions despite their previous positive experiences with European Americans. This context helps to highlight the fact that race is an important factor for therapists to consider in the therapeutic process. Based on the women’s narratives, it may continue to be important that European American therapists remain aware that Black or African American women may hold a degree of skepticism toward working within a cross-racial context. This skepticism may be held regardless of previous interactions with European American providers or European American individuals in general. Sims (2010) stressed that European American healthcare providers need to be aware of cultural mistrust in order to decrease misinterpretations that can influence their interactions with older Black women.

The women in the study described a process in which they held positive and optimistic attitudes toward treatment but then developed skeptical attitudes upon meeting European American clinicians. Contrary to the literature regarding cultural mistrust and the correlation between negative attitudes and discontinuing treatment, the women in this study continued treatment and went on to have a positive experience with the facilitators. One explanation for continued treatment having a positive experience may be the overt communication that the treatment was for culturally specific for Black/African American women and the therapeutic environment was affirming. The very nature of the treatment placed an emphasis on affirming the experience of Black/African American women and the unique cultural factors that may influence stress and depression. The supportive environment may have contributed to the women
feeling comfortable continuing to engage in treatment. This finding may suggest that cultural sensitivity and affirming contexts can buffer against discomfort with racial differences within therapy.

*Unanticipated Preconceived Cultural Barriers*

Issues regarding race were somewhat expected to become issues or barriers within the group; however age surprisingly emerged as a salient characteristic that served as a potential barrier for the participants. Age as an identified variable was surprising given that no literature reviewed for this study addressed the cross-section of race and age impacting the process of cross-racial therapy. Similar to preconceived notions based on race, the women described not knowing if the facilitators could help them because of the age difference. They reported feeling like the facilitators were too young and did not have enough life experience to have had significant experiences working with Black women or counseling in general. The trepidation that the women experienced has been reflected in the literature. Although no study was located that addressed the intersection of race and age as important factor within cross-racial therapy, there is literature suggesting that older adults (in general) prefer older therapists. For example, Lauber and Drevenstedt (1993) conducted a study examining older adults’ preference for the age and sex of a therapist. Thirty European American females and 30 European American males age 60 and older were provided several vignettes with scenarios in which the age and sex of the therapist was manipulated. The results indicated a significant interaction in which female participants had a preference for older and female therapists. Like this study, the age of the participants may have contributed to their focus on age.

The fact that the average age of the participants was 52 and the facilitators were in their 20s may have contributed to the salience of age. As aforementioned, similar to preconceived
notions about racial differences, the women thought they would have a difficult time connecting because the facilitators were too young to understand their concerns or lack experience needed to be helpful. Luber and Drvenstedt (1993) explained the results of their study through the Age Matching hypothesis (Gatz et al., 1985 as cited in Luber and Drvenstedt), which stipulated that older clients prefer older therapists because of their assumption that older therapists will better understand their experience. The Luber and Drevenstedt study, however, was based on vignettes and not actual contact with therapists. It is possible that these preconceived notions are beliefs based on natural tendencies to have expectations but are not rigid. Although clients’ negative expectations of therapy may influence outcomes/experiences in therapy, it may be that the degree to which clients hold rigid beliefs around their expectations account for whether or not these perceived barriers (e.g. race and age) remain barriers once treatment begins. The ability to have flexibility may have been an important extratherapeutic factor to consider, particularly in instances where the reality of the experience did not fit or match the preconceived notion. The women in this current study discussed changes in their perceptions of the facilitators early on in the intervention. It seems like flexibility and openness to experiences may be an important extratherapeutic factor contributing to positive cross-racial psychotherapy.

Although there were not enough participants describing the facilitators’ age as a positive aspect of group to warrant a theme, one participant did describe that associating the facilitators’ generation as that group that “elected Obama.” Specifically the participant stated:

“I do, I believe the younger the better because the 20-something generation is what actually got President Obama elected. And I think it's because they are sick and tired of the status quo. That things must be different, it has to be different if we want to live in the equal playing field society, we have to change the way we think, we have to change the way
we talk, we have to change everything about it. And I noticed that. And it's like when you get to a
certain age group of anybody, any culture, any group that, there becomes this stone wall of
rebellion and I'm like, no, I'm not changing, but if you get the younger the better.” (Participant
109)

The participant indicated that although she questioned how experienced the facilitators were that
she had openness to them due to the fact that they were young and were probably more inclined
to want change in terms of racial inequality. She further indicated that her experience may not
have gone as well should the facilitators have been younger. Specifically the participant stated:

“So, and that's why I think that Oh' Happy Day had the positive experience that it did,
because you didn't get the older generation to facilitate this. The facilitators were in their
mid 20's, early 20's, and they just sat back and they just let us old folks go, and they
weren't trying to interject anywhere except for giving us the coping skills.” (Participant
109)

To date no research has been conducted with Black women or ethnic minorities regarding age
and perceptions of cultural openness. More research in this area may be useful, particularly in
further understanding what cultural factors help to facilitate connection within cross-racial
contexts.

Therapist Factors: Empathy, Transparency, and Willingness to Learn Decreases Salience of
Difference

The experience of therapy is not only attributed to personal qualities of the client, but also
the characteristics pertaining to the therapist. Examining the relationship between individual
therapists’ characteristics (e.g. race, experience, interpersonal style, theoretical orientation) and
clinical outcomes has not historically been a focus of research but has gained more attention in
the past 15 years. Research findings have consistently concluded that the outcomes of some therapists are better than others (Luborsky, McLellan, Woody, O’Brien & Auerbach, 1985; Huppert, Bufka, Barlow, Gorman et al. 2010). Significant variance in treatment outcomes among therapists supports the notion that therapist effects are an important component of the therapeutic process.

The women in this current study identified several perceived characteristics of the therapists that they felt contributed to having a positive experience in group counseling as well as making cultural difference less salient (i.e. not a barrier). The women identified traits such as being empathetic, non-judgmental, genuine/personable, and having investment in the group as positive characteristics that made them feel more connected to the facilitators and made race less of an issue. This finding is consistent with literature regarding cross-racial therapy and positive therapist qualities that help to promote a strong alliance and positive therapeutic outcomes. For example, Chang and Yoon (2011) conducted a qualitative study with racial and ethnic minorities engaged in cross-racial therapy. The participants in their study reported that therapist characteristics such as compassion, caring without judgment, and being open with talking about difficult issues as more important than cultural or racial differences. The women in this current study expressed similar sentiments, stating that the facilitators communicated their care and empathy through providing supportive statements and giving the women room the express their feelings without judgment. Additionally, participants in the current study reported that they felt connected to the facilitators because they genuinely cared about group members. A majority of group members discussed a situation in which food was no present for the pre-session meal and a facilitator was frustrated by this and shared food with women because he recognized that many
of the women came to group straight from work and did not have dinner. Personal acts of kindness such as this brought realness to the group that seemed to help assuage early trepidation.

Transparency was also an important characteristic highlighted by the women in this current study. They described that the facilitators would share their feelings with group, disclose some of the challenges they experienced, and were open about their limitations and growth areas. Specifically, the facilitators were open about not knowing what it is like to be a Black/African American woman, but could connect to the general condition of human suffering and wanted to help and support the women through their challenges. Again these genuine expressions and interactions seemed to create a safe environment that helped the women to have a positive connection with the facilitators. These characteristics also suggested that the facilitators expressed general comfort interacting with the women. This comfort with interacting is consistent with cross-racial therapy literature. In Brooks’ (1980) seminal work describing working with Black women who have been battered, the author stated that for European American therapists they should:

“…no attempt to relate or serve Black women if you feel fearful or hesitant approaching them. Your attitude will be interpreted as racist or not caring. You would be wise, as helping professional, to seek help in dealing with your attitudes and phobias (p. 13).

Brooks’ sentiments highlighted what many in the counseling psychology field (e.g. Arredondo & Perez, 2006; Sue & Sue, 1999) refer to as cultural self-awareness, recognizing biases, and developing cultural competence.

