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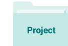

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Correspondence to Todd E. Brown, M.A., University of California, Los Angeles, Department of Psychology, 1285 Franz Hall, Box 951563, Los Angeles, CA 90095 toddbrown@ucla.edu

ACCESS & EQUITY

Using Functional Analytic Psychotherapy to Improve Awareness and Connection in Racially Diverse Client-Therapist Dyads

Annette Miller and Monnica T. Williams, *University of Louisville*

Chad T. Wetterneck, *Rogers Memorial Hospital*

Jonathan Kanter and Mavis Tsai, *University of Washington, Seattle*

As of 2010, non-Hispanic Whites comprised 63% of the U.S. population, yet the number of minority psychologists lingers under 25% (American Psychological Association [APA], 2010; U.S. Census Bureau, 2011). The limited data available on psychologist demographics is encouraging insofar as APA membership is shifting to include greater numbers of ethnic and racial minorities in its various membership categories. Even so, the rate at which ethnoracially diverse populations seek mental health services is outpacing the availability of minority psychologists. Ethnic and racial minorities are projected to exceed 57% of the population by 2060 as non-Hispanic White Americans become a minority over the next three decades (U.S. Census Bureau, 2012). As a result, ethnoracially diverse therapy dyads are increasingly common. This growth in diversity accelerates the need for ongoing scholarship, informed attitudes, and clinician competency for multicultural clinical training at parity with other important therapeutic skills.

Discrimination resulting from stigmatized minority status is associated with negative mental health outcomes, such as depression, anxiety, substance use, posttraumatic stress disorder, and overall psychological distress (Banks & Kohn-Wood, 2007; Blume, Lovato, Thyken, & Denny, 2012; Chae, Lincoln, & Jackson, 2011; Pieterse, Todd, Neville, & Carter, 2012). As a result, such experiences and the related psychological sequelae may require focused clinical attention (e.g., Williams, Gooden, & Davis, 2014). Additionally, research indicates that the adaptation of cognitive-behavioral therapies (CBT) for cultural competency may be superior to nonadapted CBT (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Miranda et al., 2003). Thus, the mental health community is ethically bound to cultivate multicultural competency and continue investigating empirically supported treatments for diverse populations (Constantine, Miville, & Kindaichi, 2008; Ridley, 1985; Sue, Zane, Hall, & Berger, 2009).

This need is met with a host of challenges as many therapists are unprepared to address cultural issues due to inadequate multicultural education and/or social taboos surrounding racism, discrimination, and White privilege (Neville, Worthington, & Spanierman, 2001; Terwilliger,

Bach, Bryan, & Williams, 2013). There is currently no standardized training model for multicultural competency. Although a handful of scholars have devoted significant energy to measuring multicultural competency, training for therapists to engage clients of diverse racial, ethnic, and cultural backgrounds may remain inadequate (Worthington, Soth-McNett, & Moreno, 2007). One systematic review found that although multicultural training made clinicians feel more knowledgeable, there was poor evidence that patient outcomes were improved; furthermore, the vast majority of programs omitted the concepts of racism, bias, or discrimination from their content (Price et al., 2005).

Matching by racial group has been one approach used to serve ethnoracial minorities seeking mental health services. Proponents of matching point to an elevated perception of multicultural awareness, treatment retention, and client preference (Lee, Sutton, France, & Uhlemann, 1983; Meyer & Zane, 2013). However, matching may oversimplify both the client's and clinician's experience as it assumes a high degree of similarity in backgrounds, values, level of assimilation, religion, and language (Williams, Chasson, & Davis, 2015). It may also remove a critical opportunity for client and clinician to grow and connect as they learn to appreciate differences in cultural values and experiences. Although matching is preferred by most clients, alliance, skill, knowledge of client culture, ethnicity, and race appear to have a greater impact on positive therapeutic outcomes (Cabral & Smith, 2011). Most recently, Ibaraki and Hall (2014) examined ethnic matching, finding it functions as a proxy for shared culture, where common values and closely held beliefs influence the content minority clients discuss in therapy. This suggests therapeutic outcomes are linked to the clinician's ability to understand the client's perspective and cultural background (Flicker, Waldron, Turner, Brody, & Hops, 2008).

