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Faith-Based Counseling Versus Traditional Psychotherapy: A Phenomenological Evaluation of African American Protestant Experiences

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Faith-Based Counseling Versus Traditional Psychotherapy: A Phenomenological Evaluation of African American Protestant Experiences

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Abstract

This phenomenological study was designed to evaluate the experiences of African American Christian adult clients within traditional psychotherapy and faith-based counseling settings. Research has shown various therapist/counselor identities affect Christian African American clients, and that Christians as well as African Americans have historically been less likely to pursue traditional psychotherapy for a variety of reasons. Participants were six African American Christian adult participants (three traditional psychotherapy participants and three faith-based counseling participants). All participants were asked open-ended questions about their experiences in traditional psychotherapy or faith-based counseling. In addition, they were asked to evaluate several aspects of their therapy/counseling experience on a scale of 1–10: (a) their overall experience within traditional psychotherapy/counseling, (b) the overall effectiveness of their therapist/counselor, and (c) how effectively they thought their therapist/counselor was in their ability to address faith-related content or concerns. To provide context for this study, a literature review was conducted on the history of psychology, the demographics of psychotherapy, the potential impact of psychotherapy on African American clients, and potential gaps in faith-based training among mental health providers. In addition, this study considered additional factors that may influence the traditional psychotherapy/counseling experiences of African American clients. These included barriers to access of care and the underutilization of mental health services among African Americans, the overall health disparities affecting African American people, working alliance factors, the impact of the Black Church on African American life, and the common reliance on faith as a means of coping. This project also considered

current research on community-based interventions and culturally sensitive and acceptable means of seeking care for African Americans. Results showed that though all African American Christian participants acknowledged benefits of therapy (across both types), there was an inherent secondary gain for African American Christian clients paired with faith-based therapists/counselors.

Keywords: faith, religion, spirituality, intersectionality, Black Church, psychology, faith-based counseling, coping, culturally sensitive treatment

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Chapter One: Introduction

The aim of this phenomenological study was to examine the similarities and differences that exist between African American Christian (Protestant) adult clients who have participated in traditional psychotherapy versus those who have participated in faith-based counseling. This was accomplished by identifying themes that underscore African American Christian client experiences, highlighting any nuanced similarities and differences between and within groups, and seeking to understand the role faith plays within the therapy/counseling process. The researcher in this study interviewed a limited number of participants in depth as a means to generate hypotheses that can be verified in later, larger-scale studies.

Purpose of the Study

The purpose of this study was to contribute to the existing literature on the experiences of African American Christian adults in traditional psychotherapy and faith-based counseling settings. Given the socioeconomic and political challenges of African Americans, in addition to the treatment disparities that have existed within White healthcare systems, faith-based coping mechanisms have emerged. Delaney et al. (2007) observed that the overall field of psychology, as well as its individual practitioners, has traditionally operated from a secular approach, which may have negatively affected Christian client experiences. As those in the field of psychology continue to address the barriers that have prevented African American clients from seeking traditional psychotherapy or feeling comfortable within the process, there is a coinciding need to

further acknowledge the needs of Christian clients. This requires a new level of openness and support that has not yet been seen within the field of psychotherapy. One solution may include new provisions that encourage the more effective integration of faith-based practices or support for Christian clients.

Relevance to Clinical Psychology

This study aimed to advance the research and clinical practice by illuminating the unique experiences of African American Christian clients within traditional psychotherapy and faith-based counseling. Although many in the field of psychology have worked to support Christian clients more effectively, the ability of practitioners to address the topics of faith and spirituality has remained underwhelming. Graduate programs continue to neglect the training needs of therapists who are responsible for assisting clients in navigating their spiritual and faith-based concerns. Consequently, the present study was designed to address the gap in the literature by exploring African American Christian clients' experiences within traditional psychotherapy and faith-based counseling settings.

Chapter Two: Literature Review

The African Diaspora

The African diaspora includes many people and extends across multiple cultures and geographical settings. As a researcher, it is important to recognize the individual racial, ethnic, cultural, geographic, and sociopolitical realities of the various sub-groups within this population. This project was specifically focused on the experiences of African American or Black Christian adult clients within the United States.

Sigelman et al. (2005) compared the historical context of the terms "African American" and "Black" and asserted there is value in understanding the preferred terminology of a group. "The collective term that members of a group use to refer to themselves can provide interesting clues about the group's status in society and its strategy for advancement" (Sigelman et al., 2005, p. 429). The authors indicated there has been conflicting research on the way in which the term "Black" has been perceived versus the term "African American" within mainstream White America.

When conducting a survey to evaluate racial identity and terminology preferences, Sigelman et al. (2005) found that of the 2,381 respondents surveyed, 1,146 (48.1%) voiced a preference for use of the term "Black"; 1,173 (49.2%) stated a preference for the term "African American"; and the remaining 63 (2.7%) respondents declined to express an opinion. The authors further examined individual factors, such as gender, age, education, geographical location, and setting, and the ways in which these factors also influenced terminology choices. One of their primary conclusions was that those who scored higher on the racial identification scale were significantly more inclined to use the term African American. Understanding terminological preferences may

continue to shed light on the ways in which African Americans view themselves and the ways in which they aspire to be viewed in the future.

The Protestant Church

The African American faith experience within the Protestant Church was primary to this study. Results of a survey conducted by the Pew Research Center indicated two-thirds of Black Americans (66%) identify as Protestant, 6% identify as Catholic, and 3% identify with other Christian faiths (Mohamed et al., 2021). As diverse as the African American community remains, so must be considered the beliefs and faith practices among congregants. Avent and Cashwell (2015) observed that religious experiences and the practices within the Protestant Church are often individually specific to the churches and congregants they serve. They stated there is significant variance in theological approach and the ways in which leaders execute their beliefs, roles, and responsibilities within the church. D. W. Sue and Sue (2013) acknowledged the need for culturally competent counselors who can integrate clients' histories, worldviews, and life experiences into the counseling relationship.

Mental Health Demographics

Mental illness statistics for African Americans remain relatively high when compared to those of other racial subgroups. Neely-Fairbanks et al. (2018) stated the most common mental health diagnoses for African Americans include major depression, attention deficit hyperactivity disorder, suicide, and posttraumatic stress disorder. The authors also cited a study completed by the Centers for Disease Control and Prevention from 2010 in which the results showed African Americans had the highest rates of depression (12.8%), followed by Hispanics (11.4%), and then Whites (7.9%).

Neely-Fairbanks et al. (2018) also found high rates of anxiety among African American populations. They reported social anxiety occurring at a prevalence rate of 8.6%, generalized anxiety disorder (GAD) at a rate of 4.9%, and other panic disorders at a rate of 3.7%. This can be contrasted against the lifetime prevalence rates reported by Asnaani et al. (2010), who found founds that White Americans were diagnosed with social anxiety at a rate of 12.6%, GAD at a rate of 8.6%, and panic disorders at a rate of 5.1%. Though lifetime prevalence rates remain highest among White Americans, treatment inequities continue to negatively affect racial minorities. Cabral and Smith (2011) concluded, "Racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss of their overall health and productivity" (p. 537).

Cultural Considerations and Barriers to Care

Though significant research has been conducted on Christian clients and their experiences within psychotherapy, less research has been focused on the specific experiences of African American Christian clients. African American Christians are influenced by numerous psychosocial factors. Peterson (2012) stated African Americans are affected by complex system dynamics operating at the biological, psychological, interpersonal, institutional, and community levels.

Brown et al. (2003) highlighted the socioeconomic and political factors that affect African Americans, such as low socioeconomic status, physical hardships, blocked opportunities, discrimination, and the need to acculturate to a foreign culture. These challenges have also been acknowledged by other researchers within the field. Hankerson et al. (2013) stated,

> Despite national initiatives to reduce racial disparities in mental health care, African Americans continue to under-utilize mental health services compared with White Americans. Factors associated with these disparities include stigma of mental illness, lack of access, financial cost, and distrust of providers. (p. 686)

Hankerson et al. proposed that one way to address these inequities is by providing community-based interventions (e.g., mental health or medical services provided in cooperation with the church), as this has been found to reduce racial disparities within treatment and further promote access and utilization. Peterson (2012) suggested African Americans are likely to seek out culturally or spiritually acceptable means of treatment. For many African American persons, this will mean seeking assistance from their community, church, or family. Hays and Aranda (2016) reported "faith-based interventions have emerged to respond to racial disparities in mental health while incorporating a preference for informal care and clergy support among African Americans" (p. 777). Additionally, terms such as church-based, faith-placed, faith-based, and collaborative programs have been used to describe interventions that incorporate religion or spirituality into health promotion efforts.

Microaggressions

A great deal of multicultural counseling research has focused on examining negative racial/ethnic experiences. Specifically, the area of microaggressions has drawn significant interest from researchers over time. Owen et al. (2011) defined microaggressions as a wide range of verbal and nonverbal communications, intentional and unintentional, that convey insensitivity, disrespect, or negligent attention to a salient

aspect of one's cultural heritage. This definition was given additional context by Nadal et al. (2015), who stated the following:

> The notion of microaggressions was first conceptualized as subtle, stunning, often automatic, and non-verbal exchanges which are put downs. Microaggressions have more recently been defined as brief and commonplace daily verbal, behavioral, or environmental indignities whether intentional or unintentional, which lie beneath visibility or consciousness and which communicate hostile, derogatory, or negative slights and insults toward targeted groups, persons, and/or systems. (p. 147)

Nadal et al. indicated there have been few quantitative studies focused on how an individual's multiple identities may influence their experience of microaggressions. The authors suggested the absence of literature on intersectional microaggressions (e.g., microaggressions that occur due to multiple identities) could be tied to researchers' failure to consider multiple identities within their research analyses. Nadal et al. suggested that when researchers conduct studies on a specific racial group, they may not consider other individual factors such as gender, sexual orientation, social class, or other identities that affect qualitative data outcomes.

Owen et al. (2011) stated microaggressions can take several forms within therapy, including (a) clients perceiving their therapist as idealizing their cultural group, (b) therapists making insensitive treatment interventions, or (c) therapists neglecting cultural issues. As a result, the client's perception of microaggressions can influence treatment outcomes by harming the working alliance. Gattis and Larson (2017) examined perceived microaggressions among Black youth (ages 16–24 years) who identified as homeless and

lesbian, gay, bisexual, and transgender (LGBT). The authors reported depressive rates as being high among homeless persons (congruent with other research findings). However, the depression and suicide rates for racial minorities identifying as homeless and LGBT were even more significant. “We found a positive association between perceiving microaggressions targeted at Black LGBT status and self-reported depressive symptoms. Although we found no independent association between microaggressions and suicidality, depressive symptoms were associated with the likelihood of suicidality in our sample” (Gattis & Larson, 2017, p. 13). As a result of the intersectionality components that increase at-risk status for homeless LGBT Black people, the authors called for increased advocacy on behalf of mental health practitioners in aiding this group. Gattis and Larson advised,

> The dynamics of LGBT and racial microaggressions make them difficult to comprehensively address with secondary or tertiary means. Thus, we promote research, policy, and practice that focus on the primary prevention of pervasive forms of heterosexism, gender normativity, and racism. (p. 15)

Owen et al. (2011) noted that when clients perceive microaggressions from their therapist, it can negatively influence the working alliance. The client may experience feelings of being invalidated or disrespected, which can result in a rupture within the therapeutic relationship, therefore detracting from therapeutic tasks and goals.

History of Misdiagnosis of Black Clients

Burse et al. (2021) acknowledged the mistrust among African Americans, stating, “Historically, African Americans have had feelings of distrust and lack of faith towards mental health professionals” (p. 138). This was further supported by Whaley (2010), who

evaluated the level of mistrust among African Americans toward clinicians and found cultural mistrust or healthy cultural paranoia was one of the most significant mental health variables affecting African Americans, and reported that the inability of clinicians to differentiate between cultural and clinical dimensions of paranoid symptoms in Black Americans may influence their ability to properly diagnose. In addition, Whaley (2010) found non-African American clinicians were far more likely to attribute paranoid symptoms to Black psychiatric patients than were African American clinicians when diagnosing schizophrenia and stated 86% of the African American bipolar patients within his study were misdiagnosed as schizophrenic because of perceived paranoid symptoms. Cultural and clinical training and understanding continue to play a vital role in addressing these concerns.

Depression Among African Americans

African Americans are uniquely influenced by their experiences of depression. Multiple studies have evaluated depressive diagnoses among African Americans and people of color. The research of Williams et al. (2007) on major depressive disorder (MDD) documented the relative prevalence rates for Caucasians, Caribbean Blacks, and African Americans. The research illuminated lifetime as well as year-long chronicity rates across groups. The researchers found lifetime estimates for MDD were highest among Caucasian participants (17.9%), followed by Caribbean Blacks (12.9%), and then African Americans (10.4%). However, when reviewing the chronicity rates among these population, the researchers noted significantly higher chronicity rates among both Black groups. Williams et al. discovered MDD at a chronic rate of 56.5% for African Americans and 56% for Caribbean Blacks. The authors also cited research outcomes

from the National Comorbidity Survey, which showed that although Blacks had a lower lifetime risk of mood disorder than Whites, once they received a depressive diagnosis, they were more likely to be chronically ill. Williams et al. reported less than half of the African Americans (45%) and fewer than a quarter of the Caribbean Blacks (24.3%) involved in their study received treatment, although they met the diagnostic criteria for MDD.

One may inquire as to why these statistics are meaningful. The authors asserted, "Blacks are overrepresented in high-need populations, have reduced access to mental health services, and often receive poorer quality of care than Whites" (Williams et al., 2007, p. 305). The field of psychology (along with the authors) continue to acknowledge that mood-related diagnoses remain among the most economically debilitating conditions within the United States. Though both Black groups had a lower lifetime prevalence rate, their chronicity rates were higher, and they were less likely to seek out or receive treatment. This supports that mental health tolls remain highest among this population.