Self-disclosure is an important intervention within psychotherapy that helps to facilitate rapport and trust within therapeutic relationships. Ward (2005) in her study examining the experiences of African Americans within psychotherapy described clients as engaging in an
assessment process with their counselors in order to monitor and manage self-disclosure. Within her study self-disclosures were broadly coded as therapist sharing factual information (e.g. being students, taking examines, relationship status) to more process orient self-disclosures (e.g. sharing feelings/emotions, disclosing racial/ethnic identity beliefs or limited work with Black/African American women). Based on the narrative of the women in Ward’s study it appears that self-disclosure and transparency was especially important in connecting to the facilitators within a cross-racial context. Specifically self-disclosure related to issues of culture seemed of have significant importance for facilitating connection within cross-racial therapy. Chang and Berk (2009) conducted a phenomenological study examining the experiences of successful cross-racial therapy. The study focused on the individuals who were in individual treatment and the sample consisted of 16 people, in which 6 were Black or African Americans (three men and three women). The participants in their study reported similar findings to the women in this study in that both set of participants believed that self-disclosure made the therapists seem more real, approachable, and promoted a sense that group members and therapists were equal.

Positive therapist characteristics such as empathy, genuineness, directiveness have been identified as attributes that clients find helpful in a therapist (e.g. Keijsers, Schaap, & Hoogduin, 2000; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Lafferty, Beutler, & Crago; 1989; Najavits & Strupp, 1994). In a review of empirical studies examining therapists’ interpersonal behavior on the outcome of cognitive behavioral therapy, Keijsers, Schaap, and Hoogduin (2000) found two clusters of therapist behaviors that impact the outcome of treatment. The first cluster of characteristics was consistent with traditional Rogerian variables such as empathy, support, genuineness, and warmth. While the other cluster of therapist variables centered on the therapeutic
alliance, including therapist activity level. The findings from the Keijzers et al. (2000) study support the findings of the current study and highlight the importance of positive therapist variables in considering the outcome of treatment.

When asked about how the therapists contributed to their experiences, all of the participants in this current study reported qualities consistent with traditional (Rogerian) positive attributes. Additionally the majority \((n = 4)\) of participants discussed fact that the facilitators’ openness in addressing race helped with creating a safe environment. The women indicated that they appreciated the clinicians being open to talking about issues related to race and validating their experiences with discrimination. This is consistent with literature suggesting the clients of color have experiences in therapy when European American clinicians are open and transparent about discussing or addressing issues of race (e.g. Chang & Berk, 2009; Chang & Yoon, 2011; Keiter Humbert, Burket, Deveney, & Kennedy, 2011; Pope-Davis et al. 2002). Additionally, all participants described the importance of having therapists who were caring, dedicated, empathic, non-judgmental, and supportive as factors that contributed to them trusting the facilitators and building a strong relationship with them. This finding may have implications for understanding how potential barriers within cross-racial therapy can be navigated. It seems like the degree to which European American therapists are open, genuine, transparent and comfortable. That is, counselors who do not ignore approaching difficult conversations may help to build trust with Black or African American female clients. Therefore a clinical implication of this current study is that therapists continue to be open to discussing cultural differences with clients. One way to assist with this is to continue to incorporate difficult and critical dialogue around cultural difference within training programs.
Group Dynamic as a Buffer for Racial Barriers

Although not a focus of the current study, it is important to address how the context of the group counseling experience may have implications for understanding the process of culturally sensitive treatment within the context of cross-racial therapy. The current study did not focus on the structure of treatment (i.e. individual versus group counseling) due to the priority and importance of selecting a treatment that was culturally-adapted. In this sense, the important quality of the treatment was that it had identifiable elements that addressed culture. However, after completing the interviews with the participants it was evident that: 1) their experience reflected universal themes of group process (e.g. universality, normalization, catharsis), as identified by Yalom (1995) and 2) a unique group dynamic arose as a function of the racial makeup of the group.

It was clear from the themes of the interviews that the women in this study experienced a process that was common within group counseling. The women reported feeling like they were “not alone” and had a place of their own where they could receive and get support. In Yalom’s (1995) seminal work regarding group counseling, he identified several therapeutic factors including universality (commonality among group members in suffering), group cohesiveness (a sense of belongingness in the group that implores members to remain in the group and help others achieve their goals), and catharsis (expressing and experiencing a release of emotion). For example, regarding universality, participants reported feeling like they had similar experiences to other members of the group and that they felt less alone by hearing and sharing stories with one another. Regarding group cohesion, the women indicated that they were invested in the group and looked forward to their “Thursday meetings.” Additionally, some of the women described the group as a “sisterhood” or “family,” which further suggested a strong sense of group
cohesion. Finally, the women also reported the importance of being able to express their emotions and have a “release” while in group. As previously explained, for some of the women in the study, the group was the only context in which they were able to focus on themselves without having to attend to the needs of others (e.g. family responsibilities). As such, the group experience became a safe place to experience emotions. Although not an intended focus of this study, it is important to highlight that the group processes, as traditionally described within the field of psychology, was experienced by the women in this group—particularly given its cross-racial context. That is the group counseling process was therapeutic in spite of the group being facilitated by European American clinicians.

The cross-racial nature of this group provided the context for a group dynamic that was specific to its racial composition. The racial composition may have also contributed to the women persisting with treatment despite their skepticism with European American clinicians facilitating the group. Group dynamics are created and shift depending on the composition of its members. Factors influencing group dynamics include personality and interpersonal factors in addition to cultural factors such as age, gender, race, sexual orientation and so forth (e.g. BenEzer, 2011; Hardwood, 2003; Yalom, 1995). In traditional interpersonal therapy groups, selection of group members are often screened with pre-group interviews designed to take individual characteristics into consideration in how it may affect group dynamics (Yalom, 1995). The hope is to provide balance in order to build group cohesion to maximize the therapeutic quality of the group.

The environment of the group for this current study was one where the facilitators were the numeric racial minority and all group members were of similar racial backgrounds. Theoretically, this specific group dynamic would be qualitatively different from a group that was
racially-mixed or if the group was primarily European American. It is possible that the racial composition of the group and the fact that clinicians were the numeric minority served as an initial buffer for continuing to participate in the group. The process of group counseling is fundamentally different from individual therapy in that group works toward relying less and less on facilitators to process their experiences and rely more and more on other the group members as a means for healing (Yalom, 1995). It is possible that the inherent nature of group counseling to focus more on the relationships among group members and not relationships with the clinicians might have been an important environmental factor contributing to the positive experience the group. Additionally, the transition of focus from the therapist to group members may have decreased concerns about racial differences.

Group counseling provides a natural way for focusing less on therapist/client interaction and more about the group’s interaction. Certainly, the interactions between group members and facilitators are not negligible, as these interactions, especially in early sessions, can serve as important modeling for establishing group norms (Yalom, 1995). However, the goal of group is to foster group members focusing on their support of one another and processing within the group. As one participant indicated “the group was more about us and less about the [facilitators].” One clinical implication of this finding may be that it is important for European American clinicians working with Black/African American women to be aware that an “us” and “them” dynamic may arise regarding race. This dynamic has the potential to be a positive function for the group. This may be positive in that it creates a dynamic that reduces some of the power held by the facilitators and places them in a vulnerable position that is not usually experienced in society.
Although there were not enough participants endorsing this belief for it to serve as theme, one participant discussed recognizing that the facilitators were the minority in the room and that they were brave to place themselves in a position where they would be the minority. The participant stated:

“I think you made a good choice at choosing those two there that you made. Because you got to have - I'll say, like say if I was to go in to facilitate a bunch of Mexican women. I might be scared, I might be scared because I don't know how far I can go with something. But you just got to stay focused.” (Participant 105)

It may be that this type of environment helped to promote a balance of power in the room that allowed the women to be open to continuing therapy despite their reservations. This may suggest that group counseling is advantageous environment for culturally sensitive care to be delivered within a cross-racial context. For example in a seminal article on guidelines for working with Black women within group counseling contexts, Nayman (1983) provided strategies for engaging Black women in group counseling in addition to providing contextual background regarding the salient issues for Black women. However the ideas presented in the article, focused on a context in which European American clinicians were working with a Black woman who was the racial and numerical minority in the group. Nayman wrote “because of the visibility of color and its pejorative connotations in American society, the Black female group participant represents a deviant in the group” (p. 34); that is, a Black woman in a group with members who are culturally/racially different from her may cause her to stick out in a way that may leave her feeling unsafe or not a part of the group. The context of the group for this current study was completely opposite in that group members represented the racial and numeric majority. Again, these environmental factors may have been useful in decreasing that sense of being an “other” in
the room, and may have made it easier to engage the facilitators. Future studies may want focus on the experience of Black/African American women in culturally sensitive treatment with individual therapist to better understand relational factors contributing to navigating cross-racial therapy.