One risk in diverse dyads is unintentionally stigmatizing the client. Lack of insight about the client's cultural, racial, or ethnic identity might result in inadvertent microaggressions or other expressions of bias; this may alienate the client, threaten the therapeutic relationship, impede treatment progress, and increase risk of early dropout (Constantine, 2007; Sue, Capodilupo, Torino, & Bucceri, 2007). Additionally, when culturally normative behaviors are not considered in treatment, therapists risk misdiagnosing minority clients (Chapman, DeLapp, & Williams, 2014). Rather than adopting a color blind approach, which discourages the client from expressing their experiences as a racialized minority and exploring protective factors (Terwilliger et al., 2013), therapists can benefit the relationship by bringing this part of the client's experience into therapy. To do this effectively, therapists must first understand their own relationship to diverse groups and acknowledge race as a social power construct (Cardemill & Battle, 2003). By building on this attunement to social power and privilege, therapists can benefit from experiential learning to explore their own feelings, beliefs, and attitudes about race, ethnicity, and culture, to gain greater cross-racial understanding (Devereaux, 1991; Okech & Champe, 2008). In describing the experiential process of growth and change, McKinney (2006) found that "most of the turning

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point experiences involved a White person first coming into sustained contact with persons of color." Similarly, cross-racial friendships have been found to enhance cross-racial therapeutic relationships (Okech & Champe). Taken together, this suggests experiential contact and closeness with diverse populations may expand clinical awareness.

Functional Analytic Psychotherapy

Functional analytic psychotherapy (FAP), an approach rooted in the contextual behavioral tradition (Hayes et al., 2012), focuses on the therapeutic relationship as the agent of change to improve the client's outside relationships (Tsai et al., 2009). It is similar to many CBT interventions because it focuses on concrete behavioral change and includes homework assignments, but it differs with respect to the amount of time and attention given to building a strong therapeutic relationship that serves as the primary vehicle for client change. A basic position of FAP is that the therapeutic relationship is a genuine human relationship. This relationship is powerful in promoting learning and change, fostering motivation, and keeping clients engaged in treatment and adherent to treatment plans.

FAP promotes increased awareness both in the client and the therapist. FAP therapists take interpersonal risks by experiencing, processing, and disclosing reactions to the client immediately as they occur in-session in the service of client growth and, in turn, encourage their clients to do the same. When the client engages in courageous self-expression in session, the therapist responds with genuine feedback to increase the connection through the exchange. This vulnerability and immediacy serves as a model to help the client improve connections with others, which is an important transdiagnostic outcome (Wetterneck & Hart, 2012). In this way, FAP provides a complement to peer systems' techniques such as psychoeducation, cognitive restructuring, behavioral experiments, and exposure.

FAP leverages five core principles, or rules, to conceptualize client behaviors, evaluate their functions, and conditionally change or reinforce behaviors through the interpersonal dynamics in the dyadic relationship (Tsai, Callaghan, & Kohlenberg, 2013; Tsai, McKelvie, Kohlenberg, & Kanter, 2014). These client behaviors are identified as clinically relevant behaviors, or CRBs (see Figure 1). Maladaptive CRBs (CRB1s) and adaptive CRBs (CRB2s) are identified collaboratively by both the therapist and client and analyzed for function at both the micro and macro level to broadly understand and effect change in the client (Tsai, Kohlenberg, Kanter, Holman, & Plummer Loudon, 2012). Similarly, therapist-relevant behaviors (TRBs) have a clinically relevant impact in treatment as well.

Recent FAP writings have discussed how the implementation of FAP's five behavioral rules may be supplemented with an understanding of awareness, courage, and therapeutic love towards clients (Tsai et al., 2009; Tsai et al., 2012). The first rule of FAP centers on awareness of how a client's CRBs appear in session and promotes self-awareness as well, including awareness of one's attitudes, biases, and assumptions about the client. The second rule is that clinicians evoke CRBs in therapy, and this may at times involve being courageous and vulnerable with clients. The third rule centers on being therapeutically loving to reinforce positive CRBs while challenging maladaptive CRBs. As behaviors are exhibited in-session, the fourth rule calls for the therapist to be aware of their impact on clients, both as a clinician and as a person. Finally, the fifth rule calls on the therapist to facilitate generalization of in-session client behavior changes to promote sustainable change in the client's life. FAP is particularly well-suited for culturally sensitive CBT and clinician growth because of its focus on the relationship as a primary change mechanism, and FAP is flexible enough to be used for analyzing the functions of behaviors in client-specific content across cultures and ethnicities (Vanderburghe, 2008).