Psychology and Religion

The use of secular psychotherapy approaches with self-identified Christian clients remains controversial. Previous studies have shown highly religious Christians tend to be skeptical of psychology and Christian clients commonly fear their beliefs will be misunderstood, underappreciated, ridiculed, or eroded by psychological practices (Cragun & Friedlander, 2012). Additionally, research shows Christian clients' reluctance to engage in psychotherapy may be a direct result of psychotherapists' traditional endorsement of secular beliefs (Delaney et al., 2007).

Faith and religious practice have been foundational for African Americans since migrating to the United States. African Americans have used their faith as a means of addressing mental, physical, and spiritual health concerns. Avent and Cashwell (2015) reported that surveys show higher rates of church attendance among African Americans when compared with other racial-ethnic groups. The authors indicated more than 80% of African Americans identify religion as being important to them. As a result of heavy engagement with and reliance on the Black Church, community-based interventions hold promise for reducing racial disparities in health treatment. Hankerson et al. (2013) noted:

> The Black Church has a history of confronting racial disparities by providing health and social services to community members. Church-based health programs are designed to provide measurable benefits to individuals through education, screening, and treatment. Such programs have effectively improved health outcomes for cancer screening, dietary change, weight loss, smoking cessation, and diabetes treatment. However, the literature on church-based programs for mental disorders is limited. (p. 686)

Though African Americans have continued to acknowledge faith as an integral aspect of life, practitioners in the field of psychology continue to work to more progressively meet Christian client needs.

Secular Psychology

Historically, the connection of psychology to the experience of Christian and African American clients has been quite limited. Delaney et al. (2007) examined the prevalence of secular beliefs among psychology practitioners by surveying 109 female and 149 male psychologists who were members of the American Psychological

Association (APA). Results showed that of the members surveyed, “Relative to the general population, American psychotherapists are far less religious with regard to affiliation, attendance, belief, and values than the population as a whole” (Delaney et al., 2007, p. 538). In fact, psychologists were found to be more than twice as likely as the public to identify as having no religion, three times more likely to classify religion as unimportant within their lives, and five times more likely to deny any belief in God (Delaney et al., 2007). The authors observed that the gap between psychotherapists and the public relative to religious belief and practice is widening. Furthermore, they suggested this gap may have significant treatment implications that could jeopardize therapists’ abilities to competently treat religiously-oriented clients (Delaney et al., 2007).

Another consideration around treatment for Christian clients involves traditional psychotherapy training. Delaney et al. (2007) suggested additional competency training related to religion/faith should be incorporated into graduate program curricula. They stated that overwhelmingly, psychologists have reported that religious and spiritual issues were seldomly mentioned within their graduate training. Pargament (2007) also highlighted the lack of training psychologists receive in addressing spirituality, stating only 18% of training directors reported having a class within their program focused on religion or spirituality.

Faith, Spirituality, and Religion

Worthington and Sandage (2001) provided definitions of and distinctions between religion and spirituality: “Contemporary views often emphasize their differences, with religion being focused on the search for the sacred within formal institutional structures

and spirituality referring to the more experiential dynamics of personal meaning and transcendence" (p. 473). The authors further noted that for many individuals, religion and spirituality are interrelated, and for some, spirituality is detached from religion.

Worthington and Sandage (2001) contended that though most therapists embrace the idea of spirituality as separate from religion, many clients see spirituality as an aspect of their religious life. They emphasized the potential negative impact therapists may have on their clients by failing to understand this point. "Some highly religious clients might resist a therapist talking about spirituality without engaging traditional religious language. Conversely, other clients might have an aversion to religion but identify strongly with certain language about spirituality" (Worthington & Sandage, 2001, p. 474). As a result, they contended that therapists must assess clients' religious and spiritual practices to determine how to best use religious and spiritual language within therapy.

Worthington and Sandage (2001) discussed ways in which religion and spirituality commonly manifest within therapy. Several examples cited by the authors included (a) a client's explicit request for religious therapy, (b) a client's personal opposition toward religion and request for its explicit omission from therapy, and (c) ways in which differences or values about religion and spirituality arise within personal relationships and personal faith development.

African Americans and Spirituality

African Americans have traditionally coped with various types of struggles by connecting with their use of spirituality and finding support within the Black Church. Neely-Fairbanks et al. (2018) contended that the Black Church has long been a place

where African Americans can commune. It has served as a primary location for worship, practice in private prayer, Christian programming, and religious coping messaging. Additionally, the authors highlighted the Black Church as a place for emotional expressiveness, educational endeavors, civic meetings, pastoral care, and counsel. Clergy within the Black Church often serve as initial responders within the African American community. As a result, they commonly connect congregants with formal healthcare systems.

Burse et al. (2021) examined the perceptions ministers held regarding congregants' mental health needs. After surveying 246 African American ministry leaders, their findings showed the participants had an ability to remain within their scope of expertise and seek additional support when needed. "Most congregant leaders were able to recognize when individuals desired or were in need of a higher level of mental health services, rather than the usual services they are typically offered through prayer and counseling" (Burse et al., 2021, p. 138). Faith-based leaders recognized their limited understanding of mental health disorders and indicated a desire to collaborate with partners to address the health needs of their congregants. Still, Burse et al. noted faith-based organizations sometimes failed to collaborate with mental health professionals because of a lack of knowledge and understanding of mental health issues.

The Black Church

Hankerson et al. (2013) provided a definition of the Black Church as the seven predominantly African American denominations of the Christian faith. African Americans classify religion as important to them at higher rates than other racial groups

and report attending weekly church services at a higher rate as well (Avent & Cashwell, 2015).

Allen et al. (2010) stated, “A majority of ethnic minority group members living in the United States, including African Americans, do not have equal access to more formal mental health professionals, even within their own communities” (p. 117). Black clergy acknowledge that though they serve as a primary source of support for members within their communities, they are likely to experience limitations in the services they can provide around mental health. “Unfortunately, Black clergy and their leaders continue to struggle to meet many of their congregants’ mental health care needs without all the necessary clinical skills to assess, diagnose, and treat certain mental illnesses” (Allen et al., 2010, p. 124).

Avent and Cashwell (2015) noted African American congregants may receive messages that the church is able to take care of all their needs, including health-related needs. They suggested this can be a detriment to both the individual and collaborative relationship. Though allyship is necessary, it must be accompanied by personal and professional investment. “In order to understand the Black Church and the people who worship therein, counselors must familiarize themselves with the historical context and theological underpinnings that frame the Black Church and likely influence individual parishioners’ help-seeking behaviors” (Avent & Cashwell, 2015, p. 82).

Community-based partnerships between churches and mental health agencies offer one way in which the field of psychology may facilitate change. Avent and Cashwell (2015) suggested pastors within the Black Church often provide psychological aid to their congregants and are more likely to refer congregants to persons who are

visible within their community. “Rather than depending on African Americans to initiate communication with mental health professions, counselors can volunteer outreach services and host programs at local churches to increase access to African Americans” (Avent & Cashwell, 2015, p. 86).

The Needs of the Christian Client

Cragun and Friedlander (2012) found most Christian clients had a desire to discuss spiritual or religious issues in treatment. They stated therapists are likely to work with Christian clients who use religious practices to cope, manage personal difficulties, and solve problems. Additionally, Worthington and Sandage (2001) observed that highly religious clients preferred working with value-similar therapists. Cabral and Smith (2011) endorsed the idea that when a client is working with a value-similar therapist, it can have a significant impact on the therapeutic relationship: “There is some research evidence that similarities in the values of client and therapist predict positive client outcome” (p. 538). The question of how Christian clients are influenced when working with secular or value-dissimilar therapists/counselors remains ambiguous.

Psychotherapy Approaches With Christian Clients

When evaluating the use of traditional psychotherapy with Christian clients, researchers have found mixed results. Worthington et al. (2011) completed a meta-analysis in which they compared the effectiveness of secular psychotherapy to that of spiritually-oriented therapy approaches with highly religious clients. The researchers concluded that when evaluating symptom reduction, both treatments were equally effective. However, for a subset of clients who identified their problems as being primarily religious or spiritual in nature, religious/spiritual treatment was rated as being

far superior to psychotherapy treatment. This may indicate the presenting concern influences elements of the treatment process.

Cragun and Friedlander (2012) conducted research in which they paired 11 Christian clients with a Christian or secular therapist. The authors concluded that for clients who expressed positive sentiments about their therapy/counseling experience, they overwhelmingly identified their ability to process their faith as a key factor. For those sharing positive reflections, they highlighted that they perceived their therapist/counselor as being accepting of their religious views and being open, non-judgmental, and respectful in relation to the religious attitudes they displayed. When reflecting on the negative experiences provided by Christian clients within this study, the researchers commonly found participants expressed concerns related to not feeling comfortable about discussing their faith with the therapist (Cragun & Friedlander, 2012). This indicates that regardless of the therapist/counselor's faith identification, Christian clients want to feel comfortable processing their faith within the therapy context.

Another example of this can be seen when examining studies comparing the effectiveness of Christian-accommodative versions of individual psychotherapy versus traditional cognitive behavioral therapy (CBT) with depressed populations (Worthington & Sandage, 2001). One specific study examined the use of Beck-style CBT, which also incorporated Bible scriptures, religious imagery, and references to Christian theology. Overall, religiously accommodative forms of CBT were found to be either equally effective as standard CBT, or on occasion, more superior to standard Beck-style CBT when reducing depression. Christian accommodative therapies were also found to be

particularly effective in increasing spiritual well-being compared to secular psychotherapy approaches.

In recent years, some steps have been taken regarding openness toward religious issues within psychotherapy. Multiple surveys indicate most therapists are in favor of discussing religion with their clients (Cragun & Friedlander, 2012). Furthermore, multiple studies have evaluated the treatment of Christian clients by nonreligious therapists. One such study examined the administration of a religiously accommodative form of CBT by Christian and non-Christian therapists and found it to be equally effective regardless of administrator (Cragun & Friedlander, 2012). This may allow for increased effectiveness as non-Christian therapists provide faith-based treatments to Christian clients.

Spiritually Integrated Psychology

Kuczewski (2007) suggested faith-based interviewing and personal self-disclosure within therapy are central to aiding Christian clients. The first technique he recommended was a patient-centered interview. This interview method is designed as a means of helping the therapist explore the client's religious or spiritual worldviews. According to Kuczewski, understanding these worldviews will aid the therapist in helping the client to translate their beliefs into choices. Second, he recommended that psychologists become more involved and personally engaged in discussion and disclosure of their own personal religious and spiritual worldviews. Kuczewski suggested that when spirituality is regarded as a cultural competence, "One wishes to know about common belief systems among patients in order to understand their motivations and preferences, thereby respecting their rights" (p. 5). Finally, he highlighted the need for informed consent so

clients are actively consenting to treatment choices that are in accordance with their values.

Pargament (2007) also acknowledged the need for spiritual assessment within psychotherapy. In this process, the therapist is ideally engaging in initial spiritual assessment and preparing for spiritual dialogue. This process is supported through an openness to learning, followed by an openness to sharing. “Spiritual dialogue must be a two-way street. To encourage that dialogue, therapists must be willing to learn from the client, but also to share parts of themselves with the client, both personally and professionally” (Pargament, 2007, p. 205).

Pargament (2007) acknowledged that “spirituality is not reserved exclusively for times of crisis and transition. It is interwoven into the fabric of everyday. Spirituality can reveal itself in the ways we think and the ways we react to each other” (p. 3). He argued that early on within the field of psychology, the separation of spirituality and psychology was necessary. However, as the field of psychology has evolved, it has more readily aligned itself with the natural sciences. He suggested that though spirituality is often viewed as problematic by psychologists, spirituality might be better viewed as a valuable part of the solution. “In a study of Black and White elderly women facing medical problems, prayer emerged as the most frequent method of coping” (Pargament, 2007, p. 10). He also highlighted other times where we as a country turn to faith (e.g., September 11, 2001).

Worthington and Sandage (2001) stated it is essential for therapists to “assess clients’ religious and spiritual practices and reflect on how to use religious and spiritual

language in therapy" (p. 474). Pargament (2007) noted that when spiritually-attuned persons are not encouraged to practice spirituality, concerns can arise:

> Disconnected from rituals, people cannot participate in purposeful acts of transformation that propel them over sacred thresholds from one place in life to another. Instead, they become stuck in particular emotions (e.g., anger, shame, sadness), particular ways of life (e.g., constant work, social isolation), or particular life conditions (e.g., widowhood, unemployment). (p. 261)

Therapists can more effectively engage in support and client growth within these areas by enhancing general faith-based skills and knowledge.

Help-Seeking Behaviors

Researchers, scholars, and counseling practitioners continue to note the differences in help-seeking behaviors among ethnic minority clients. Ayalon and Young (2005) evaluated help-seeking behaviors among 70 Black and 66 White community college students and discovered Black students were less likely to use psychological or social services and more inclined to use religious or spiritually based services. Ayalon and Young noted previous studies have attributed differences in seeking psychotherapy services to financial and geographical disparities. However, multiple studies have shown that African Americans with insurance coverage are still less likely to use outpatient mental health services than are their White counterparts with similar coverage (Padgett et al., 1994).

Multiple studies recognized the preference of African Americans to rely on their spiritual and religious communities (e.g., the Black Church) for support in dealing with mental health issues, rather than seeking help from professional mental health counseling

resources (Avent & Cashwell, 2015). African Americans are more likely to call upon practices such as prayer, whereas Hispanics rely heavily on social relationships and family systems (Stewart et al., 2012).

Health Benefits Associated With Religious Practice

Cragun and Friedlander (2012) discussed the health benefits associated with religious practice, indicating religious practice has been positively correlated with mental health, recovery from physical and mental illness, subjective well-being, and marital satisfaction. George et al. (2000) stated, "Abundant evidence reveals robust relationships between religiousness and health" (p. 107). Additionally, Hankerson et al. (2013) referenced the results of the National Comorbidity Survey, which showed that of a sample of 8,098 adults polled in the United States, a higher percentage of people sought help for mental health disorders from clergy (25%) than psychiatrists (16.7%) or general medical doctors (16.7%).

Neely-Fairbanks (2018) asserted that "African Americans suppress topics of hardship, depression, and strategies to cope with mood or emotional life changes" (p. 163). Additionally, Black people access mental health services at about half the rate as do White people. As a result, Neely-Fairbanks et al. contended "underrepresented groups have been reported to use prayer and spirituality as coping resources in lieu of counseling or psychotherapy and seek help from clergy first to manage mental illness" (p. 163).