Culturally Adapted Treatment: Implications of Cross-Racial Therapy

The context of therapy seems to dominate our understanding of how therapy can be experienced by Black or African Americans. A unique feature of this current study was the fact that the experience of culturally-adapted treatment was provided within the context of cross-racial therapy. Culturally-adapted treatment within the context of cross-racial therapy is unique given that racially homogenous tends to be highly examined within the field of psychology (Helms & Carter, 1991; Morten & Atkinson, 1983; Thompson, Bazile, & Akbar, 2004; Vanders Thompson & Alexander 2006; Want, Parham, Baker, & Sherman, 2004; Wintersteen, Mensinger, & Diamond 2005). The literature pertaining to cross-racial therapy in general is significantly less investigated and the trend within this area of scholarship tends to be exploratory in nature and focus on uncovering the experiences of clients (Chang & Berk, 2009; Chang & Yoon, 2011) and the experience of therapists (Aitken & Burman, 1999; Cooper & Lesser, 1997; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003).

The experiences of the participants in this current study, as it pertains specifically to treatment, revealed that the women were unclear of what “culturally sensitive” meant. During the interviews the lead researcher asked follow up questions such as “did you feel like this class was culturally sensitive? How so? How not? If not, what could have made the class more culturally sensitive?” The participants did not seem understand what “culturally sensitive” mean and often gave responses reiterating that the group was a useful experience. One participant even stated
that she did not experience the group as culturally sensitive despite providing positive experiences within the group. One explanation of this could have been the language used in this question, which is jargon-like, and may be more representative of the academic and professional language. Should other studies seek to explore culturally-adapted and sensitive treatment, it would be important to explore the participants’ perceptions or beliefs about culturally sensitive care in order to use language that is consistent with their conceptualization of this construct. No study could be found examining lay understanding of culturally-sensitive care. Future studies may examine how Black/African American women perceive or describe care that affirms/validates their race. This may further deepen our understanding of not only how treatments can be culturally adapted, but also when doing so is necessary.

Despite the participants in this current study having difficulty addressing question directly related cultural-sensitivity, their experience was that of being administered a culturally-adapted treatment within a cross-racial context. The fact that they did not recognize the treatment as culturally sensitive may have been due to how the questions in the interview were framed; however this lack of awareness may be indicative of how culturally sensitive treatment is perceived. A common theme that emerged from the participants’ narrative was the notion that after feeling comfortable within group and that preconceived notions regarding cultural difference were not salient or an issue. The experience of “race not being an issue” with the context of cross-racial psychotherapy may imply that the experience of cultural sensitivity is one in which racial difference is not experienced as a salient discomfort. Although it does not appear that the participants ever forgot that the facilitators were culturally different (i.e. implying a colorblind orientation), the cultural difference became less salient to the experience. The participants described their preconceived notions regarding the facilitators’ ability to relate to
them and be helpful as not being an issue as the group progressed. This lack of salience with cultural difference may in part explain why themes regarding the experience of the treatment as culturally sensitive did not emerge.

There were also several unique and important systemic factors to consider when understanding how a positive experience developed for participants in this study. First, the staff who were used for this study was racially diverse, which could have provided a contextual comfort and in turn may have helped to facilitate and ease or comfort with the clinicians. The lead researcher who recruited and interviewed the women is a self-identified Black woman. As the first contact with study, the lead researcher and inherent endorsement of the counselors may have provided a level of “buy in” to trust the counseling experience, despite the participants’ initial discomfort with having European American clinicians. But more importantly, it may have sent a message that diversity is embraced and is a safe context. One of the unintentional but consequential results of this study was that the staff and professionals involved were diverse. For example the guest speakers ranged in age, race, and gender. Additionally, one of the primary personnel for the study was a self-identified Black female. The diversity of the staff may have been important to consider in that it may have helped to create a message that diversity was respected and celebrated. It is possible that the experience of the participants may have been different if everyone involved in the study was European American. Although, none of the participants specifically discussed the staff’s diversity as something positive, one participant reported feeling more comfortable after seeing a staff member (Black female).

There is some evidence to suggest that the experience of racial and ethnic diversity among staff is related to positive perceptions of the environment (Hurtado, Griffin, Arellano, & Cuellar, 2008; Hurtado, Milem, Clayton-Pederson, & Allen, 1998). This research is
overwhelming represented within educational settings. For example within higher education settings research has concluded that for racial and ethnic minority students, perceptions of diversity among faculty (Lee, 2010), diversity of training (Green, Callands, & Radcliffe, 2009), and beliefs that there is racial diverse representation both numerically and hierarchically (Unzueta & Binning, 2012) are associated with positive perceptions with regards to campus climate and satisfaction.

Within counseling settings, there is limited research related to clients’ perception of the clinical environment based on the diversity of staff. In fact no study was located that specifically examined how culturally diverse clinical staffs impact clients’ perceptions of care. However, there is some research to suggest that health clinics and other mental health systems are interested in diversifying staff to make systems more welcoming to cultural minorities (e.g. Anderson, Scrimshaw, Fullilove, Feilding, et al., 2003; Paez, Allen, Carson, & Cooper, 2008; Pearson, Srivastava, Craig, Tucker, et al. 2007). For example, Anderson et al. (2003) conducted a systematic review of culturally competent healthcare systems. Within the review “culturally competent” was operationalized to include recruiting diverse staff and providing educational materials (e.g. brochures, artwork) that reflect cultural diversity. The findings from this study suggest the assumption the cultural diversity may improve the delivery of services.

Give the assumption that a culturally diverse staff may improve the perceptions of an environment within a system (e.g. educational, healthcare), it is possible that the racial and ethnic diversity of staff within this current study may have contributed to satisfaction with the participants’ experiences. This may point for the need to promote more diversity and celebration of differences within counseling agencies and systems. Unlike racial matching, inclusion of diverse staff and personnel may have communicated that a those involved in the research
program were open to diversity. Several of the participants remarked that they believed the facilitators would be better clinicians because they had an experience working with Black women and would therefore be more comfortable when working other Black women. The women in this study seemed to appreciate strongly the genuineness and apparent comfort that the facilitators had interacting with them. A shift in focus away from racial matching and more towards systemic inclusivity among staff may be useful in promoting cross-racial therapy. This may be achieved through hiring staff to reflect diversity, having staff (particularly European American clinicians) be more active/visible in community outreach efforts, ongoing training related to cultural sensitivity, in addition to having physical space reflect diversity (e.g. artwork, magazines, and music).