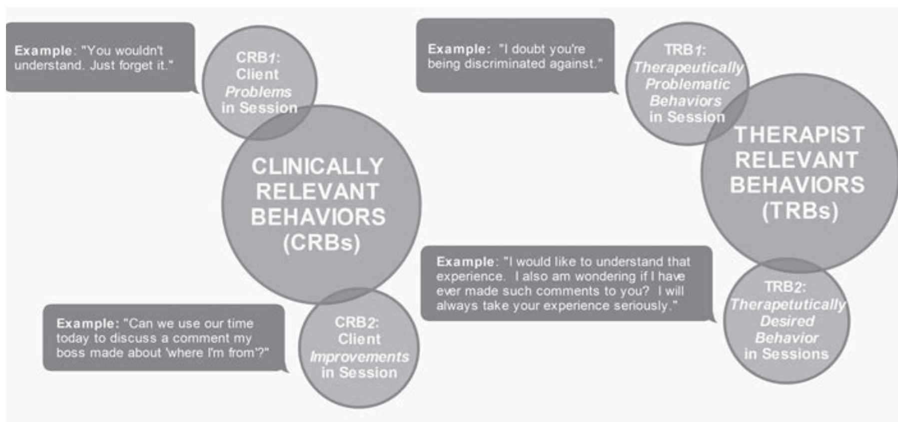

Figure 1. Clinically relevant behaviors

Common Therapist Problem Behaviors

All therapists stand to gain increased competency across treatment approaches, settings, goals, and client backgrounds using an authentic and culturally sensitive approach. Below we describe examples of common challenges therapists experience when working in racially and ethnically diverse therapist-client dyads and how they might be addressed using FAP interventions.

Discomfort Addressing Racial Differences With Clients

Race is one of the first features perceived when encountering a new person, yet despite the obvious differences in an unmatched dyad, many therapists are uncomfortable discussing race (Knox, 2007). FAP emphasizes the unique history of each client, and, for minority clients, ethnic and racial identity are an important part of this history that should be addressed early in treatment. Therapeutic awareness, acceptance, and exploration of discomfort related to racial differences in the service of client growth can be an important shift toward therapist growth that ultimately bolsters trust and connection with the client. Although it may be anxiety-provoking for therapists who have previously avoided such discussions to address racial differences, acknowledging diversity in the therapeutic relationship is likely to result in greater satisfaction and connection with minority clients, as it demonstrates cultural sensitivity (Neville, Tynes, & Utsey, 2009). Working to understand a client's potential struggles with identity, self-concept, and intersectionality may mediate feelings of

invisibility often reported by racial and ethnic minorities, and correspondingly, acknowledging cultural strengths, such as collectivism and racial pride, can promote resilience in the face of challenge (Franklin, 1999; Hays, 2009).

Failure to Understand White Privilege

As a culture, we are socialized not to acknowledge Whiteness and the power and unearned privilege it affords (Neville et al., 2001). As a result, therapists are often confused and uncomfortable with related topics, such as discrimination, racism, and stigmatized minority status. Acknowledging unearned privilege may provoke guilt, shame, and defensiveness. FAP, because it locates the source of this problem in our social context and not in the individual, allows therapists to increase awareness and exploration of White privilege and differential access to important reinforcers (e.g., money, education, promotions) as a result of differences in power and privilege. Deliberate self-disclosure of this status, when used in the service of client growth, may be linked to higher levels of trust and perceived sensitivity in ethnic minority clients and improvements in the quality of the therapeutic relationship (Constantine & Kwan, 2003; Tsai et al., 2009). Indeed, privilege and social group membership are inseparable components of the emergent therapeutic context (Terry, Bolling, Ruiz, & Brown, 2010). For a White therapist, admitting to a stigmatized minority client that the therapist has benefited from race in a way that the client has not, and to exhibit a willingness to change behaviors that maintain power and privilege (e.g., have a sliding fee scale, being open to learning more about indigenous therapies such as soul retrieval for Native Americans) exemplify a commitment to genuineness that can promote authenticity, growth, and connection.

Endorsing Stereotypical Beliefs About Clients

Because of pervasive negative social messages about ethnic and racial minorities, we tend to make automatic and inaccurate judgments about others based on pathological stereotypes, which in turn lead to microaggressions (Blair, Judd, & Fallman, 2004; Williams et al., 2012). Microaggressions committed by therapists have been demonstrated to be a significant predictor of dissatisfaction with the therapeutic experience (Constantine, 2007) and present significant barriers to FAP's fundamental and necessary intimate, trusting, and safe transactions that celebrate the client's expression of his/her full self as an ethnic and cultural being. It is helpful for therapists to acknowledge their own tendency to make unfair judgments and demonstrate a willingness to reject stereotypes. By being courageous enough to admit a lack of accurate knowledge about important cultural, racial, or ethnic topics, therapists can exhibit vulnerability and seek understanding with clients in a manner that will facilitate an open exchange of information. FAP's behavioral and interpersonal techniques allow therapists to admit they are not the authority on all topics, such as the minority experience. In this way, clinicians can begin to understand the client's daily life without relying on stereotypes and subsequently reducing the likelihood of committing harmful microaggressions.

It is not enough, however, just to admit a lack of cultural knowledge. It is important

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to remediate these deficits by seeking information from sources other than clients, as ethnic minorities often report feeling weary of bearing the burden of educating others. Furthermore, in order to minimize stereotyping clients, it is important to maintain relentless emphasis on understanding the cultural context of CRBs and the adaptive functions of "problem" behaviors. For example, what may be seen as "dependence" and "enmeshment" by young Asian clients with their families can be understood within a cultural context of emphasis on interdependence and prioritizing family needs over individual needs (Sue & Sue, 2008).