Though there has traditionally been recognition of physical health concerns by the church, there has been less recognition around mental health. "Historically, the Black community has been reluctant to discuss mental health conditions. Many times, the lack of knowledge leads this population to believe it is a sign of personal weakness" (Neely-

Fairbanks et al., 2018, p. 162). The authors cited that in 2007, Mental Health America reported that 63% of African Americans believed depression was a "personal weakness," whereas only 31% reported the belief that depression was a health issue. Additionally, the authors cited that distrust of medical providers and lack of access to resources could be alternative reasons for not seeking mental health care, although more research is necessary.

Ayalon and Young (2005) evaluated cognitive-affective variables that may have an impact on psychotherapy with African American clients. They noted individuals operating from an internal locus of control belief system are more inclined to attribute their successes and failures to their own actions. Meanwhile, individuals operating from an external locus of control belief system are more likely to focus on beliefs that underscore the importance of forces outside of themselves (i.e., fate or God). Research has found African Americans tend to have beliefs that emphasize an external locus of control, whereas most White people have beliefs that emphasize an internal locus of control (Ayalon & Young, 2005).

Ethnic Matching

Cabral and Smith (2011) completed research on the ways in which implicit bias, self-perception, cultural values, and stereotypical thinking may influence ethnic matching outcomes. They reported a need for nuanced interpretation, stating the following:

> Given differences in cultural values and mores, it should not be surprising that racial/ethnic matching may not impact all racial/ethnic groups in the same manner. For instance, White/European American clients may implicitly expect to see a therapist of their own race and may therefore initially mistrust a therapist of

> color, but this possibility has not been confirmed. In contrast, research has consistently shown that African American clients tend to mistrust mental health services provided by White/European American therapists. Explanations for this finding include the possibility of perceived racial bias in the provision of mental health services and the implicit association of mental health services with the values of White/European Americans. (p. 539)

Cabral and Smith reviewed the presumptions associated with the ethnic matching of clients and therapists by completing a meta-analysis on the subject. After reviewing 52 studies in which participants rated their preference for working with a therapist from a similar ethnic background, the average effect size (Cohen's *d*) was 0.63, indicating a moderately strong preference for a therapist of one's own race/ethnicity. "Across 81 studies of individuals' perceptions of therapists, the average effect size was 0.32, indicating a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists" (Cabral & Smith, 2011, p. 537). Additionally, across 53 studies of client outcomes in mental health treatment, the average effect size was 0.09, indicating almost no benefit to treatment outcomes from the racial/ethnic matching of clients with therapists. Though these statistical outcomes are meaningful, it is important to recognize that they may not be fully representative of all African American clients given individual factors and considerations.

Gamst et al. (2004) also highlighted mixed results within this field of research. When examining studies on ethnically matched children and adolescents, they discovered ethnically matched middle adolescent Latino and African American clients with mood disorders yielded significantly better clinical outcomes than their White counterparts.

However, these outcomes were not clinically significant across age range, population group, or diagnostic features. Additional variables influence the benefits associated with ethnic matching. The authors noted the importance of factors such as citizenship, trauma, referral source, language match, gender match, and diagnosis (Gamst et al., 2004). They concluded that additional research is needed to understand the interpersonal and systematic level impact of ethnic matching.

Cabral and Smith (2011) asserted that client preference is complex and imperfect, stating, “Categorical conceptualizations of race/ethnicity do not account for related variables such as level of client interracial mistrust or therapist multicultural competence. Race/ethnicity is too imprecise and too complex to consistently impact averaged therapy outcomes” (p. 544). The authors indicated African American clients commonly prefer to be ethnically matched with African American therapists and rate these therapist as being slightly more effective than other therapists. Asian Americans did not display a strong preference for ethnic matching but did rate ethnically matched therapists slightly higher than other therapists. Hispanic/Latino clients indicated a strong preference for ethnic matching with a therapist and slightly rated those therapists more highly than other therapists. One of the most significant takeaways for Cabral and Smith was that racial/ethnic matching was identified as more important to people of color than to White persons.

Client–Counselor Preference Considerations

Helms and Carter (1991) proposed that up until the time of their research, the question of counselor preference for racial/ethnic minorities was mostly centered around racial constructs. The authors noted potential concerns with this approach, including (a)

visible characteristics of the counselor other than race have been overshadowed or treated as mutually exclusive (e.g., gender), (b) racial preference is treated as if it were only endemic to ethnic/racial minority clients, and (c) research generally dismisses the idea that characteristics other than race may affect a client's preference of counselor. The authors observed that racial identity constructs have informed the way in which much preference-based research has been conducted.

> In these studies, racial identity has been broadly defined as the quality of a person's commitment to her or his socially ascribed racial group and has been assumed to be an aspect of identity development in all of the various racial/ethnic groups in the U.S. (Helms & Carter, 1991, p. 446)

They suggested research needs to move beyond an exclusive focus on Black racial-identity stages to consider other factors. Researchers have considered the viability of the phenomenological-demographic perspective, which contests the use of Black racial-identity attitudes for examining within-group variability. The premise of the phenomenological-demographic framework is that people's preferences are determined by their perceptions of shared demographic membership characteristics (e.g., perception of social class).

Helms and Carter (1991) suggested framing research hypotheses in this manner would give credence to both the racial-identity and phenomenological-demographic perspectives and provide the best opportunity for predicting preferences for counselor characteristics. Additionally, the authors hypothesized that racial-identity attitudes associated with elevated positive feelings about one's own racial group should be associated with stronger preferences for counselors of the same race. Conversely, they

suggested attitudes associated with rejection of the other race should be associated with weaker preferences for counselors of that race.

Helms and Carter (1991) found that White participants' racial and gender attitudes indicated a preference for White counselors despite self-reported social class. Black participants' racial identity attitudes tended to be predictive of their preference for Black counselors; however, their gender and social class did not significantly improve the prediction of this preference. When evaluating cross-racial preferences, racial identity attitudes alone did not predict Black participants' preference for White counselors. However, when gender and social class variables were added the criteria, they became more predictive of preferences.

Helms and Carter (1991) highlighted that research cannot ascertain outcomes based on racial identity alone and must account for other individualistic factors. The authors stated there are gender differences based on subgroup, noting Black men are more open to working with White counselors than other subgroups included within the study. The authors noted that prior to their work, this premise was generally opposed. "The results of the present study suggest that combinations of counselor characteristics, as well as the race/ethnicity of subject populations, should be varied in future counselor-preference research" (Helms & Carter, 1991, p. 456). Cabral and Smith (2011) provided an additional example of this finding:

> Previous research findings indicate that men may experience stronger in-group bias than women and that men seek mental health treatment less often than women. Indirectly related to racial/ethnic matching, studies of gender matching across racial/ethnic groups, have observed benefits for Asian American male

clients matched with male therapists but have found no benefit for female clients or for African American, Hispanic/Latino(a), or Native American clients. (p. 539)

Therapist–Client Alignment

S. Sue (1998) evaluated past work on therapist–client matches in terms of ethnicity and language as it relates to therapy attendance, dropout rates, and treatment outcomes. Though the outcomes failed to show consistent or significant differences, it was apparent that ethnic-specific services were associated with lower dropout rates. S. Sue highlighted concerns related to premature dropout rates among minorities and increased likelihood to attend fewer sessions on average. “Treatment outcomes have consistently demonstrated a direct relationship with the number of sessions in treatment. The fact that clients stay in treatment longer may mirror the greater rapport, comfort, or cultural consistency of ethnic-specific services” (S. Sue, 1998, p. 441).

S. Sue (1998) specifically addressed common concerns that arise within the therapeutic context. One of the common errors he found was associated with therapists’ attempts to focus on scientific mindedness resulting in premature conclusions. S. Sue asserted that mistakes are made in cross-cultural relationships because of assumptions. An example of this is the “myth of sameness” in which therapists label client processes or dynamics as being the same across different cultures. S. Sue stated that to become more culturally competent, therapists must devise different means of creating and testing their hypotheses about their clients. Another key element of culturally effective treatment, according to S. Sue, is familiarity with culture-specific experts (e.g., shamans, witch doctors, fortune-tellers, acupuncturists, folk healers, etc.). S. Sue emphasized that specific knowledge of the cultural group to which the client belongs, sociopolitical influences,

and specific skills (e.g., intervention techniques and strategies) is needed when working with different cultural groups.

Phenomenological Research Theory

Phenomenological research focuses on the lived experiences of people who are involved in the topic being investigated and is often helpful in developing contextually rich accounts of phenomena as well as refining hypotheses for future research. Groenewald (2004) observed that many within the social sciences do not use established, predetermined methodological approaches because they find that such approaches do an injustice to the complexity of the phenomenon being studied. Phenomenological research often operates from a framework that allows data to emerge in the process of the research. “Doing phenomenology means capturing rich descriptions of phenomena in their settings” (Groenewald, 2004, p. 47). This occurs through the allowance of unrestrictive language and free expression.

Grounded Theory

Grounded theory (GT) offers an alternative approach that is also systematic and flexible. Tie et al. (2019) asserted, “The aim of all research is to advance, refine and expand a body of knowledge, establish facts and/or reach new conclusions using systematic inquiry and disciplined methods” (p. 1). GT is particularly useful when little is known about a phenomenon. The aim of GT is to produce an explanatory theory that uncovers a process inherent to the area.

Tie et al. (2019) suggested there are three subtypes of GT: (a) traditional GT, which is used to generate a conceptual theory that accounts for a pattern of behavior that is relevant and problematic for those involved; (b) evolved GT, which focuses on

symbolic interactionism and sociological perspective and relies on the way in which people ascribe meaning to the processes of social interaction; and (c) constructivist GT, which is used to investigate how participants construct meaning in relationship to the area of inquiry. Though there are commonalities among all subtypes of GT, there are significant factors that differentiate them, some of which are the philosophical position, the approach to coding, analysis of data, and theory development.

> While GT studies can commence with a variety of sampling techniques, many commence with purposive sampling, followed by concurrent data generation and/or collecting and data analysis through various stages of coding, undertaken in conjunction with constant comparative analysis, theoretical sampling and memoing. (Tie et al., 2019, p. 3)

Purposive sampling occurs in a way that is similar to other phenomenological research and involves the researcher selecting participants or data sources that can best answer the research question. Data generation generally happens through the use of focus groups, questionnaires, interviews, surveys, and transcripts. GT may also incorporate constant comparative analysis, an analytical process used for coding and category development. The process of constant comparative analysis allows for increasingly abstract concepts and theory generation as the research proceeds. “The constant comparative technique is used to find consistencies and differences, with the aim of continually refining concepts and theoretically relevant categories” (Tie et al., 2019, p. 4).

Chapter Three: Methodology

Research Design Overview

The aim of this study was to assess and evaluate the clinical experiences of six African American Protestant participants. The examiner relied on participants' self-reports regarding their treatment providers and treatment services. Though the goal was to interview participants who had fully completed therapy or counseling within the past 5 years, persons with at least 4 weeks of therapy experience were able to be accepted into the study. The 4-week minimum threshold was intended to ensure the participants had been in therapy long enough to evaluate the utility of services and draw reasonable conclusions about the effectiveness of the therapist, faith expression within therapy, and other aspects of the study.

Researcher Description

As a child, I was raised within the Christian Methodist Episcopal (CME) Church. This shaped a large part of my life and experience. Though I will always appreciate my time as a member of the CME Church, I have since chosen to practice my faith as a member of several non-denominational Protestant Churches. This has resulted in an evolution of how I relate to God and the ways in which I view faith-related experiences, and has influenced the way in which I may integrate my faith into my practice as a Christian psychologist.

One of the seminal moments within my research project occurred while having a conversation with a pastor. This pastor was introducing himself and asked what I did for employment. I proceeded to explain that I was a graduate student studying clinical psychology. He responded by sharing his personal insights as to how psychology did not

align with theology and the Christian faith. I was quite taken aback by his response but thought further as to how my beliefs about psychology aligned with my personal faith as a Christian. I was ultimately able to reconcile ways in which psychology, and more specifically, CBT, multiculturalism, and family systems, fit into my broader Christian framework.

As a therapist-in-training, I have placed a high value on learning about and working with underserved and marginalized populations. I believe African American Christian clients largely constitute such a group. African Americans and Christians have long been overlooked and underserved within the field of psychology. My goal for this project was to continue to promote change and increase culturally sensitive treatments that encourage positive outcomes for these populations.

Participants

For the purposes of this research project, three psychotherapy participants and three traditional faith-based counseling participants were recruited. Traditional psychotherapy participants were to have engaged in or completed traditional psychotherapy within the past 5 years with a certified psychologist, therapist, counselor, or social worker. The remaining three participants were to have engaged in or completed faith-based counseling within the past 5 years with a certified psychologist, therapist, counselor, or social worker who holds a theological degree or implements faith-based practices as a primary part of their orientation/approach to therapy. Additionally, an ordained pastor or minister would meet the criteria.

Participants were recruited through various methods, including direct outreach to churches and pastors, school advertisement, the Illinois Psychological Association, the

National Registry of Health Psychologists, and anyone with an awareness of the study (e.g., family, friends, colleagues). Participants resided across the United States and completed therapy/counseling in various healthcare settings. All participants were screened to ensure they were at least 18 years of age, self-identified as Christian (Protestant), and African American. The researcher confirmed that all participants in the study were sharing therapy/counseling experiences that occurred after the age of 18 years. Participants were not asked about childhood experiences.

Several participants were seen in both traditional therapy and faith-based counseling settings. When this occurred, the therapist ensured the participant met the previously mentioned criteria for the study and ensured the participant was clear as to which therapy experience was being evaluated. At times, participants did make meaning of previous therapy/counseling experiences and contrasted their current group assignment against past experiences (e.g., a client previously received traditional psychotherapy and was currently receiving faith-based counseling). The examiner conducted a brief assessment to ensure participants had no past or current cognitive impairment, thought disorder, or psychosis-related symptoms.