Another important systemic factor to consider is the issue of access to treatment. For participants who did not have transportation cab coupons were provided. It is important to note that there was a 100% retention rate for participants in this study. In addition to the overall positive and healing experience that may have influenced the participants staying in study, it is important to highlight the important pragmatic importance of access to treatment via transportation and affordability. For many low-income Black or African American women issues such as transportation or child care can be significant barriers to treatment (Chow, Jaffe, & Snowden, 2003; Lowe, 2006; Ward, Clark, & Hiedrich 2007), regardless of the racial context of therapy (i.e. racial matching versus cross-racial). These systemic issues are far beyond the scope of counseling agencies, centers, and private practices; issues pertaining to transportation, costs, and child care reflect health disparities that are pervasive within the United States. As clinicians, part of social justice work includes having awareness of these issues and possible involvement at the county, city, state, or national level with regards to supporting political measures that aim at
reducing health disparities. Similar to promoting diversity via hiring practices, outreach, and constructing therapeutic spaces, our involvement in political processes aimed and reducing health disparities can help to communicate an implicit message that issues of diversity and inclusivity is a value held by individuals who make up the systems that promote psychological well-being.

Finally, the most frequently cited theme regarding the experiences of the participants was the caring, non-judgmental, positive, genuine, and supportive nature of the facilitators in creating a safe and healing environment. At a very basic level it appears that the ability for the facilitators to be themselves and utilize the qualities that therapists are commonly expected to possess, left a positive imprint on the experiences of the participants in this study. Similar to the experiences of many graduate students receiving training in counseling psychology, the facilitators in this study had taken at least one course in multicultural counseling or engaged in a course aimed at recognizing the self and others as cultural beings. One of the facilitators had experience working with a Black female client before while the other facilitator had not. Overall, the facilitators had relatively limited to no experience working with this population. However, the lead researcher trained the facilitators in delivering the intervention, and part of this training incorporated exploration of cultural biases and the self as a cultural being. Through the trainings, the facilitators were prepped to have conversations around race with the group, and had a parallel experience of discussing issues of race and diversity with a Black lead researcher. However, they also brought their genuine selves to the experience. The training process undoubtedly had an impact on the delivery of this intervention and may suggest the importance of continued cultural awareness training within graduate programs. Specifically, training focused on self-exploration
may be an important area to stress within multicultural courses (Buckley & Foldy, 2010; Chao, Okazaki, & Hong, 2011; Richardson & Molinaro, 1996).

Multicultural courses, particularly within Counseling Psychology, focus on providing a survey of information regarding challenges that multiple groups have experience (Arredondo & Perez, 2006; Sue, Arredondo, McDavis, 1992; APA, 2003). However, there has been a movement toward shifting this process more toward self-awareness. Chao, Okazaki, and Hong (2011) reviewed pedagogical approaches to multicultural competence training. These authors suggested that training that empathized learned facts about “others” created a sense of false competence and may unintentionally contribute to intergroup hostility. They suggested that a shift in focus to critical self-awareness may improve cultural competence. Providing this knowledge is very important to imparting basic information to students with varying experiential experiences around diversity. Multicultural competence training also incorporates a strong component of self-awareness building, challenging of cultural bias, and recognizing discomforts/comforts with regards to conversations around culture (Buckley & Foldy, 2010). Buckley and Foldy (2010) specifically called for this shift training within the field of counseling psychology. Similar to the shift in pedagogical emphasis for cultural competence, the training for this study included content regarding Black women but was also highly experiential. The trainings focused on self-awareness and the process of interactions between the therapist and the lead researcher. During the training facilitators were prompted to focus more on their internal processes to information and scenarios as opposed to the content of information regarding working with Black or African American women. These conversations seemed to help raise the facilitators’ awareness to potential conversations around race but also to help to reduce trepidation about having these conversations. When possible, it may be useful to incorporate
more experiential and interpersonally process oriented structure to multicultural competence training in order to maximize social learning and self-awareness.

Similar to the implications of systemic diversity that may have impacted the participants’ experiences, another clinical implication of this study may be that training programs continue work toward diversifying their staff in terms of cultural diversity as well as diversity in research interests; as diversity in research teams can lead to culturally diverse experiences for students. In a qualitative study of examining clinicians’ perspectives of multicultural sensitivity, Vallianatou, Leavey, and Brown (2007) interviewed 10 White clinicians working in multicultural settings. The clinicians in this study reported that cultural-sensitivity was gained predominantly through direct contact with clients rather than gained through additional training and supervision (i.e. external advice). Consistent with an experiential approach it may be that increasing students’ ability to have experiences outside of their “cultural norm” may be particularly important to increasing comfort and genuineness within cross-racial contexts.

To date, not one study could be located that specifically examined the experiences of clients receiving culturally-adapted treatment within a cross-racial context. This current study is important because it provides exploratory data that supports the effectiveness of delivering culturally-adapted treatments within the context of cross-racial therapy. As aforementioned, the majority of studies examining culturally-adapted treatment included an element of racial matching (e.g. Carrington, 2006; Kohn et al., 2002). An important implication for counseling research is to further investigate examining the experiences and outcome data of Black women receiving culturally adapted treatment delivered within a cross-racial context, in addition to investigating training European American clinicians to deliver culturally-adapted treatment may assist in further understanding what constitutes cultural adaptation. Specifically, the current
definition of “culturally-adapted treatment” with the literature is broad, ranging from theoretically-driven adaptations to racial matching. More examination of adaptations sans racial matching may shed light on the degree to which racial matching alone is sufficient for treatment to be “culturally adapted.”

Symptom Relief

In addition to understanding the experiences of Black women receiving a culturally-adapted treatment within a cross-racial context, was to examine contextually if women experienced symptom relief while in treatment. The results suggested that although the trend was in the “right” direction (i.e. decrease in symptom endorsement from baseline to week 12), the findings were not statistically significant. The probable explanation for this finding is small sample size (N = 6) that was utilized for the data analysis. Additionally, in order to reduce Type I error, the p-values were divided by the number of tests conducted (i.e. three) tests. This made the criteria for significance highly conservative. Despite the results being insignificant the reduction of symptoms throughout the intervention seems congruent with the subjective reports of the participants and provides evidence that of symptom relief. This finding is promising in that it provides contextual support of how useful the intervention was for the participants managing their symptoms of depression. Future studies should include larger samples in order to increase statistical power, thereby increasing the reliability of the results.

Limitations

Despite the promising findings in this study there are a few limitations to consider. One limitation of the study was the inability to control for the effects of group dynamics. Even though the group counseling context may have provided a powerful experience for the participants to connect with one another and the facilitators, the interpersonal dynamics of the group
undoubtedly had an impact of the experience of the intervention. As Yalom (1995) suggested, group dynamics are highly influenced by the interpersonal and personality characteristics of the individual group members. This is why most groups conduct pre-group interviews with potential group member in order to screen for interpersonal and personality characteristics that may impact group cohesion. It was clear from the interviews that the women in the current study felt connected to one another. Group cohesion was important because it assisted with promoting the therapeutic factors of counseling and at a very basic level provided safety and comfort. Group cohesion affects issues such as member attendance, self-disclosure, and exploring and expressing emotions (Yalom, 1995). Given these factors, it was plausible that had the group not been cohesive the experience of the group would have been affected. Additionally, as aforementioned the cohesiveness of the group may have played a role with facilitating comfort with the European American therapists. Therefore findings need to be cautiously interpreted.

Another challenge with the study was the difficulty in recruiting counselors for the study. The recruitment method employed consisted of emails posted to listservs and direct contact with graduate students who fit the criteria for the study. The initial recruitment of counselors took about five months. However, due to the time needed to recruit participants, the counselors originally recruited for the study were no longer able to continue with the study. Consequently, the recruitment process resumed for another month and a half. The time commitment and level of openness required to explore actively cultural differences may have been barriers to recruitment and may pose challenges with the replication of this study; however the difficulty in the recruiting therapists for this study highlights the need to graduate programs to continue to support and nurture students toward involving themselves in clinical experiences that will assist with multicultural development.
There is also a limitation with regards to the language used in the interview protocol regarding “culturally sensitive treatment.” It appears that not all women in the study were familiar with what this term meant and provided answers that reflected this confusion. The lack of clarity in this construct provided a limitation in that it was unclear the extent to which the participants believed they were experiencing culturally sensitive treatment or that the treatment met their needs specifically as Black women. Without understanding how the women experienced “culturally sensitive” treatment it was difficult to make definitive conclusions with regards to cultural sensitivity within the participants’ experience. The participants’ reflections of their experience suggested that race/culture was not a barrier to treatment; however it unclear whether not experiencing racism is equivalent to “culturally sensitive” treatment. Knowing how Black women conceptualize culturally sensitive treatment may help with clinical training for working with this group and future cultural adaptations that accurately address the needs of this population.