Failure of Therapist to Continually Develop as an Instrument of Change

FAP emphasizes that a therapist's potency as a change agent can be increased by continually cultivating awareness of the impact of one's own history on potential biases. It may be helpful to explore individually or in consultation group questions such as the following:

What were your first experiences with feeling different?

What were you told about others who were ethnoracially different?

What were your earliest memories of race or color?

What stereotypes do you hold of pluralistic populations?

What are your experiences as a person having or not having power in relation to race or class?

What steps can you take to learn more about your clients' cultural backgrounds?

What are your preferred therapeutic methods that may not be culturally attuned or adequate?

How might you be inadvertently repeating negative or oppressive interactions representing the dominant culture with clients?

How can you make use of therapeutic "mistakes" or microaggressions in ways that increase therapeutic alliance?

What is difficult for you to address regarding race, culture, or other differences you have with your clients?

Table 1 lists a few examples of common therapist issues surrounding race, ethnicity, and culture (Daily Life Problems), how the problem might look in a therapeutic relationship (TRB1), and one way that a therapist might overcome the problem from a FAP perspective (TRB2).

Conclusion

As the scholar-clinician community seeks to improve quality of care for everyone, it is imperative that we acknowledge the importance of multicultural knowledge and skills. This includes an appreciation of other psychological perspectives, such as Afrocentric research, which is often viewed critically rather than with respect (Delapp & Williams, 2015). Future scholarship should build on preliminary work to enhance and measure therapist competence in diverse dyads (Constantine, 2008;

Table 1. **Therapist-Relevant Behaviors**

Daily Life Therapist Problem	Problem Behavior (TRB1)	Goal Behavior (TRB2)
White therapist experiences anxiety, agitation, and confusion in response to racially provocative material.	Referring a minority client to another therapist of their same ethnic background.	Expressing the feelings openly with client and also recognizing own potential bias or lack of understanding.
Belief that discussing racial issues beyond a superficial level is a taboo.	Avoiding topics about race or culture and redirecting to a different topic when it is culturally sensitive.	Asking the client if the difference in race is something they would like to discuss, while recognizing that it might be uncomfortable.
White therapist denying benefits experienced from Whiteness because therapist has not previously considered this.	Denying or invalidating client when this topic or problem arises.	Acknowledging the unfair and unearned benefits of being White and validating client if the topic arises.
White therapist ashamed of his/her own ignorance on cultural topics.	Avoiding topics related to race in order to hide own shame.	Expressing feelings openly and asking the client if/how they would like to address the topic. Taking steps to learn more about applicable cultural topics.
Therapist generalizing norms of racial minorities based upon assumptions and research/statistics.	Making assumptions in session about problems and not allowing client to explain problems in his or her own words.	Exploring problems with an open mind and allowing client to express how he or she faces problems associated with race.
Latino male therapist feeling shame about his cultural heritage.	Being too deferential to White clients due to feelings of inferiority.	Acknowledging therapist may have biases due to learning history and being aware and appropriately assertive in session.
Black female therapist with dark skin believes that fairer skinned Black women are arrogant and want to be White.	Hostility toward fair-skinned Black female clients.	Asking client about her experiences as a fair-skinned Black woman, and recognizing her own biases.

Drinane, Owen, Adelson, & Rodolfa, 2014). Such investigations may reveal where cultural competency constructs diverge from general clinician competency, allowing training to better prepare clinicians to work with diverse populations.

Furthermore, many training programs may benefit from a format that is curriculum-integrated and experiential. To answer the need for culturally adapted CBT, we propose FAP for its integrative principles of awareness, courage, and love. Future research should investigate the use of such skills, including clinician self-awareness, immediacy, and connection relative to therapeutic outcomes within mismatched racial dyads. Remembering that training is a lifelong exercise for therapists, FAP provides the additional benefit of ongoing therapist self-discovery and growth (Tsai et al., 2009). In a nation built on fused genealogies and cultures, it is imperative that we advance an understanding and application of skills to enhance treatment utilization, reduce premature dropout, and promote culturally informed change. Every client is a microculture, carrying deeply rooted cultural, social, generational, and reinforcement histories. The building blocks of inclusion, racial equity, social justice and prosocial change can begin within the therapeutic alliance (Vandenberghe et al., 2010).

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Correspondence to Monnica Williams, Ph.D., Center for Mental Health Disparities, University of Louisville, Department of Psychological & Brain Sciences, 2301 South Third St., Louisville, KY 40292; m.williams@louisville.edu

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