Once approved for the study, all participants were provided the consent form referenced in Appendix A. The researcher explained the interview process and reminded participants that this was a voluntary study. Interviews were conducted via telephone due to COVID-19 restrictions. Participants were advised that interviews were being recorded for the purpose of analysis by the researcher. All audio recordings were deleted following transcription. Transcribed documents remained on a password-protected external hard drive until the study was completed.

Data Collection

Data were collected through semi-structured interviews with each participant. Interviews ranged from 45 minutes to slightly over an hour. Interviews followed an open, semi-structured format. Sample questions for gathering information are located in Appendix B. Throughout the interviews, the researcher asked a series of open-ended questions about participants' subjective experiences related to therapy/counseling. Though this research project was primarily designed as a qualitative study, some basic quantitative data were collected. Every participant was asked to rate the following three questions using a Likert response scale (1–10): (a) How would you rate the effectiveness of the therapy you received? (b) How would you rate the effectiveness of the therapist/counselor? (c) How would you rate the effectiveness of the therapist in addressing faith-related concerns? The data were generated out of professional interest and are not clinically indicative of participant outcomes.

Data-Analytic Strategies

For the purposes of this study, the researcher used Groenewald's (2004) approach to phenomenological research. This approach to qualitative analysis was chosen because its methodology best aligned with the purpose of this study's inquiry into the phenomenological experiences of African Americans, it acknowledges the social positioning of researchers, and it is practical in its approach to explicating results. Groenewald observed that phenomenologists' beliefs about their research cannot be detached from the presuppositions they hold. An example of this is non-probability sampling, a process in which the researcher is trusting their own judgment in selecting participants who have experiences related to the phenomenon being researched.

Groenewald (2004) stated, “Doing phenomenology means capturing rich descriptions of phenomena in their settings” (p. 47). This occurs through the allowance of unrestrictive language and free expression. Furthermore, he suggested participants should be encouraged to express their experiences, feelings, beliefs, and questions about the themes being investigated. Groenewald referenced the importance of “memoing” within the work of phenomenology, stating this is the medium through which the researcher hears, sees, experiences, and evaluates information during the collecting and reflecting processes. “It is important that the researcher maintain a balance between descriptive notes and reflective notes, such as hunches, impressions, feelings, and so on” (Groenewald, 2004, p. 48).

Explication Process

Groenewald (2004) emphasized the importance of the explication process. Explication involves the systematic procedures through which essential features and relationships are identified. “It is transforming the data through interpretation” (Groenewald, 2004, p. 49). He highlighted five steps within this process: bracketing and phenomenological reduction, delineating units of meaning, clustering of units of meaning to form themes, summarizing each interview, and identifying general and unique themes for all the interviews and developing a composite summary.

Bracketing and Phenomenological Reduction. Bracketing and phenomenological reduction involves the deliberate and purposeful recognition of the phenomenon by the researcher. This involves recognizing the ability of a phenomenon to exist “in its own right, with its own meaning” (Groenewald, 2004, p. 50). Additionally, researchers should remain neutral during this phase, taking no position either for or

against their own presuppositions. Part of the objective during bracketing is to avoid allowing the researcher's meanings, interpretations, or theoretical concepts to enter the unique world of the informant/participant. Groenewald (2004) acknowledged the benefits of repeatedly listening to and revisiting the audio recording of each interviewee to become more familiar with the participants' language and begin to develop a more holistic understanding of the interview content.

Delineating Units of Meaning. Groenewald (2004) contended that delineating units of meaning is a critical element of the explication process because the examiner illuminates (isolates or extracts) the interviewee's statements that highlight the researched phenomenon. "The researcher is required to make a substantial amount of judgment calls while consciously bracketing her/his own presuppositions in order to avoid subjective judgments" (Groenewald, 2004, p. 50). Within this process, the interview is scrutinized as the researcher considers both the literal content and the number of times a specific item of meaning was mentioned.

Clustering of Units of Meaning to Form Themes. During this step, the researcher tries to understand how each of the previously identified units of meaning fits into a more holistic understanding of the topic. "Particularly in this step is the phenomenological researcher engaged in something which cannot be precisely delineated, for here he is involved in the ineffable thing known as creative insight" (Groenewald, 2004, p. 50). This involves the clustering of individual units into broader group units of meaning. Often there is overlap in clusters, which is to be expected given the nature of human phenomena. "By interrogating the meaning of the various clusters, central themes are determined" (Groenewald, 2004, p. 50).

Summarizing Each Interview. During the summarization process, interviews are validated and modified. All themes from the interview are summarized and incorporated into a more holistic context.

> The aim of the investigator is the reconstruction of the inner world of experience of the subject. Each individual has his own way of experiencing temporality, spatiality, materiality, but each of these coordinates must be understood in relation to the other and to the total inner world. (Groenewald, 2004, p. 51)

During this phase, the researcher may be required to return to the interviewee to ensure the essence of the interview was correctly captured.

Identifying General and Unique Themes for All the Interviews and Developing a Composite Summary. When evaluating general and unique themes, the researcher looks for "themes common to most or all of the interviews as well as the individual variations. Care must be taken not to cluster common themes if significant differences exist" (Groenewald, 2004, p. 51). It is equally important that the unique or minority voices serve as counterpoints regarding the phenomenon being researched. Initial theorizing occurs as the qualitative data are reviewed.

Additional Considerations

Groundedness

Levitt et al. (2017) discussed the concept of "groundedness," which addresses the fundamental question of whether the findings are grounded in the data. One way in which this is assessed is through consideration of authenticity. Fossey et al. (2002) evaluated authenticity using the following questions: Are participant views accurately captured

within their own voice? Are there consenting or dissenting voices or views being represented by participants?

The researcher in the current study conducted a line-by-line review of the interview transcripts to examine consistencies/inconsistencies within the thematic material. If, for example, a participant rated therapy/counseling as being highly effective and then proceeded to rate the therapist/counselor's effectiveness as poor, the examiner would have sought clarification around potential dissenting views.

Coherence

Levitt et al. (2017) discussed the concept of coherence, which is used to evaluate how consistent one finding is with another. Fossey et al. (2002) suggested evaluating potential links between participant responses and the findings is essential. An example of how this is applicable can be viewed through whether there is coherence between how effective the participant perceives their therapist/counselor to be in addressing faith and their willingness to discuss faith-related items. Another aspect of coherence is related to evaluating how the results of one study compare with outcomes in similar studies. If there are similar outcomes, what associations can be made? If there are different outcomes, what might these differences suggest?

Meaning Contributions

Levitt et al. (2017) encouraged researchers to assess their findings and determine whether they are meaningful toward the goal of the project. Individual outcomes can assist in estimating what was most and least beneficial for the individual. This can be compared with data from other studies. Evaluating individual, within-group, and across-

group outcomes will allow for a greater understanding of the benefits as defined by the participants.

Perspective Management in Analysis

Levitt et al. (2017) described perspective management as the researcher's remaining aware of how their own perspective influences or guides their analysis. Fossey et al. (2002) referred to this as permeability of the researcher's intentions, engagement, and interpretations. Questions include was the researcher's role transparent within the interview and interpretive process? Are there instances of countertransference? Did the participants perceive the researcher's intentions, values, or theories? If the answer is "yes" to any of these questions, how did the researcher address the aforementioned items? The researcher evaluated whether there was any point during which these items influenced the study.

Chapter Four: Results

All participants met the requirements for the study. Each self-identified as Christian, African American, and was at least 18 years of age. Additionally, all participants reported working with and reporting experiences related to working with a therapist/counselor within the past 5 years. Participants reported that their therapists/counselors were certified at the master's or doctoral level. Participants reported being seen primarily in private practice settings, with one participant having been seen in a military facility. Participants were asked to describe their current frequency of therapy/counseling and most reported meeting with their therapist remotely since the onset of COVID-19.

Overall Results

Each participant was asked to rate the following questions: (a) On a scale of 1–10, how would you rate the effectiveness of therapy/counseling? (b) On a scale of 1–10, how would you rate the effectiveness of the therapist/counselor? (c) On a scale of 1–10, how would you rate the effectiveness of your therapist/counselor to address faith-based concerns? Table 1 displays the results for traditional psychotherapy participants and faith-based counseling participants.

Table 1

Overall Participant Rating Results

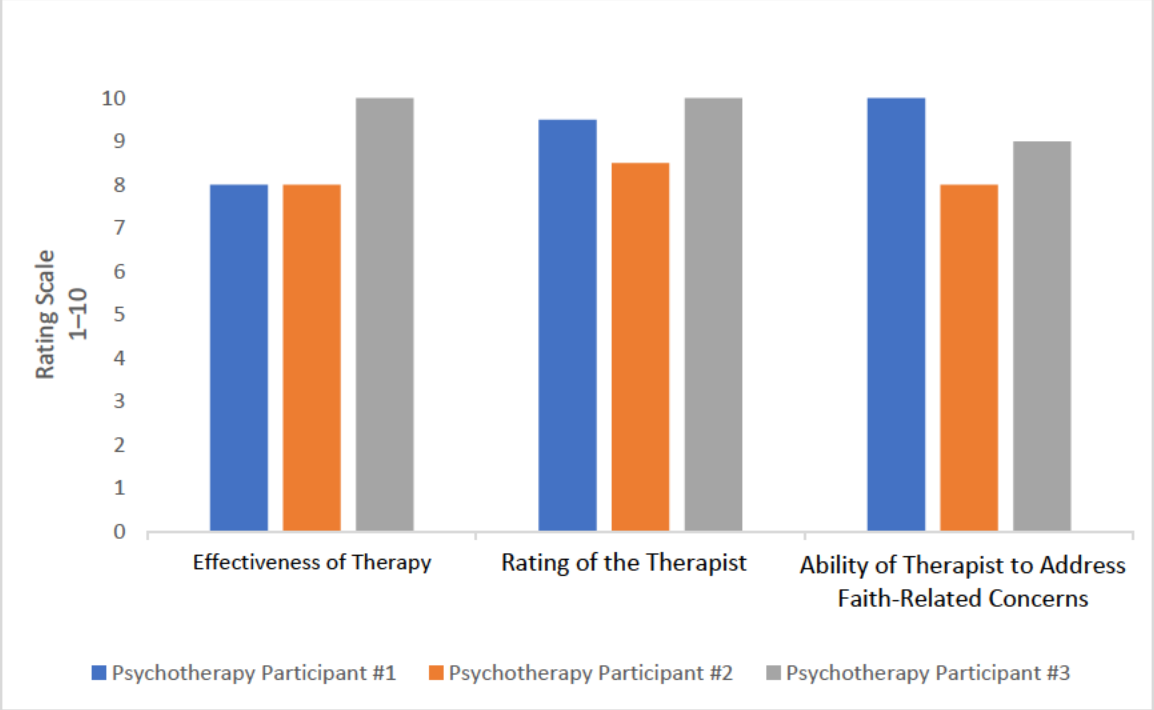
Participant group	Effectiveness of therapy/ Counseling rating	Effectiveness of therapist/ Counselor rating	Effectiveness of therapist's ability to address faith-related issues
Psychotherapy			
Participant 1	8	9.5	10
Participant 2	8	8.5	8
Participant 3	10	10	9
Group rating average	8.66	9.33	9
Faith-based counseling			
Participant 1	8	9.5	9.5
Participant 2	8.5	8.5	10
Participant 3	10	10	8
Group rating average	8.83	9.33	9.16

Traditional Psychotherapy Group Results

The traditional psychotherapy group consisted of three participants. A participant synopsis is provided for each participant to highlight demographic and background information. Groenewald's (2004) explication process was used to examine each participant's responses to the interview questions. Figure 1 represents the reported data for traditional psychotherapy participants only.

Figure 1

Traditional Psychotherapy Participant Findings



Traditional Psychotherapy Participant 1

Psychotherapy Participant 1 self-identified as a 27-year-old African American male from the greater Chicago area and stated he continued to reside in the area. He reported being married and described his partner as being from a South American country. Psychotherapy Participant 1 reported that his presenting concerns were primarily related to anger/stress management and challenges within his marriage. He described his therapist as being an older White woman. Psychotherapy Participant 1 described himself as growing up in the Baptist Church, which he attended from Grades 1 through 8. He reported that this church closed in the early 2000s. Psychotherapy Participant 1 would later attend a Catholic high school and converted to Catholicism during his junior year of

college. Although he currently attends Catholic mass, he reports that he is still very connected with his Baptist belief system.

When asked if he was motivated to seek one form of counseling versus the other (i.e., traditional psychotherapy vs. faith-based counseling), he reported he was motivated to seek therapy regardless of the therapy type, although he did acknowledge his faith as being important to him.

> Honestly it was not a consideration for me. My employer had a list of mental health providers, I chose based off their experience and reviews. And what I found was a nice older lady who has been through some things and understands.

Benefits of Therapy. Psychotherapy Participant 1 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 8 out of 10. When asked why he provided the rating he did, he stated,

> It's only because when I leave, I do feel a little bit better. But on that car drive home, I feel like I want to talk more. When I leave, I'm okay, but some days I feel like an hour is just not enough. Some other benefits would be, less aggression, a deeper sense of focus and self-responsibility. I feel like I might know myself a little bit better.

When asked if there were any other additional benefits of therapy, he stated the following:

> Well, she has a dog in her sessions. Her dog kind of helps. Whenever it's painful, the dog knows. It's cool. The dog picks up on it. Even when I have a session where she's doing all the talking and I'm thinking in my head, no that's not right. I just don't say anything. I can tell the dog is like, something is wrong with this

> guy. And just the space in general, having an intimate space and having her pet around to alleviate any problems or emotions that I am scared to share.

The researcher asked the participant whether he addressed the moments where his therapist/counselor incorrectly summarized or misunderstood his emotional experience. Psychotherapy Participant 1 stated, "I have corrected her sometimes. Not a lot, but a few times. Sometimes she's right on, and other times not so much. I always try to be respectful." The researcher further explored these experiences of client–therapist misalignment. After further consideration as to how he responds in these moments, Psychotherapy Participant 1 stated:

> I don't think I do respond. I think I just compartmentalize it and just withhold it. And then when I see her again, I can kind of bring it up, but usually I don't. I usually just lock it away and deal with it internally . . . I just move on. I say, she probably doesn't get it, I'll just figure it out on my own or something.