Another limitation of this study was that participants did not engage in the post-treatment 3-month follow-up. The OHDC, when administered within a research context, was designed to include a 3 month follow-up. The decision was made not to include a 3-month follow-up due to the focus of this study being on the experience of the participants and not the fidelity of the treatment itself. However, a follow-up could have provided more data regarding the post-treatment symptoms relief. Similarly, another challenge based on the context of this study being research was that the participants were reimbursed. Like many intervention studies participants were compensated for their time. Because payment for engagement in therapy does not parallel “real world” treatment settings, it important to highlight that reimbursement may have impacted participation.
A final limitation is that attendance to group was not taken. Based on the role of the lead researcher overseeing logistical support to the research staff and communicating with them regularly, it is clear that not all participants attended every session; however, based on the facilitators’ report, the participants attended “most” of the sessions. Having data on participant attendance could have provided more support for investment in the group and overall comfort with engaging in this intervention. Additionally, the number of participants present for each session may have impacted the experience of members (e.g., groups that were smaller lead to less/more disclosure). Having this data could have better contextualized the findings.

**Future Research**

The current study is one of the first to examine the experiences of Black women receiving culturally sensitive treatment from European-American clinicians. As aforementioned, examining effective treatment for Black women experiencing mental health concerns continues to be Culturally adapted treatment (CAT) delivered to Black women is an important area for continued study. Thus far research involving CATs has promising data supporting that it is effective (Griner & Smith, 2006) and that is preferred modality of treatment for Black women with depression (Carrington, 2006; Kohn et al., 2002). Within the field of psychology it appears that CATs are important component to understand in progressing to the next level of promoting culturally competent clinicians and care. As the cultural demographic continues to shift, there is an increase in the likelihood of therapeutic contexts to be cross-racial. The findings of this current study have several implications for future research regarding CATs delivered in a cross-racial context.

First, although qualitative research is important for understanding subjective experiences and is arguably the best methodological approach for explorative studies examining phenomena
with relatively little research, there needs to be more quantitative research exploring the outcomes of CATs with Black women. There are relatively few studies examining CATs with Black women experiencing depression in general; but there are virtually no studies examining CATs with Black women within a large clinical trial. Data from such studies can provide more empirical support for the development of CATs. Additionally, findings from such studies can provide more generalizable results.

In addition to larger clinical trial studies examining CATs with Black women, in general there needs to be more research examining CATs within cross-racial or cross-cultural contexts. The current definition for CATs ranges from making theoretically informed cultural adaptations of bonafide treatments, to keeping the structure of the treatment unchanged but having it delivered by clinicians who are racially similar to participants. In order to address this issue, larger clinical studies aimed at examining how clinicians’ race impacts outcome of treatment would provide more generalizable data regarding the effectiveness of European American clinicians delivering CATs.

With regards to specific findings in this study, there remain questions regarding the influence of that group counseling may have on the experience of CATs within a cross-racial context. The results from this study suggest that the group dynamic may have helped to facilitate more comfort with the European American clinicians because of the strong connection the women had with one another and the fact that they were a numerical majority. Research examining the impact of group counseling in facilitating cross-racial comfort may be helpful. Additionally studies examining the experience of women in individual treatment with European clinicians providing CATs would assist in better understanding the complexity of how the structure of counseling can help to promote strong cross-racial therapeutic alliances.
Finally, the results of this study have implications for research with regards to training European American clinicians to deliver CATs. Although not a focus of this study, the clinicians were provided specific training to facilitate the group. Within current training modalities, multicultural coursework tends to focus on raising self-awareness to cultural bias and gaining knowledge regarding various cultural groups. What is less focused on are the skills that may be useful in working with specific cultural groups. Research examining the experiences and clinical outcomes of European American clinicians who have received training to provide CATs may further strengthen our understanding of culturally competent care.
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in women from families with recurrent, early-onset, major depression.

*American Journal of Medical Genetics, 114*, 980-987.
Appendix A

Table A1 Coping with Depression Course Session Content Summary

<table>
<thead>
<tr>
<th>Week</th>
<th>Focus of Session</th>
</tr>
</thead>
</table>
| 1    | **Depression and Social Learning**  
     | Session focuses on learning how feelings are related to outcomes of interpersonal/environmental interactions and learn to increase positive interaction outcomes |
| 2    | **How to Design a Self-Change Plan**  
     | Session focuses on teaching self-change skills based on self-identified problems and participants develop self-change plan |
| 3    | **Learning to Relax**  
     | Session focuses on teaching Jacobsen progressive muscle relaxation technique, Benson relaxation technique, and visual imagery |
| 4    | **Relaxation in Everyday Situations**  
     | Session focuses on applying relaxation techniques and strategies in problem situations |
| 5    | **Pleasant Activities and Depression**  
     | Session focuses on the relationship between engaging in pleasant activities and mood |
| 6    | **Formulating a Pleasant Activities Plan**  
     | Session focuses on guidelines for writing a weekly activities plan |
| 7    | **Two Approaches to Constructive Thinking**  
     | Session focuses on impact of negative and unconstructive thoughts on mood  
     | Two approaches used: (1) Methods to decrease negative thoughts (e.g. thought stopping) and (2) Methods to think more constructively (e.g. ABC technique) |
| 8    | **Formulating a Plan for Constructive Thinking**  
     | Session focuses on additional methods for controlling thoughts such as self-instructional techniques and positive self-statements |
| 9    | **Social Skills: The Ability to be Assertive**  
     | Session focuses on assertiveness as a skill for interacting with others in a rewarding way |
| 10   | **Using Your Social Skills**  
     | Session focuses on using social skills to increase pleasant social interactions, specific plan is developed |
| 11   | **Maintaining Your Gains**  
     | Session focuses on summarizing material and assisting participants in developing a plan to maintain goals |
| 12   | **Developing a Life Plan**  
     | Session focuses on developing a life plan that incorporates gains made during treatment |
## Appendix A

Table A2 Oh Happy Day Class Session Content Summary

<table>
<thead>
<tr>
<th>Week</th>
<th>Focus of Session</th>
</tr>
</thead>
</table>
| 1    | *Introduction and Overview of Group Counseling  
• Participants learn about the process of group counseling |
| 2    | *Depression—Etiology, Risk Factors, Symptoms & Treatment  
• Risk factors highly relevant to African Americans such as poor physical health, poverty, racism, discrimination, and caregiving burden is discussed |
| 3    | *Women and Depression  
• Session focuses on issues relevant to women and depression such as how common depression is among women, risk factors, seeking behavior, and healthy coping |
| 4    | *Depression and Chronic Physical Illness  
• Session focuses on providing health information about the relationship between physical health and mood. Registered nurse guest speaker |
| 5    | *Depression and Anger Management  
• Session focuses on identifying anger and developing healthy ways to control and manage anger |
| 6    | *Community Resources  
• Session focuses on identifying anger and developing healthy ways to control and manage anger |
| 7    | Stress Management and Learning to Relax  
• Session focuses on teaching Jacobsen progressive muscle relaxation technique, Benson relaxation technique, and visual imagery |
| 8    | Two Approaches to Constructive Thinking  
• Session focuses on impact of negative and unconstructive thoughts on mood  
• Two approaches used: (1) Methods to decrease negative thoughts (e.g. thought stopping) and (2) Methods to think more constructively (e.g. ABC technique) |
| 9    | *Forgiveness  
• Session focuses on helping participants understand one model of forgiveness (Enright & Fitzgibbons, 2007) and the health benefits of forgiveness |
| 10   | Depression and Pleasant Activities  
• Session focuses on the relationship between engaging in pleasant activities and mood |
| 11   | Maintaining Gains & Developing a Life Plan  
• Session focuses on summarizing material and assisting participants in developing a plan to maintain goals. Participants develop life plan for integrating material into everyday life. |
| 12   | Wrap Up & Review  
• Participants reflect on class and discuss life changes they will continue to make |

* Session = culturally adapted modification
### AUDIT

The following questions are about your general drinking behaviors. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times a month</th>
<th>2-3 times a week</th>
<th>4 or more times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

QIDS-CR<sub>16</sub> QUESTIONNAIRE (Screening Measure)

Quick Inventory of Depressive Symptomatology (Clinician-Rated) (QIDS-C<sub>16</sub>)

Patient Name: ____________________________

Date: ____________________________

Please circle the 1 response to each item that best describes the patient for the last 7 days.

1. Sleep-onset insomnia
   0 Never takes longer than 30 minutes to fall asleep.
   1 Takes at least 30 minutes to fall asleep, less than half the time.
   2 Takes at least 30 minutes to fall asleep, more than half the time.
   3 Takes more than 60 minutes to fall asleep, more than half the time.

2. Mid-nocturnal insomnia
   0 Does not wake up at night.
   1 Restless, light sleep with few awakenings.
   2 Wakes up at least once a night, but goes back to sleep easily.
   3 Awakens more than once a night and stays awake for 20 minutes or more, more than half the time.

3. Early-morning insomnia
   0 Less than half the time, awakens no more than 30 minutes before necessary.
   1 More than half the time, awakens more than 30 minutes before need be.
   2 Awakens at least 1 hour before need be, more than half the time.
   3 Awakens at least 2 hours before need be, more than half the time.

4. Hypersomnia
   0 Sleeps no longer than 7-8 hours/night, without naps.
   1 Sleeps no longer than 10 hours in a 24-hour period (including naps).
   2 Sleeps no longer than 12 hours in a 24-hour period (including naps).
   3 Sleeps longer than 12 hours in a 24-hour period (including naps).

Enter the highest score on any 1 of the 4 sleep items (1-4 above): __________

5. Mood (sad)
   0 Does not feel sad.
   1 Feels sad less than half the time.
   2 Feels sad more than half the time.
   3 Feels intensely sad virtually all the time.

6. Appetite (decreased)
   0 No change from usual appetite.
   1 Eats somewhat less often and/or lesser amounts than usual.
   2 Eats much less than usual and only with personal effort.
   3 Eats rarely within a 24-hour period, and only with extreme personal effort or with persuasion by others.

7. Appetite (increased)
   0 No change from usual appetite.
   1 More frequently feels a need to eat than usual.
   2 Regularly eats more often and/or greater amounts than usual.
   3 Feels driven to overeat at and between meals.

8. Weight (decrease) within the last 2 weeks
   0 Has experienced no weight change.
   1 Feels as if some slight weight loss occurred.
   2 Has lost 2 pounds or more.
   3 Has lost 5 pounds or more.

9. Weight (increase) within the last 2 weeks
   0 Has experienced no weight change.
   1 Feels as if some slight weight gain has occurred.
   2 Has gained 2 pounds or more.
   3 Has gained 5 pounds or more.

Enter the highest score on any 1 of the 4 appetite/weight change items (6-9 above): __________
Appendix B

**QIDS-CR\textsubscript{16} QUESTIONNAIRE (Screening Measure)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
</table>
| 10. Concentration/decision making | 0. No change in usual capacity to concentrate and decide.  
1. Occasionally feels indecisive or notes that attention often wanders.  
2. Most of the time struggles to focus attention or make decisions.  
3. Cannot concentrate well enough to read or cannot make even minor decisions. |
| 11. Outlook (self) | 0. Sees self as equally worthwhile and deserving as others.  
1. Is more self-blaming than usual.  
2. Largely believes that he/she causes problems for others.  
3. Ruminates over major and minor defects in self. |
| 12. Suicidal ideation | 0. Does not think of suicide or death.  
1. Feels life is empty or is not worth living.  
2. Thinks of suicide/death several times a week for several minutes.  
3. Thinks of suicide/death several times a day in depth, or has made specific plans for or attempted suicide. |
| 13. Involvement | 0. No change from usual level of interest in other people and activities.  
1. Notices a reduction in former interests/activities.  
2. Finds only 1 or 2 former interests remain.  
3. Has virtually no interest in formerly pursued activities. |
| 14. Energy/fatigability | 0. No change in usual level of energy.  
1. Tires more easily than usual.  
2. Makes significant personal effort to initiate or maintain usual daily activities.  
3. Unable to carry out most of usual daily activities due to lack of energy. |
| 15. Psychomotor slowing | 0. Normal speed of thinking, gesturing, and speaking.  
1. Patient notes slowed thinking, and voice modulation is reduced.  
2. Takes several seconds to respond to most questions; reports slowed thinking.  
3. Is largely unresponsive to most questions without strong encouragement. |
| 16. Psychomotor agitation | 0. No increased speed or disorganization in thinking or gesturing.  
1. Fidgets, wrings hands and shifts positions often.  
2. Describes impulse to move about and displays motor restlessness.  
3. Unable to stay seated; paces about with or without permission. |

Enter the highest score on either of the 2 psychomotor items (15 or 16 above): _______
Appendix C

DEMOGRAPHIC QUESTIONNAIRE

ID Number: ________________________ Date: __________________

Directions: Please answer the following questions to the best of you knowledge.

1. What year were you born? ______________________

2. How many people contribute to your household income? ______________________
   What is your range of household annual income?
   - _______00-10,000
   - _______10,001-20,000
   - _______20,001-30,000
   - _______30,001-40,000
   - _______40,001-50,000
   - _______50,001-60,000
   - _______60,001-70,000
   - _______70,001-80,000
   - _______80,001 +

3. How would you describe your socioeconomic status?
   - _______1. Working Class
   - _______2. Middle Class
   - _______3. Upper Middle Class
   - _______4. Upper Class
   - _______5. Retired

4. Do you have health insurance? _______Yes _______No
   If yes, how long have you had insurance? ______________________

5. Are you? (check all that apply)
   - _______1. Married
   - _______2. Living with partner
3. Separated
4. Divorced
5. Widowed
6. Never married

6. Do you have any children? _____No _____Yes.
If yes number of children? _____
If yes, how old are your children? ___________________________

7. What is the highest level of education you have completed?
1. Elementary
2. Completed 8th grade
3. High School Diploma or GED
4. Two-year College or Technical College
5. Bachelor’s Degree
6. Master’s Degree
7. Doctorate Degree
8. Other (please specify_______________

8. Have you ever been diagnosed with a mental illness (depression, anxiety, PTSD etc)?
_____No _____Yes.

9. If you marked “Yes” to the question 8, which of the following mental illness did you have:
_____ Depression _____ Anxiety Disorder
_____ Schizophrenia _____ Posttraumatic Stress Disorder
_____ Bipolar Disorder _____ Panic Disorder
10. Have you ever sought professional treatment (e.g. counselor, therapist, psychologist, social worker) for a mental illness (e.g. depression, anxiety etc)? ______No ______Yes.

11. If you marked “yes” to question 10, please provide more information about your therapy experience. We are interested in knowing how many providers you have seen, how long you were in treatment with that provider, and what the quality of your treatment was. We are only interested in treatment provided by therapists, counselors, social workers, or psychologists and NOT medical doctors or psychiatrists.

A. Provider 1:
What was the race of your mental health Provider 1?

[ ] Black/African American  [ ] White/Caucasian
[ ] Asian American/Pacific Islander  [ ] Native American
[ ] Biracial/Multiracial  [ ] Latino/Hispanic
[ ] Other (please specify) ________________________________

How many sessions did you have with Provider 1? ___________________

In general, how would you rate the quality of the mental health services you have received with Provider 1?