Psychotherapy Participant 1 was asked if there were any specific challenges related to attending therapy. He stated the following:

> One of the challenges of therapy was really wanting to go. I knew I needed to go, but I would have those days where it's like, man, I have to go to therapy on Saturday. And I know I need to go, but one of the challenges was if I should go.

Therapist Identity and Impact on Therapy. Psychotherapy Participant 1 was asked to rate the effectiveness of his therapist on a scale of 1–10 and reported a score of 9.5 out of 10. When asked why he provided this rating, he stated the following:

> At the beginning I was like, it's an old lady, what does she know? On top of her being an old White lady, I was like she doesn't know anything about the Black

> man or whatever. And then after a while I loosened up and was like naw, she does. And after a while I loosened up and realized she's kind of hip. I learned a few things about her. There are some times where we were scheduled to meet, and she totally forgot. And then I'm like oh my gosh, I got an older person. I should have stuck with someone my age. I wanted to tell her, you wasted my time. But then I remembered I was in her house and wanted to be respectful. I think she could kind of read it, because I was grinding my teeth when I was talking to her. I was like yeah, it's okay, it's fine. In my head I'm thinking you just made me waste gas.

Psychotherapy Participant 1 reported having a long-standing relationship with his therapist, stating he has been working with her for approximately 4 years (estimated 100 sessions). Psychotherapy Participant 1 estimated his therapist was licensed at the master's level and had many years of experience working within a private practice setting. He reported that his therapist currently worked from her home and stated that in the beginning he was mildly uncomfortable participating in therapy at her home. He reported initially meeting weekly, transitioning to bi-weekly, and then meeting monthly via telehealth since March 2020.

When evaluating his experience of being seen within his therapist's home, psychotherapy Participant 1 stated the following:

> It was kind of frightening at first. The first session was in her home. I was like okay that's cool, it's quiet, peaceful, you don't have to worry about getting killed or anything. White picket fence neighborhood. She had a little small space where she conducted her work. Since then, she has moved into a condo in the South

> Loop area. I think I like the condo better. It's not an open space, her office is in a separate room, but it's still open if that makes any sense. I guess being in her home does make it a little bit more personal. I feel like if she's offering her home to conduct work, then why can't I be personal with her? Which makes sense to me.

The researcher inquired whether race or gender may have influenced how psychotherapy Participant 1 felt about entering his therapist's home. He responded, "Looking back, no it had nothing to do with gender, race, or anything. Just more so fear of going into someone's home I don't know and being able to be myself."

Faith Considerations. Psychotherapy Participant 1 was asked if he had addressed issues of faith with his therapist, and he reported that he had not. Because he did not present any faith-based content, he was asked to estimate how effective he believed his therapist would have been in addressing faith-based concerns on a scale of 1–10. The participant provided a score of 10 out of 10.

The researcher asked about the participant's past faith identity (Baptist) and current faith identity (Catholic), and ways in which he related to both. Psychotherapy Participant 1 stated that his faith remains a struggle for him. This is highlighted in the following statement:

> I currently do go to church. I grew up in a traditional Baptist church. I was afforded the opportunity to go to Catholic school and experience Catholicism. I didn't convert from being Baptist to being Catholic at that time. I struggled with faith; I still struggle with faith to this day. In undergrad, I met my wife. She was Catholic, and she encouraged me to come to Mass with her on Sundays. This is

> gonna sound bad but going from service that was from 9 a.m. to 9 p.m., and then converting to Catholicism where we were done in an hour. I could go home and watch the Bears game. I know this sounds bad. I currently identify as a Catholic, and I attend church on YouTube. We watch Mass for about an hour and a half on Sundays.

When asked why he had never addressed faith within the context of therapy, he responded with the following:

> I think she could at least make space for it. As for addressing it directly, I don't know. She's definitely open, so I'm sure if I brought the issue up, we would talk about it. And talking to you right now makes me think maybe I should talk to her about it. I know for sure she would definitely make time if I brought it up.

The researcher inquired as to how psychotherapy Participant 1 viewed Catholicism and his ability to address concerns with a priest. Psychotherapy Participant 1 provided the following statement:

> When it comes to mixing Catholicism and counseling, I'm not gonna lie to you, I'm not talking to a priest with everything going on. I don't want to generalize, because we all know, it's like saying all Black people are thugs and that's not true. It does kind of hit a nerve, knowing I'm supposed to be going to a place where I'm supposed to be safe. A safe place for all people, not just Blacks or Whites, where I can talk to God or a priest. It's hard when you know they've been documented as a pedophile. It really has impacted my desire to have confession. Having confession is a bit difficult. For one, it's kind of intimidating to be honest. You go into this little box, and I'm not claustrophobic or anything, but it's hot and

> you can't see the person you're talking to. You just hear them. Granted the fact that you can't see them is helpful, because you can say whatever you want to say however you want to say it. But you don't know if this is one of the people [priests] who got moved. Maybe he is, or maybe he's not. And he's going to tell me about loving God and how God loves me, when you might be one of the guys who is a pedophile.

Psychotherapy Participant 1 continued to highlight his separation of Catholicism versus that of his Baptist upbringing:

> I kind of separate the two. Don't get me wrong, my grandmother is a deacon. I still tetter between getting ideas from Catholicism and ideas from the Baptist Church. And when I talk to her, I try to take lessons from life from her. And I'll be honest with you, the majority of people who are Catholics are mostly White people. Don't get me wrong, the Latino community is also Catholic. But from what I've seen, I don't see too many Blacks, I just don't. And so sometimes I go back to what I'm comfortable with. Sometimes I turn on the TV to Rev. Meeks, he's a young guy on the south side of Chicago. And it's not often, but every now and again, just to hear my own people speak about how they feel about things. I mean to get deeper into the situation. I've read the Bible inside and out. I went to a private school, so I can tell you anything about the Bible because it was drilled into our heads. You have to pass those classes and take tests to really prove you understand what God wants you to do. But I do wrestle with my faith, I really do. Even right now I struggle with faith. I do know there is a God, that I definitely know for sure. I wouldn't be her without the Most High.

Psychotherapy Participant 1 further illuminated his experiences as an African American male within the Catholic Church and Baptist Church:

> As far as the Catholic Church, there's certain ideas I just can't vibe with. I don't know how to explain it without trying to make the Catholic Church seem like it's all bad. It's not. We all know you can't generalize a few bad apples. And I know for a fact the priest who baptized me is a really good man. It's funny because I went to his church before the pandemic started, and he saw me. He gave me the wafer at communion. He recognized me and kind of winked at me, so I think he knew who I was. The Catholic Church is like a bowl of rice with a few raisins in it. When I'm at church and see another Black person, I'm excited! I would wish they would come sit next to me. Sometimes I would go and see another Black person, male or female, and give them the usual head nod. Sometimes I get looked at like I'm crazy. But I notice when I'm back in the Black Church, everybody is cool. It's like man you came, let me get you something to eat. It's just more personable. And maybe it's because you're there from 9 a.m. to 9 p.m. You have nothing else to do but learn other people and their ways.

Psychotherapy Participant 1 further explored his social positioning and race/ethnicity in the following statement:

> I can definitely say for the Baptist Church, it's more like family. Even if it wasn't a church my grandmother preached at, when I've gone to church with my mom, when I see Black folks, I get excited. I don't care if you're dirty, rich, male, or female, when I see another Black person, I'm happy! So, when I see them at the Baptist Church it's just welcoming. And don't get me wrong, I've gotten

> somewhat of a warm welcome from the Catholic Church, but it's kind of like a standoffish welcome. And I've seen the stares, and I've talked to my wife about it. You think I don't know what I'm talking about, but I do. I don't know if it's because of race, maybe its fear. But you know when someone is being kind of standoffish, you can see it in their eyes. That's why I say look people in their faces when they talk to you. I get the cold shoulder when I go to those churches. And it's not all, don't get me wrong. Because before we actually found the church that we liked, we were going to churches all around Chicago, I kid you not. And there's not too many Black people who are Catholic. Here in the U.S., the Catholic churches I've gone to, it's kind of like a shock factor when you walk in. But then when I sit down, or someone actually has a conversation with me, then they're like, okay he's a good one. It's just crazy.

Observations. When evaluating the comments made by psychotherapy Participant 1, several significant conclusions can be drawn. Working with an older White woman was meaningful for this client. He potentially viewed her Whiteness and her gender as initial barriers to understanding his experience. However, as their relationship evolved, he was able to recognize her ability to relate to his experiences. He also appeared to value her lived experiences and the unique perspective she can provide. Though this was beneficial to him, there were instances when his therapist appeared to miss the mark. He discussed times where her dog appeared to better comprehend or relate to his emotional experiences than she did. Overall, he rated himself as benefitting from therapy.

Psychotherapy Participant 1 contrasted his experiences in the Catholic Church versus the Baptist Church. The complexities of his religious experiences brought up many questions for him. One key element of this appeared to be ties to his racial experience as well as his theological/religious differences within the worship experience. Though he can competently navigate these two worlds, we see instances in which he feels more comfortable returning to his Baptist roots. Also, we may wonder how psychotherapy Participant 1 fully integrates his religious beliefs into practice, or if these two areas remain more compartmentalized. This may have been an area to further discuss within therapy/counseling; however, it was not of primary importance to the participant at that time.

Traditional Psychotherapy Participant 2

Psychotherapy Participant 2 self-identified as a 39-year-old African American male. He reported he is currently in the military and is originally from Texas. Due to his military service, he was residing in Oklahoma at the time of his interview. He reported being married. Psychotherapy Participant 2 reported that his primary presenting concerns were associated with a diagnosis of MDD and posttraumatic stress disorder. He indicated his therapist was a White, middle-aged female. Psychotherapy Participant 2 reported she was a military psychologist and estimated that she was licensed at the doctoral level. The client was asked if he intentionally selected one form of therapy over the other (i.e., traditional therapy vs. faith-based counseling). He responded that he made his choice based upon what was readily available to him.

Benefits of Therapy. Psychotherapy Participant 2 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 8 out of 10. When asked why he was providing this score, psychotherapy Participant 2 stated:

> For me, nobody is perfect. To me, there is no perfect therapist. There is only someone who works for you, and I feel like she does work for me. We get along very well. There are times where we may not see eye to eye about something, but for the most part she's good. I like her.

The researcher provided clarity that the question was intended to understand how the participant classified the therapy process versus just the therapist, and if there was a difference for him. The participant stated,

> I don't really see a difference. Maybe it's just me, I don't look at anything as being perfect. I never rate anything as a 10. The highest anybody would get rated from me is an 8. An 8 to me, because there is always something that will knock it down.

When asked about the reasons psychotherapy Participant 2 sought counseling, he stated the following:

> It got to the point where I didn't know what to do. I wanted to make changes within my life; and there were changes to be made and I didn't know how to make them. There were a lot of unresolved issues in my life. I thought I dealt with them, but I didn't. And I needed to see somebody, so I started off with a counselor. And it got worse, which led me to go to a mental hospital. I felt like I needed to do it because I was at the edge. I needed someone to help, and she offered that to me, and I took it.

Therapist Identity and Impact on Therapy. Psychotherapy Participant 2 was asked to rate the effectiveness of his therapist on a scale of 1–10 and reported a score of 8.5 of 10. When asked why he provided this rating he stated,

> She has a way of listening and relating, I guess. She sometimes shares a little bit about what she's gone through and her experiences within marriage and things. I like how relatable she is. She's professional, but she's also an easy person to talk to.

Psychotherapy Participant 2 reported seeking assistance before and after his release from an inpatient stay at a mental health hospital. He estimated having worked with his therapist for about 6 months at the time of this interview.

Psychotherapy Participant 2 highlighted some challenges associated with his therapist, specifically related to politics. He stated, "We had a discussion about politics, and I don't really like her politics because she is a Trump supporter. Without her verbally telling me, the way she responds to things, let me know she supports that." Psychotherapy Participant 2 was asked to provide further context for these experiences and stated:

> I think I remember saying that this election, there's no way, in my opinion a person cannot see something wrong. There's no way that you can vote for this man. That just says more about you, rather than about him. Because he shows you who he is, and he's just a flawed man. And all men have flaws, but this man is morally bankrupt. And he shows that he does not care about anybody except himself. And he will do whatever it takes to stay where he's at. And he lies, and you know that he's lying. And she went on the side of, well there are certain

> things that he does well, like the economy. And I'm like no, the economy is terrible.

The researcher inquired as to how this affected psychotherapy Participant 2 and their relationship. He stated the following:

> I noticed we ended about 5 minutes early that session. And then when I came back for the next session, we spoke about it. And she said that she was concerned she offended me. And I was like no, I wanted to talk to you about it, but I didn't know how. It was just a very humbling moment. A mutual moment where we both shared our concerns about how the other handled the conversation about politics.

Psychotherapy Participant 2 was asked if this had a long-term impact on how he viewed his therapist. He responded with the following:

> It didn't change my viewpoint of her, really it didn't. It's like anybody in this day and age with this guy. I look at you a little bit differently, but it doesn't define who you are. Because I also look at how you treat me. But maybe, I don't know. It's a tricky thing because if you support something like that, there's no other way for you to look at this but to see what this guy is saying. This guy [President Trump] brings such a racial overtone to everything in such a divisive way . . . In his views on Blacks, Hispanics, and Asians. It's never anything positive. And if it is used in a positive way, it's in a way that benefits him.

Faith Considerations. Psychotherapy Participant 2 was asked if he had addressed issues of faith with his therapist, and he reported that he had not. He did, however, report identification as a Christian. Because he had not discussed any faith-based content with

his therapist, he was asked to estimate how effective he believed his therapist would have been in addressing faith-related issues or content on a scale of 1–10. The participant provided a score of 8 out of 10.

Psychotherapy Participant 2 was asked about his current relationship to and practice of his faith, and stated the following:

> I identify as Christian. I never believed I needed to be in a church every Sunday to be a Christian and to believe in Jesus Christ. I believe that relationship is between me and Him. I speak to Him through prayer. I don't believe I need to go to a church in order to feel growth. That's what I am experiencing here, so I don't attend church here. I've told her that I am a Christian, and she is one as well. We haven't gone too far into our faith, but I can tell that she is. We touched on prayer, and we touched on going to church and things like that.