[ ] Poor  [ ] Fair/Adequate  [ ] Good  [ ] Excellent

B. Provider 2:
What was the race of your mental health Provider 2?

[ ] Black/African American  [ ] White/Caucasian
[ ] Asian American/Pacific Islander  [ ] Native American
[ ] Biracial/Multiracial  [ ] Latino/Hispanic
[ ] Other (please specify) ________________________________
How many sessions did you have with Provider 2? ___________________

In general, how would you rate the quality of the mental health services you have received with Provider 2?

_____ Poor  _____ Fair/Adequate  _____ Good  _____ Excellent

C. Provider 3:

What was the race of your mental health Provider 3?

_____Black/African American  _____White/Caucasian
_____Asian American/Pacific Islander  _____Native American
_____Biracial/Multiracial  _____Latino/Hispanic

_____Other (please specify) _______________________________________________

How many sessions did you have with Provider 3? ___________________

In general, how would you rate the quality of the mental health services you have received with Provider 3?

_____ Poor  _____ Fair/Adequate  _____ Good  _____ Excellent

D. Provider 4:

What was the race of your mental health Provider 4?

_____Black/African American  _____White/Caucasian
_____Asian American/Pacific Islander  _____Native American
_____Biracial/Multiracial  _____Latino/Hispanic

_____Other (please specify) _______________________________________________

How many sessions did you have with Provider 4? ___________________
In general, how would you rate the quality of the mental health services you have received with Provider 4?

[ ] Poor  [ ] Fair/Adequate  [ ] Good  [ ] Excellent

**E. Provider 5:**

What was the race of your mental health Provider 5?

[ ] Black/African American  [ ] White/Caucasian
[ ] Asian American/Pacific Islander  [ ] Native American
[ ] Biracial/Multiracial  [ ] Latino/Hispanic
[ ] Other (please specify) ____________________________________________

How many sessions did you have with Provider 5? ___________________

In general, how would you rate the quality of the mental health services you have received with Provider 5?

[ ] Poor  [ ] Fair/Adequate  [ ] Good  [ ] Excellent

12. Are you currently seeing a therapist?

[ ] No  [ ] Yes.

If “yes” to question 12, what is the race of your therapist?

[ ] Black/African American  [ ] White/Caucasian
[ ] Asian American/Pacific Islander  [ ] Native American
[ ] Biracial/Multiracial  [ ] Latino/Hispanic
[ ] Other (please specify) ____________________________________________
Appendix D

BDI-II QUESTIONNAIRE (OUTCOME MEASURE)

Name: ___________________________ Marital Status: _______ Age: _______ Sex: _______
Occupation: ______________________ Education: ________________________

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including item 16 (Changes in Sleeping Pattern) or item 18 (Changes in Appetite).

1. **Sadness**
   0  I do not feel sad.
   1  I feel sad much of the time.
   2  I am sad all the time.
   3  I am so sad or unhappy that I can’t stand it.

2. **Pessimism**
   0  I am not discouraged about my future.
   1  I feel more discouraged about my future than I used to be.
   2  I do not expect things to work out for me.
   3  I feel my future is hopeless and will only get worse.

3. **Past Failure**
   0  I do not feel like a failure.
   1  I have failed more than I should have.
   2  As I look back, I see a lot of failures.
   3  I feel I am a total failure as a person.

4. **Loss of Pleasure**
   0  I get as much pleasure as I ever did from the things I enjoy.
   1  I don’t enjoy things as much as I used to.
   2  I get very little pleasure from the things I used to enjoy.
   3  I can’t get any pleasure from the things I used to enjoy.

5. **Guilt Feelings**
   0  I don’t feel particularly guilty.
   1  I feel guilty over many things I have done or should have done.
   2  I feel quite guilty most of the time.
   3  I feel guilty all of the time.

6. **Punishment Feelings**
   0  I don’t feel I am being punished.
   1  I feel I may be punished.
   2  I expect to be punished.
   3  I feel I am being punished.

7. **Self-Dislike**
   0  I feel the same about myself as ever.
   1  I have lost confidence in myself.
   2  I am disappointed in myself.
   3  I dislike myself.

8. **Self-Criticalness**
   0  I don’t criticize or blame myself more than usual.
   1  I am more critical of myself than I used to be.
   2  I criticize myself for all of my faults.
   3  I blame myself for everything bad that happens.

9. **Suicidal Thoughts or Wishes**
   0  I don’t have any thoughts of killing myself.
   1  I have thoughts of killing myself, but I would not carry them out.
   2  I would like to kill myself.
   3  I would kill myself if I had the chance.

10. **Crying**
    0  I don’t cry anymore than I used to.
    1  I cry more than I used to.
    2  I cry over every little thing.
    3  I feel like crying, but I can’t.
Appendix D

BDI-II QUESTIONNAIRE (OUTCOME MEASURE)

11. Agitation
   0 I am no more restless or wound up than usual.
   1 I feel more restless or wound up than usual.
   2 I am so restless or agitated that it’s hard to stay still.
   3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of interest
   0 I have not lost interest in other people or activities.
   1 I am less interested in other people or things than before.
   2 I have lost most of my interest in other people or things.
   3 It’s hard to get interested in anything.

13. Indecisiveness
   0 I make decisions about as well as ever.
   1 I find it more difficult to make decisions than usual.
   2 I have much greater difficulty in making decisions than I used to.
   3 I have trouble making any decisions.

14. Worthlessness
   0 I do not feel I am worthless.
   1 I don’t consider myself as worthwhile and useful as I used to.
   2 I feel more worthless as compared to other people.
   3 I feel utterly worthless.

15. Loss of Energy
   0 I have as much energy as ever.
   1 I have less energy than I used to have.
   2 I don’t have enough energy to do very much.
   3 I don’t have enough energy to do anything.

16. Changes in Sleeping Pattern
   0 I have not experienced any change in my sleeping pattern.
   1a I sleep somewhat more than usual.
   1b I sleep somewhat less than usual.
   2a I sleep a lot more than usual.
   2b I sleep a lot less than usual.
   3a I sleep most of the day.
   3b I wake up 1-2 hours early and can’t get back to sleep.

17. Irritability
   0 I am no more irritable than usual.
   1 I am more irritable than usual.
   2 I am much more irritable than usual.
   3 I am irritable all the time.

18. Changes in Appetite
   0 I have not experienced any change in my appetite.
   1a My appetite is somewhat less than usual.
   1b My appetite is somewhat greater than usual.
   2a My appetite is much less than before.
   2b My appetite is much greater than usual.
   3a I have no appetite at all.
   3b I crave food all the time.

19. Concentration Difficulty
   0 I can concentrate as well as ever.
   1 I can’t concentrate as well as usual.
   2 It’s hard to keep my mind on anything for very long.
   3 I find I can’t concentrate on anything.

20. Tiredness or Fatigue
   0 I am no more tired or fatigued than usual.
   1 I get more tired or fatigued more easily than usual.
   2 I am too tired or fatigued to do a lot of the things I used to do.
   3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
   0 I have not noticed any recent change in my interest in sex.
   1 I am less interested in sex than I used to be.
   2 I am much less interested in sex now.
   3 I have lost interest in sex completely.
Appendix E

INTERVIEW PROTOCOL

Directions: Explain to the participant the purpose of the interview. Review confidentiality and how the audio recordings will be used. Clarify any questions the participant may have. Questions 2-10 are major probe areas that should be covered. The “lettered” questions are probes that should be asked if the participant does not address. Ask participant if she would like to review the results for validity check.

1. “Grand Tour” question: Please describe for me your experience in the Oh Happy Day Class, stating at the beginning and taking me thought the very end.

2. Think back to the very first class, when you first met all the group members and the facilitators. What do you remember about that first class?
   a. What was your impression of the class?
   b. What was your impression of the facilitators?
   c. What was your impression of the class and the facilitators as the class went on?