When asked to provide further detail about faith-based dialogue, psychotherapy Participant 2 provided the following:

> I just described prayer to her as a way for me to calm myself down. And that led into the conversation of meditation and things of that nature. And, how I am allowing God to start to guide me, rather than me trying to take over the wheel. She related, at least that's what I took away from it.

When asked if conversation related to faith was important to him, psychotherapy Participant 2 stated the following: "It didn't completely matter. Honestly, as long as she wasn't saying I'm an atheist and I don't believe in Christ. You know what I'm saying? One of those types of people." When asked if that would have affected his experience, the participant stated, "I would not have gone back. What mattered is that she be

accepting of my belief system, whatever my belief system is. That she be respectful of whatever my choice is."

Observations. Psychotherapy Participant 2 provided unique insights into his traditional psychotherapy experiences. He voiced the importance of therapy for him and the help it provided him during what was a difficult time. He also spoke to the sociopolitical values of his therapist and ways in which they may have affected the therapeutic relationship. He outright addressed Trump politics and what it meant for him as an African American male. Although there appeared to be a small rift within the relationship, the client remained steadfast in his attendance of therapy. The client appeared to be the party who addressed the rift. This was a meaningful moment of understanding that appeared to strengthen the relationship. Working across difference may have propelled the relationship forward, although the client may have made concessions along the way.

When considering the role of faith within the therapy process for psychotherapy Participant 2, we can observe that it is secondary to his mental health treatment. He stated it is important for his therapist to remain respectful of his religious views, but stated it is not of high importance to process his faith within session. Psychotherapy Participant 2 viewed himself as requiring help and was open to receiving that help in whatever form it arrived. Also, perhaps he did not view his presenting concern as being specifically tied to a religious/spiritual concern. Additionally, does the client potentially compartmentalize his faith and his mental health treatment? Is there an innate separation between mental health treatment and faith because of the treatment setting (i.e., military installation)?

Traditional Psychotherapy Participant 3

Psychotherapy Participant 3 self-identified as a 34-year-old African American woman. She reported being a graduate school student who resides in Indiana. She reported that she sought therapy following the start of her graduate program. Psychotherapy Participant 3 indicated her counselor was an African American female and a licensed social worker. She reported having worked with her counselor since 2017, for approximately a year and a half and discontinued therapy when the COVID outbreak intensified. Psychotherapy Participant 3 reported a diagnosis of adjustment disorder. When asked if there was a specific reason the participant sought one form of therapy versus the other, she indicated she did not have a preference and that her decision was based on a friend's recommendation.

Benefits of Therapy. Psychotherapy Participant 3 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 10 out of 10. She provided further context regarding her presenting concern by stating:

> It was my first time ever being in an environment where there were so many privileged people, and I had a really hard time responding. I had a lot of anxiety which I never had it before. I felt like it was something I needed to do before it got even worse. I felt like they kind of made me feel inferior. And I had to learn more about what privilege means and how to manage my emotions.

Participant 3 was asked to clarify her score about the effectiveness of therapy, and she stated:

> I went in knowing this was an issue and I didn't want to allow it to exacerbate. I went in ready for whatever. I felt like I was seeing a Black therapist who had been

> in the field for like 30 years, so she could understand my experience. I felt like I could be me. I could go in and say whatever. I didn't have to be worried about being judged. I liked her flow, I liked her presentation, I liked I was able to do me. I liked that she challenged me, and she was somebody I didn't know. It can be as effective as you make it. If you meet with someone that can identify with your feelings; that may have experienced some of the same things or have a background similar to yours, it will be effective.

Therapist Identity and Impact on Therapy. Psychotherapy Participant 3 was asked to rate the effectiveness of her therapist on a scale of 1–10 and reported a score of 10 of 10. When asked why psychotherapy Participant 3 provided this rating, she responded:

> She's very skilled. She's been in the field for a very long time. And she didn't even have to ask questions. She did ask questions, but I knew what was coming next. Her flow, I guess. I would know what she's getting ready to ask me. She was good.

Psychotherapy Participant 3 highlighted specific benefits associated with working with an African American therapist by stating, "I couldn't image sitting in the principal's office, that's what I call it, and discussing my feelings to a privileged individual. How can they possibly understand what I'm trying to say?" Psychotherapy Participant 3 contrasted her current experiences against a previous experience with a White female traditional psychotherapist:

> I was younger, and I was probably a little ignorant of racial injustice in the field or I didn't really recognize it as much as I do now. I didn't get a good feeling

> about her, I felt judged. Some of the questions she was asking, I would be quiet. I had gone through a recent breakup with my first child's father, and I was having trouble adjusting. We used to have a house, and so the questions she would ask when I would say things, it just came off judgmental for me. I was saying I didn't know if I wanted to seek child support, and she would say, child support?! You know what I'm saying. It's like yeah, child support. I never went back to her after that. I felt like, I don't need therapy from that therapist. I felt like maybe she doesn't know what breakups are like. It didn't feel right. I felt like I was being judged. I didn't feel like she wanted to help me, she was just there doing her job.

Faith Considerations. Psychotherapy Participant 3 self-identified as Christian and a member of the Church of God in Christ (COGIC). She reported that since the pandemic started, she had been attending Sunday church services remotely on a weekly basis. She also reported attending Bible Study on Thursday evenings whenever possible. When asked if she had addressed issues of faith with her therapist, she stated she had not. Because Participant 3 did not address faith-related concerns in therapy, she was asked to estimate how effective she believed her therapist would have been in addressing faith-based concerns on a scale of 1–10. Psychotherapy Participant 3 provided a score of 9 out of 10. When asked about her rating, she indicated:

> It's kind of hard to say. I don't know if you know much about the COGIC background or whatever, but homosexuality is like an abomination. I really can't say how things would have gone now that you've got me thinking about it. Maybe I would have brought it up if she would have looked different.

Psychotherapy Participant 3 was asked if there was a reason she had not addressed faith within the therapy context. She provided the following response:

> Well, to be honest, she appeared to be gay. And so, I didn't go in there for that, to talk to her about anything but my issues. As far as faith, I feel like I have my pastor. I have help on that end. If I need encouragement, I have others I can reach out to. It's something I never brought up or felt the need to bring up.

Psychotherapy Participant 3 was asked if she views therapy as a place where could have addressed issues of faith. She provided the following response:

> I think it could be both. I didn't know anything going in, so I was pretty much just going in blindly. When I got there, I think her appearance pushed me to go more in the direction of not bringing up my faith. I didn't feel as if that was needed. I do believe if your therapist believes as you do, it is something you can bring up with your therapist. For me, with her, it was something I didn't bring up. I will be honest, some of the things that were going on in my life go against the grain. I couldn't tell somebody in my church some of the things that I did. And I didn't want to come off like I'm holier than thou or whatever. With the issues I was bringing up, religious people would frown upon that.

Observations. When evaluating the responses provided by psychotherapy Participant 3, we can view ways in which therapist–client factors may have influenced the therapeutic relationship. Psychotherapy Participant 3 appeared to view her therapist/counselor as gay. As a result, she opted to compartmentalize her faith and focus on her mental health treatment. She also stated she was not there to address issues of faith, although we know her faith is highly important to her. It appears that this limited

her experience of therapy and her ability to integrate faith into practice and potentially create new choices for herself.

Psychotherapy Participant 3 also acknowledged that the subject of sexual orientation (especially for persons not identified as heterosexual) was highly contentious within her church denomination (Church of God in Christ). She may also share ambivalent feelings as a Christian, therefore negating her ability to address issues of faith. She also stated that the church (and its congregants) may have judged her for some of her actions (e.g., having children outside of marriage), and she did not want to be judgmental toward her therapist. Was psychotherapy Participant 3 making an intentional, conscious choice not to address faith within therapy? Was her choice not to engage in religious dialogue potentially protective for herself or her therapist/counselor?

Psychotherapy Participant 3 also made meaning of an earlier counseling experience in which she abruptly discontinued therapy due to personal feelings of judgment. She stated her White therapist seemingly could not relate to the concept of seeking child support and highlighted the connection with her current Black therapist/counselor. This factor was highly important to her, given that she was presenting with anxiety concerns related to being around White privileged individuals. The client found explicit value in connecting with a therapist who could relate to her personal experiences and likely had similar experiences of her own.

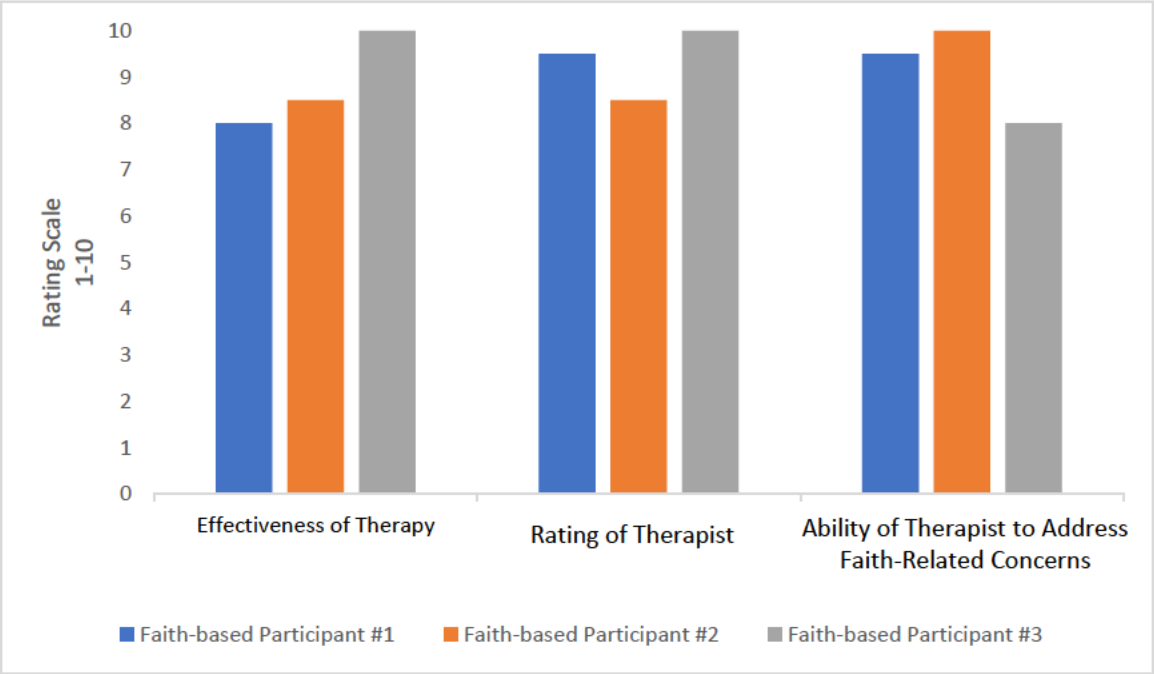
Faith-Based Counseling Group Results

The faith-based counseling group consisted of three participants. A participant synopsis is provided for each participant to highlight demographic and background information. Groenewald's (2004) explication process was used to examine each

participant's responses to the interview questions. Figure 2 represents the reported data for the faith-based counseling participants.

Figure 2

Faith-Based Participant Findings



Faith-Based Counseling Participant 1

Faith-based counseling Participant 1 identified as a 29-year-old African American male who resided in greater Chicago area and worked in the information technology career field. The participant reported working with his therapist for approximately 9 months (estimated 36 sessions). The participant estimated that his therapist was African American and Indian, and a licensed psychologist. The participant reported a history of anxiety and indicated he sought treatment for issues related to his marriage:

> I had an issue prior to marriage. An issue of feeling lonely and rejected. And I ended looking at pictures that I shouldn't have. Basically, my wife found out about it and that brought it up. I knew based on that I needed to address the issue.

When asked if there was a specific reason the participant sought one form of therapy versus the other, he indicated the following:

> There are two reasons. Number one, I'm a Christian and my perspective is based on how I believe God would want individuals to be helped in that way. I sought someone who to some degree embodied that. And secondly, I considered the secular versus sacred label. On the traditional side, I hear how you can get help by way of drugs or other types of things that would help the person manage themselves better; rather than faith-based where people are trying to incorporate holistic approaches, instead of this person needs drugs to help them think clearer. As a Christian, I would rather go with the worldview that I have.

Benefits of Therapy. Faith-based counseling Participant 1 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 8 out of 10. When asked about the reason for this rating, he stated it was "based on my level of growth. There are some things I'm still learning." The researcher asked if there were additional elements that went into his rating. The participant shared the following:

> There are a couple things that factor into it. Intentionality of the counselor pushes it towards an 8, or greater than that. Another one, what was the level of comfort. I was taught to read my environment a long time ago. Even though I'm the one seeking counseling, how comfortable is this person with me? If they show me, they're unwilling or uncomfortable with me, then that's when I decide I'm going to put my guard up, or maybe I should find somebody else.

When the participant was asked about the intentionality of the therapist and how he experienced this within therapy/counseling, he stated,

> I will say there was a point where she tried to make sure I didn't want a male therapist over a female therapist. And so that made me question, is she comfortable or is she just questioning if I'm comfortable?

Faith-based counseling Participant 1 indicated that his rating of an 8 was directly tied to how he viewed his growth. Additionally, he connected with various elements of the therapy process:

> One of the major benefits is being able to talk without fear or profess without fear. I enjoy writing. The therapist has had me write. It helps me to clear up confusing thoughts and confusing situations. It's also brought up how I may have been the protagonist in different situations. Another two things. There was a time we focused on family of origin. She had me walk through what I learned. I learned things I want to keep and pass down to future generations, good models. Each time I went through they exercise, I thought about are there really good things you learned and why are they important to you? As I did that, it was a good version of self-healing and self-reflection. Outside of that, different skills of communication.

Faith-based counseling Participant 1 was asked more broadly about areas that were ineffective or non-beneficial related to therapy. He responded with the following:

> As far as ineffectiveness goes, there was a portion in the beginning; and I think this usually happens with counseling, there was one or two sessions where your kind of analyzing the client. Especially for someone who has never had therapy, it could create another hurdle. I knew there was going to be a question period, but I was somewhat uncomfortable about what was brining me into therapy. I felt uncomfortable the first three or four sessions.

Therapist Identity and Impact on Therapy. Faith-based counseling Participant 1 was asked to rate the effectiveness of his therapist on a scale of 1–10 and reported a score of 9.5 out of 10. When asked why he provided this rating, he stated the following:

> I would say 9.5, there's always that .5% I leave off for anybody. Just in case things go haywire. I actually start everyone off at 0. Growing up in Chicago, that's a mentality that I have living in the city, to not trust anybody. So, for me to be that confident is remarkable. At first, I had a barrier of not trusting, then over time I saw this person made me feel comfortable enough to share things most men aren't willing to talk about. Let alone African American men. And on top of that, giving me practical tools to help me in the situations that I found myself in. Assisting me in the exact way I was looking to get assistance to reach my goal.

When asked if there was anything the therapist could have done to improve upon that rating, he stated there was not. Given previous comments related to gender (made by his therapist) and the potential for increased comfort in speaking with a male-identified therapist, he stated the following:

> I think there would have been more resistance from my family of origin. If you look at my family dynamic growing up, I started talking to my mom about anything and everything first. And then I gradually started talking to my dad. And over the years, I have changed that within our relationship, but when I was younger, it was engrained in me to go to my mom. From my mom's perspective, if I'm trying to overcome an issue like pornography, I can't just go to someone who says stop or don't do it. I'm choosing to end counseling in the next month, based on the level of growth I've had. But I'm willing to go to a male therapist

> next time around because I've had growth in men talking to other men. If I can talk to someone who I didn't know about my issues, it should make me more comfortable talking to my wife about things.

Faith Considerations. Faith-based counseling Participant 1 self-identified as Christian and a member of the Evangelical Free Church of America. He reported he attended Sunday church services remotely on a weekly basis. The participant stated his therapist was a Christian and was recommended by his church. He was asked if he had addressed issues of faith with his therapist, and reported he had. Faith-based counseling Participant 1 was asked to rate how effective he believed his therapist was in addressing faith-based concerns on a scale of 1–10. The participant provided a score of 9.5 out of 10.

The researcher asked how his therapist had gone about addressing issues of faith with the participant, as well as his personal comfort level within this process. He stated the following:

> One, she opened the door for me to be a ranter or be a quiet person. So, when I saw that, I accepted the invitation. When she asked what does church mean to me, what does faith mean to me, and how important is it in these situations? It opened the door for me to be honest about these standards that I have for myself, so I can reflect about myself in relationship to my faith. Her responses about things helped me to know she was listening and trying to help me process, which has been my biggest issue when it comes to, do I have faith? And am I for real about it? On the other end, she affirmed what you're feeling but also pointed out some things about what faith is. And how I'm on the right track with things but should continue down the path of gaining more understanding. Any time I bring up

> something about church, she doesn't tense up. Because there is a level headedness there, it gives me the ability to receive what she maybe saying

Faith-based counseling Participant 1 underscored the characteristic of openness and receptiveness as important within his experience. When asked if he believed his therapist was comfortable in addressing faith-based concerns, he indicated, "Yes, she always seemed to be. I didn't always feel comfortable within myself, but her body language let me know she was comfortable with it."

He was asked if other elements of faith were addressed in session, and he stated the following:

> I would mention prayer, and she would remind me of the ability to write my prayers down. It served as reminder when I reflected on it that God may have a different view of these situations. I think that was helpful for me using prayers and using that as a contrast. It also helped me clarify my definition of what faith is and clarify my resolve to have it.

The participant acknowledged spaces of growth and increased comfort. His ability to integrate some of his learned knowledge into practice can be seen within the following statement:

> After I ranted or talked about what I journaled, she may have said something to the effect of, have you discussed this specific thing with your wife? And it planted the seed. It helped me think about what I may or may not be truly vulnerable about with my wife. And that emotions may not be objective. There were two major hurdles, one was I talked with my wife and was very vulnerable about what my needs were at the time. And it was something I felt was important to me.

> Using some of what I learned in therapy sessions and trying to incorporate that as best as I could. And I felt I had freedom enough to talk about things. I could see self-growth in my willingness to push forward. And while I may not always be that way, there have been times where I have tried to do my best to be focused about what I may be trying to accomplish. And instead of sitting in anxiety about what might or might not happen, I chose to go forward with a better approach. Nothing is ever going to get better just by analyzing, but instead realizing this is what happened and how can I apply it into action.

Observations. Faith-based counseling Participant 1 provided a new perspective as he focused on relational concerns (including the use of pornographic materials and its impact on his marriage). Though there was some external motivation to seek therapy, he was driven to address his issues before they became any worse. Though all the participants within this study were motivated to change, we see motivation to both improve his relationship and eliminate a process addiction. He acknowledged that during the first several sessions, he could tell his clinician may have been probing for additional information. This was potentially experienced as uncomfortable or unsettling for the participant, as he was new to therapy and significant rapport had not yet been established. The participant and his therapist appeared to be able to work through this discomfort within one to two sessions and proceeded to have a very productive relationship.

When evaluating the responses provided by faith-based counseling Participant 1 regarding faith and its integration into therapy, it became clear he was looking for a therapist/counselor who could aid in the provision of faith-based advocacy and Bible-based assistance. It was evident that this was foundational to his development within

therapy/counseling. One example of this was provided when the participant was instructed to write down his prayers and reflect on ways in which they aligned with God's views on the subject. This appeared to assist the client in further solidifying his faith as well. He also acknowledged that traditional psychotherapy is often based on medication or secular thought. The participant appeared to characterize traditional psychotherapy as clients aligning with their personal views/perspectives to address or resolve problems. In contrast, the participant viewed faith-based counseling as encouragement in aligning with his Biblical or God-based approach to life so it may connect with solutions according to his faith.

Faith-Based Therapy Participant 2

Faith-based counseling Participant 2 identified as a 33-year-old African American female who resided in greater Chicago area and identified as a student. She estimated having been in therapy/counseling for the past 3–4 years in total, with the past year being with her current therapist (approximately 35 sessions). The participant described her therapist/counselor as a White female who is licensed as a master's-level counselor operating within a private practice. The participant reported seeking treatment for adjustment-related concerns: "I was having a difficult time transitioning. I was going through a bunch of transitions at one time. I just felt like something was off, and I wanted to get back on track." When asked whether there was a specific reason the participant sought one form of therapy versus the other, she indicated the following:

> Yes, there is a reason why. Originally, I sought traditional psychotherapy because I wasn't as dedicated to my faith as I am now. But once I came to Christ, and became more mature in Christ, some of the advice given by my therapist was not

> faith-based or didn't align with my religion. While being single, my therapist recommended I start masturbating as a way of addressing sexual desires. I was like, well, that definitely goes against what I believe. So, I was like I need someone who is Christian to help me with this.

Benefits of Therapy. Faith-based counseling Participant 2 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 8.5 out of 10. When asked about the reason for this rating, she stated the following:

> She is an older single White lady. She has a limited understanding of some of things that are going on in the world today. I could tell she wasn't comfortable with discussing it, and so that was the biggest ineffectiveness. I'm not sure how culturally competent she is. I'm not sure that is something we could ever really discuss, as far as race goes.

Faith-based counseling Participant 2 was asked to provide more information on this subject matter. She provided the following statement:

> Well, we were talking about me possibly taking a teaching position within a school that was 90% White kids. I was telling her I'm not sure why they would hire a young Black woman to teach White kids about business. That's not something that is common. We were going through the contract, and I was trying to tell her about some of the institutionalized racism I saw on campus when I was there. And so, she did some redirecting. She asked, why do you think they called you, you're overqualified. And I was like, yes, but when I look at everything that is going on in the world today, I'm not sure they're doing it for the right reasons. She was more so just focused on my qualifications for the job and not really the

> context of what was happening now. And another instance was when I told her, I'm grieving for my people. She didn't really get that part. I had to really explain to her what that meant. To grieve for your people . . . To see them dying on television . . . I felt like that was kind of oblivious. I felt like she's not really advocating for it or acknowledging that it's a real issue. At the bare minimum, she could have touched on some of the history. Throughout history, blah, blah, blah, but she didn't do any of that. And so, I just felt like she was lacking in that area.

When asked about the benefits of therapy, she stated the following:

> It does really help with my perspective. I tend to just repeat things in my mind but having someone bring that to my attention is helpful. When this thought comes up, try doing this. Instead of constantly replaying it in my mind. That was helpful. In terms of perspectives, someone saying maybe that's not the only perspective to have in this situation. And kind of give me the other side of the coin, so that I can really actually understand it. Also, it is really helpful to have someone to vent to, without trying to fix it. Just giving me the opportunity to have that pity party or just sit in my feelings. And then the next session we'll address how to fix things, and that was helpful. Sometimes I didn't want to fix things. I just want to be mad and then figure it out later. The breathing exercises have been really helpful. Being a teacher, I had to learn how to do that. To gather myself, and just take a moment to breathe. My counselor noticed when I would become upset and not breathe properly, and so that was brought to my attention. And she gave me various ways to communicate. One of the recommendations was that I be an

> active listener within my marriage. Also, my current counselor and I always pray before and after the session. I find that to be really helpful.

Therapist Identity and Impact on Therapy. Faith-based counseling Participant 2 was asked to rate the effectiveness of her therapist on a scale of 1–10 and she indicated a score of 8.5 out of 10. When asked why she provided this rating, she stated, "Lack of cultural awareness." Participant 2 acknowledged that the race/ethnicity of her clinician likely affected her ability to feel supported in processing social justice issues. When asked how the client was affected by the perceived lack of cultural awareness, she provided the following statement:

> I was taken aback. We had been working with one another for over a year. I felt like she would've been able to assist me in that area. I guess I talked myself into thinking that's not her expertise. I chalked it up to that's how she was trained in an industry that caters to her. I told myself, I shouldn't expect that much from her because she's been counseling a long time. I was thinking they probably don't have any folks that would help her with this specific problem. Maybe she thought she would never even need to take training. I guess I went through a lot. I guess I went through a justification process to make it seem okay.

Faith-based counseling Participant 2 was asked how this affected their relationship moving forward:

> At that point I was seeing her monthly. I guess I felt it wasn't a major problem or priority I needed to address. But I did navigate around it and try to fill the space with other issues that could be addressed, issues that I knew she could handle and just be comfortable with. I guess it did cause a rift in our relationship where I felt

> I couldn't be as open about everything, including those social justice issues. And I want that in a therapist. I guess the training for what I actually needed in a faith-based counselor was limited in some ways by my insurance.

When asked if there was anything the therapist could have done to improve upon that rating, Participant 2 stated the following:

> She could have better addressed cultural aspects. I guess that's where the deduction comes in. She is very knowledgeable about a lot of other topics, but I feel that culturally she is really lacking and could use more training. I thought maybe she isn't aware of her privilege, and it wasn't something I wanted to waste my session on. I didn't feel comfortable bringing that up to her. I guess it would have been different if she said that's not something I'm familiar with, can you help me more? Or if she would have wanted more understanding.

Faith-based Participant 2 was asked how she was able to move beyond the rift within their therapeutic relationship. She stated the following:

> I want to say I just kind of forgave her. I guess at the time it wasn't a deal breaker. I just forgave and kept moving. I didn't really let it fester. Moving forward I just stayed away from it. I think I'm good at avoiding, or just keeping the peace. I'm good at avoiding the confrontation or making things awkward, especially if it would create a weird space for us.

Faith Considerations. Faith-based counseling Participant 2 self-identified as Christian and a member of a non-denominational church. She reported she attended Sunday church services on a weekly basis. Participant 2 stated her therapist was a Christian. She was asked whether she had addressed issues of faith with her therapist, and

she reported that she had. Participant 2 was asked to rate how effective she believed her therapist was in addressing faith-based concerns on a scale of 1–10 and provided a score of 10 out of 10.

The researcher asked Participant 2 how her therapist had gone about supporting her around issues of faith, as well as her personal comfort level within this process. She stated the following:

> I was very impressed with her ability to find scriptures and apply it to what I was talking about. I guess it helped me understand where the Bible stood on things. Also, we would start and end each session with prayer. At first it was kind of weird, but it has been a good experience. It shifts my mindset and helps me to take my mind off of anything negative. I may be initially upset about something, and it kind of makes it look not so big.

Faith-based counseling Participant 2 clarified the benefits of scripture through the following statement:

> I think a lot of times she kind of sprinkled it in there [scripture]. She would definitely give me practical tools, but if there was an intersection where faith could be incorporated or was at all practical, she would definitely say this is the principle or this is where the Bible stands on this. She would find a scripture for me. We did that a few times, specifically when it came to being submissive. We referenced the Bible a lot with that.

Faith-based counseling Participant 2 also highlighted the ability to process concerns related to marriage and faith:

> Me and my husband currently attend separate churches and we're working on merging into one. So, we have dived into what is important for me in a church, we have dived into my beliefs about marriage and where did that come from. And the faith to stay or the faith to leave, which one do I lean towards more.

Observations. Faith-based counseling Participant 2 provided notable insight into faith development and the ways in which it may have influenced her experiences within therapy. She noted that during her previous traditional psychotherapy experience, her therapist provided feedback around masturbation that did not fit with her personal values. This played a role in her later seeking out faith-based counseling. This appears to be an example of how value matching may have been important for a Christian client. However, though she benefitted from having a faith-based counselor who could relate to or provide faith-based instruction, her therapist/counselor was unable to relate to her social realities as an African American.

Faith-based counseling Participant 2 identified working with a White female therapist/counselor. The lack of diversity training her therapist/counselor possessed appears to have legitimately hurt Participant 2's feelings on an emotional level, as well as negatively affected their relationship on a personal (client–therapist) level. Participant 2 acknowledged that she became less transparent about issues of race and racial injustice. The absence of critical consciousness when examining racial issues is likely something that is quite common for African American clients working with White clinicians. As we see within this case, the client is either required to directly address the cultural incompetence addressed by the provider or ignore and compartmentalize.