3. How many sessions of the class did you attend?

4. What was the class like for you?
   a. What was helpful about the class?
   b. What was unhelpful about the class?
   c. *if dropped out prior to 12 sessions* Why do you think coming to the class was no longer useful for you?
      i. What could have made the experience better for you?

5. What was it like working with the facilitators?
   a. What specific things did the facilitators do that were helpful?
   b. What specific things did the facilitators do that were unhelpful?
   c. Were there any challenges in working with the facilitators? If yes, can you give examples of the challenges you experienced?
      i. Were these challenges addressed in the class? If so, how?

6. You know that this class was specifically created for African American/Black women. What are your thoughts on this class addressing you needs as an African American/Black woman?
a. Did you feel like this class was culturally sensitive? How so? How not?
b. If not, what could have made the class more culturally sensitive?

7. What was it like for you having White facilitators lead the class?
   a. How racially/culturally sensitive did the facilitators seem to be?
      i. What made them seem/not seem culturally sensitive?
   b. How might this experience been different if the clinicians were African American/Black?

8. Reflecting back on your experience in the Oh Happy Day Class, how important were racial differences?

9. As someone who has experienced a culturally sensitive treatment that is provided by White therapists, what suggestions do you have for therapists using culturally sensitive treatments with other African American/Black women?

10. Is there anything about you experience in the Oh Happy Day Class that you didn’t talk about that you think would help me better understand what it was like for you?
Appendix F

SUICIDE PREVENTION PROTOCOL

I. Assess risk factors:

- Increased substance abuse
- Social withdrawal
- Family history of suicide
- Physical Illness
- Single, separated, widowed, divorced
- Unemployment
- Presence of a psychiatric diagnosis, particularly an affective disorder
- Previous suicidal attempts
- Participant threatening to hurt/kill him/herself or wanting to hurt him/herself
- Seeking means (e.g. accessing firearms, pills) to kill him or herself

Although these factors do not predict suicide behavior assessing, can give clinician information for further assessing the severity of possible suicidality.

Source: Jacobs, Brewer, & Klein-Benheim (1999)

II. Questions to consider if participant endorses suicidal thoughts (Suicide Risk Assessment):

- What are the thoughts?
- Are they active or passive?
- When did they begin?
- How frequent are they?
- How persistent are they?
- Are they obsessive?
- Can you control them?
- Loss of coping mechanism?
- How far has the suicide process proceeded?
- Have suicidal behaviors occurred in the past?
- Has the participant lost or anticipates losing his/her main reason for living?
- Does the participant have a plan for hurting him/herself?
- If he/she does have a plan does he or she have access to weapons or the means to complete the act?

Increased frequency, specificity and intensity of thoughts indicate that participant may be suicidal and should not participate in study.
Appendix F

SUICIDE PREVENTION PROTOCOL

Source: Risk Management Foundation of the Harvard Medical Institutions

III. Protocol for Working with Suicidal Participants:

Source: Psychology Research and Training Clinic, UW Madison Department of Psychology

1. Inform participants prior to counseling of the limitations of confidentiality (i.e. informing third parties about suicidality)

2. If participant is identified as experiencing suicidal ideation, conduct a suicide risk assessment. If participants assessment is positive (presence of strong suicidality) then follow the subsequent steps:

3. **At anytime you need to consult call your supervisor.**

4. Help the participants develop alternative plans of action. Emphasize to the participant that your understanding is that he/she is agreeing with your plan. Make sure your plan contingencies for different outcomes in the event that the client does not follow through. It is strongly suggested that you involve family members or friends for safety planning if possible. **Remember that in life-threatening situations you may break confidentiality to the extent that it is necessary to protect the participant and others.** Find out whether there are people on whom the participant can rely for assistance and support. **It is encouraged that you talk directly to support people when involving them in the safety plan.** Be sure to discuss these alternatives with the participant.

Sample alternative plans:

**Example A:** “We agreed that you will stay with your friend tonight. Your friend is planning to pick you up and I will wait with you until he/she arrives.”

**Example B:** “I have spoken to your partner and he/she will drive you to the emergency room at UW Hospital. I will call the hospital to let them know that you are coming.”
Appendix F

SUICIDE PREVENTION PROTOCOL

Example C: “You promised that you will go home and not hurt yourself. You said it will take you 15 minutes to get home. I will expect you to call me by 9:00. If you don’t call at 9:00 I will call you. I’ll let the phone ring 10 times. If you do not answer the phone I will call the police.”

If your plan involves hospitalization of the participant identify an appropriate source of inpatient service before arranging for an ambulance to transport the participant. If the participant has insurance determine the hospital which serves this carrier. Contact the emergency room at this hospital. Work with the emergency room team, and if they suggest it, the psychiatrist on call to arrange bed space. If none is available, solicit suggestions as to which hospital to contact next. If they have no suggestions, call the Dane County Crisis Line for Professionals (280-2600).

5. If at any time you feel that the participant is a serious danger to self (has had suicidal attempts in the past, has access to means, has indicated strong intent to hurt self, or does not have a support system to get involved), call 911 immediately. You can say “I am concerned that you need attention right away. I think it would be best if you called 911.” If the participant does not comply with this action, inform him/her that you are concerned for his/her safety and will call 911.

If you are uncertain about risk call your supervisor. If your supervisor is unavailable call the Dane County Mental Health Center Crisis Line for Professionals (280-2600).

6. Contact your supervisor within 24 hours.

7. Inform IRB
Appendix F

SUICIDE PREVENTION PROTOCOL

Emergency Phone Numbers

Mental Health Center of Dane County............................. 280-2700
    Crisis Intervention Service................................. 280-2600

City of Madison Police/Ambulance.................................911

City of Madison Non-Emergency Dispatcher......................255-2345

UW Non-Emergency Dispatcher..................................264-2677

Merriter Hospital 24 Hour Emergency Care......................417-6206

University Health Services /Counseling & Consultation Services......265-5600
    After hours crisis response center...........................265-6500 (#9)

University of Wisconsin Hospital & Clinics........................262-2398
Appendix G

RESOURCES FOR PARTICIPANTS

Community Resources

1. Mental Health Center Dane County
   625 West Washington Avenue
   Madison, WI (608) 280-2700
   http://www.mhcdc.org/
   *Provides both mental health and substance abuse treatment

2. Catholic Charities
   30 South Franklin Street, Madison - (608) 256-2358
   702 South High Point Road, Madison - (608) 821-3100
   426 S Yellowstone Dr # 100, Madison - (608) 833-4800
   http://www.catholiccharitiesofmadison.org/
   *Provides mental health and substance abuse treatment. For more information on substance abuse, please contact Barbara Purchas at (608) 441-3240.

3. Lutheran Social Services
   6314 Odana Rd # A
   Madison, WI (608) 277-0610
   http://www.lsswis.org/
   *Provides both mental health and substance abuse treatment

4. Access Community Health
   2202 South Park Street
   Madison, WI (608) 443-5480
   http://www.accesscommunityhealthcenters.org/

5. Psychology Research and Training Clinic
   321 Brogden Psychology Building
   1202 West Johnston Street
   Madison WI (608) 262-5929
   http://psych.wisc.edu/clinic

6. Counseling Psychology Training Clinic
   316 Educational Sciences Building
   1025 W. Johnson Street
   Madison WI, 53706 (608)-265-8779
   http://www.education.wisc.edu/cp/faculty/trainingclinic.asp
Appendix H

RECRUITMENT FLYER

Research Study for Black Women

Have you recently experienced:
- Sadness or “the blues?”
- Worthlessness?
- Stress?
- Trouble sleeping?
- Trouble concentrating?
- Trouble staying motivated?
- Unexplained guilt?
- Weight gain/loss?

If Yes...

- This research study is investigating a culturally-sensitive program for depression developed for BLACK WOMEN
- Must be between 25 and 55
- Participants will be compensated up to $100

For more information please contact:

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