Faith-based counseling Participant 2 addressed multiple benefits within the therapy context. One such example of this appeared to be exposure to perspectives outside of her own awareness. She discussed the idea of commonly getting stuck within her own head. She also acknowledged therapy/counseling benefits referenced by other faith-based counseling participants. She stated that her therapist/counselor's ability to find scripture and ways it could be applied to her situation was essential. Also, she noted she and her therapist would begin every session with prayer. Although awkward at the start, this appeared to be influential on the client and her ability to actively engage with her faith.

Faith-Based Counseling Participant 3

Faith-based counseling Participant 3 self-identified as a 34-year-old African American woman. She reported residing in Houston, Texas, and identified as a single mother, student, and administrator (employment unspecified). Faith-based Participant 3 indicated she had previously worked with a traditional psychotherapist before transitioning to a faith-based counselor. She estimated she had been in faith-based counseling for the last 4 years. Participant 3 described her therapist/counselor as an African American female who was licensed as a master's-level counselor operating within a private practice. Additionally, the participant reported that her therapist/counselor was a "preacher's kid" and was active within the church. The participant reported seeking therapy in preparation for her marriage ending:

> In 2016, it was due to me wanting to end the marriage That was more of what jump started it this time around [within therapy]. She kind of walked me through step by step of how emotions play a role, and what to expect having children and

> how it will affect them. And now that you're on your own, how do you spend your down time now that your boys will be with their father at times. It was just a lot of navigating that whole new start of life. Should you ask for child support? Do you want to stay in Houston or go back to Chicago? Acknowledging all these things that play a role in the decisions that you make. Making a decision but also having a plan. And so that involved going back to school. Making sure I didn't have to take care of the kids by myself. Understanding what life would be like now as this huge, single person, after I've been married for 6 years. After the deciding factors, a lot of that was just going to check-in.

Although Participant 3 did acknowledge some benefit within her previous traditional psychotherapy experiences, she was asked if there was a reason why she sought faith-based counseling rather than traditional psychotherapy. She indicated the following:

> I guess because I do have a religious background, I think it's more important for me to tie the two together. I know a lot of times growing up it was like, God can do anything, all you have to do is pray about it. However, that's in the spiritual realm, but in the natural realm you experience life in the natural. So, you need to be able to speak out, just like we go to the medical doctor when our bodies are not intact, it's the same mindset I when my mental health state is maybe not where it should be. I definitely wanted to tie God and the counseling together because those are the two worlds that I navigate between. And a lot of times I do like when they throw in scripture. That also kind of helps. Whereas the world, their view of coping with certain things is not necessarily our way of handling things. I

> think that's why I wanted to tie my two worlds together, versus just getting this abstract, secular kind of view. So that's always going to be different. Even when I did marriage counseling, the world handles marriage different too, but there is this Biblical principal that we should abide by in marriage. I think that's the reason I prefer faith-based counseling. I need to talk this stuff out, get it out, but I also need to be poured into, the natural and the spiritual at the same time. That would be the reason I prefer faith-based counseling over therapy.

Benefits of Therapy. Faith-based counseling Participant 3 was asked to rate the effectiveness of therapy on a scale of 1–10 and provided a rating of 10 out of 10. When asked about the reason for this rating, she provided the following:

> I think it's more of the self-discovery. I guess for Black women, there is this expectation in society that we put on ourselves. That we have to be strong and be a super woman or whatever. And a lot of times that negates our emotions, even when traumatic things happen, or something bad happens, or when we feel disrespected or offended. A lot of times when those things happen, we just keep it in. So, the effective part for me is getting it out in the open. By saying, that really hurt me, I was really touched by that, or I didn't know that that really affected me as much as it did. It's like once it comes out of your mouth and you put into the atmosphere, then you're able to recognize certain things. Like, oh wow, I didn't really realize that was in there. Because all we do is hold stuff, and that is so unhealthy. Some people think going to therapy is about the therapist telling you all this stuff to do, when really, you do more talking than the therapist does. It's almost like this weight is lifted. Every time I go to therapy, it's like a weight is

lifted. And sometimes you don't know how stressed out you are about certain things in life until you're like, oh wow, I feel so much better; but all you've done is talk this stuff out of you. So, to me that's the most effective part. Even when things happen within people's families, like a child being molested, most of the times it's kept a secret. Nobody talks about it. They don't bring that up at the family meetings, you're just keeping that stuff in. Where do you release? So, for me, the releasing in therapy is the most effective thing ever.

Faith-based counseling Participant 3 was asked if she had seen a shift in how she experienced therapy now versus when she initially started. She stated the following:

Yes. I guess the biggest benefit or change that I recognize is that I am so in tune with my whole being. I'm always thinking things through. Before when I was young, immature, life was YOLO [you only live once]. You tend to just do stuff. Now, I don't really just do stuff. If I do something, I'm asking those tough questions. Why would you do that? Why would you choose that? Would you do that again? Do you think that was the best decision? I'm always asking myself those questions that maybe most people look over. But now, I'm very in tune. It's like nobody has to check me, I check myself. You know how sometimes it's like, man that girl needs a real good checking. But now, I'm so in tune with me. It's like, you shouldn't have said that, and you need to go apologize right now. And so, I'm there, by myself. Where before it was like no, I'm not apologizing, or I don't know why I just did that. Now it affects me, like I have this gage because of therapy. And they tend to ask the tough questions. So now I've learned to ask myself the tough questions, so I don't have to get checked. Or I don't have to

walk around and I'm being offensive. Or I'm saying things to people without thinking, just flying off the handle. Or I'm impulsive. Those things don't really happen anymore. Now I just feel like I'm in tune with what it is I'm doing in the world and why.

In addition, faith-based counseling Participant 3 was asked if any challenges arose during the therapy process. She responded with the following:

I think one of the first challenges was for me to tell people that I go to counseling. Or I was thinking, you go to therapy. It's easy now for me to do that, but it really was one of the bigger challenges. Especially even in my own household with my siblings. It was that stigma of you. You think you're crazy a little bit? It was always, they gave you medication? What kind of diagnosis you got? Versus them understanding what therapy actually is; it being more talking than medication. The talking is the medication. So that probably was the biggest challenge, getting over the stigma and not being embarrassed by needing help. That sounds crazy, but there are so many people embarrassed about getting help. They know they need it, but their pride can be a challenge for them. So, I would probably say the stigma first. The other challenge probably was having to tap into my emotions. I remember going a couple of times and I wasn't really doing much talking because I was crying. So that was probably another challenge, dealing with everything that you've been holding in for so long. And not knowing how to get it all out. And then you're like, is this person going to judge me because of how I feel or who I am? So that was probably another one, understanding there is no judgment in going to therapy. Because when you talk to your friends and you tell them what

> you did, and then you make another bad decision and they are looking at you like, you did that again! You ain't learn from the last time? And that's not the environment you get in therapy. So, the first one is probably the stigma, the second one is actually dealing with the stuff you've been holding in, and third one was the no judgement zone. Those are probably the three challenges that can keep people from going to therapy, but you gotta push through that. And now of course none of those things matter. I'm the biggest advocate for therapy. Everybody needs a therapist. The therapist needs a therapist; because there is really no way you can navigate through life just doing it by yourself. That's why there's a professional. Just like we appreciate the doctor doing a surgery or finding a cure for something, the mental health state is just as important. So those things are definitely not a challenge anymore for me.

Therapist Identity and Impact on Therapy. Faith-based counseling Participant 3 was asked to rate the effectiveness of her therapist on a scale of 1–10 and reported a score of 10 out of 10. When asked why she provided this rating, she stated the following:

> So, I give therapy a 10, just in general just because I'm a straight advocate. But I give my therapist a 10 as well, and it's just not a given 10. I've referred so many people to her. The reason that I like her is that 1. She can relate with the whole religion piece, first family piece, so she gets me. 2. She listens and she takes really good notes. 3. She asks the hard questions and she's not afraid to go there. So, you know, some therapists may want to ask this question or may want to check you, but they may not actually do it. She does not hesitate to. Cause I think that therapy can only be effective if you go in and you give her the full picture.

Now you can go in there and act like you're the victim or act like everybody's against you or whatever, but that doesn't really paint a good picture. So, I tell the good, the bad, and the ugly. What I said, what I shouldn't have said, what I thought, what I shouldn't have thought. I give her all of it, so that she's able to be object in her next thought or advice. The words that she wants to share. She's amazing in that way. I tell my friends, they go to her too, she knows how to check you and you be like wait did she just check me? I just got checked. That is what is necessary for you to go to the next level because you don't want to be victim. You do want to find out why you're doing some of things you're doing. We can't go around the world going unchecked. Especially when most of us won't take the time to check ourselves. Most people won't do that. But when you go to therapy, and there is this safe space, where you're like I think she just checked me, but I think I needed to be checked. That's where you're like, aww this is so effective. Because you leave there and be like, I'm not going back there! Who does she think she is checking me? But she gets you to think. She does well with triggers. Like you give this information, but then it is like, oh I didn't know that caused that and that was connected to this. And so, she's able to help you see the big picture. After you wipe your face and you've got all these tears, now what are you going to do? Because what you've been doing hasn't been working. So, what are you going to do differently? But that's the challenge. And she challenges you. I haven't been doing that right, or I could be better in this area. So that's why she's a 10, and that's why I recommend her. The relatability, the ability to not hesitate when she needs to say something. It is so important to me because if I live alone. I

> only have to report to one person most of the time. And people have to report to me. I'm making decisions. You can walk around unchecked. I just think that is so beneficial in the process of going to therapy. And finding that good therapists that you may not initially like, are actually working for your good.

Faith Considerations. Faith-based counseling Participant 3 self-identified as Christian and a member of the Church of God in Christ (COGIC). Participant 3 reported that she attended Sunday church services on a weekly basis. In addition, she attended Wednesday night Bible study. Faith-based Participant 3 reported she is a fourth-generation member of the COGIC. She reported that her therapist was a preacher's child and was familiar with her religious identification:

> I don't know what her denomination is per se, but she's definitely Christian. She used a lot of examples. She has a way of being able to cross over the spiritual to the natural, and the natural back to the spiritual. Whether it's examples, parables, or certain questions that she asks in a way to get your mind going. Whether it's down the natural lane or the spiritual lane. Questions, examples, parables, her own life experiences, she's able to do all of that.

Faith-based Participant 3 indicated one of the primary reasons for her seeking therapy was because of her impending divorce. She stated she was the wife of a minister, and the first lady at her church. Participant 3 acknowledged the importance of her therapist challenging her and using scripture to support her moving forward. This can be viewed in the following statement:

> One of the biggest concerns was the guilt, and feeling like because of this decision that I've made, God is going to punish me forever. Or something like

> that. She helped me to see the greatness of God. That our natural mind can be kind of small-minded. But God doesn't operate how we do. And He wants you healthy as well. So, for Him to keep you in this place where you're not healthy, where you're having thoughts of wanting this all to end, where you're miserable every day, and overwhelmed and stressed out . . . That's also not the will of God for your life. It's almost like if you're married and someone is physically beating you. Everybody would be like no baby girl; you need to get out. Right? But that's kind of the bar. But you gotta think when you're emotionally drained, stressed, depressed, and it's not physical abuse but it's the mental and emotional abuse, everybody is not always on one accord with that. We're all on one accord when he beats you, or he's going to kill you. But the thought that you're so overwhelmed that you want it to end. She helped me to kind of see that I was thinking in the natural. Go a little more spiritual. That God is not going to attack a person. He does want you to prosper. He does want you to have this joy. She helped to navigate that in a way that, you can't just assume what God is going to do, that puts Him in this box.

Faith-based counseling Participant 3 was asked to rate how effective she believed her therapist was in addressing faith-based concerns on a scale of 1–10 and provided a score of 8 out of 10. When asked about her rationale for this rating, she stated the following:

> Probably because she was the kid of the preacher, whereas I was the wife of the preacher. So, I think the experiences may have been a little bit different from our perspectives per se. I guess I only said an 8 because the religious piece of

> doctrine. Some Baptist people think it's okay to drink or smoke cigarettes, whereas I may not agree with that. We're all Christians, but more of doctrine dictates what we do and what we don't do. So, I would say an 8 in regard to that.

Faith-based counseling Participant 3 was asked to speak more about potential differences in doctrine and how that may have influenced the working alliance. She stated the following:

> Apostolic or Seventh Day Adventist worship on Saturday. We worship on Sunday because we believe the greatest act, was Jesus being raised from the dead. They honor the Sabbath on Saturday. I just think those are nuances. And so how I would handle something, knowing how Church of God in Christ operates, may be a little different if that's not her background . . . So I've learned that when I have conversations, whether it be with my boss, or with my parents, or with a therapist or whatever. I've learned how to filter information. So, somebody can say this is what I did in this situation, or they can say this is what I suggest you do in this situation, or this is how you should handle it. I'm always open to information, but as far as execution, I always filter it and make it my own. So, she would share that as a preacher's kid her mom would handle things a certain way. Or provide her perspective on their family and things like that. I can listen to that information and have the ability to see it for what it is, but how can I take the information that you've relayed and relate that to this situation? How can I make it my own?

Observations. Faith-based Participant 3 had extensive therapy experiences as an adult and was therefore able to provide significant depth within her responses. She detailed her work with a therapist over the past 4 years. Faith-based counseling

Participant 3 stated that during her initial sessions, all she could manage to do was cry her way through the session. However, she would continue onwards toward a meaningful journey of self-discovery. Faith-based counseling Participant 3 faced a potentially challenging situation entering counseling, as she was divorcing from her husband, who was the pastor of their church. This was not only going to change her marriage status, but also her position within her church (which she would depart). In addition, there is a sense of judgment that often accompanies divorce, both within society and within the church. We can surmise that this was a challenging time for the participant and may have tested her faith in various ways. Finally, we must acknowledge that she initially perceived negative stigma associated with seeking mental health treatment from her friends and family. She shared her belief that Black people are often encouraged to call upon God instead of seeking professional mental health assistance.

Faith-based Participant 3 discussed many ways in which she benefitted from therapy. She processed the ways in which society more readily relates to physical abuse instead of emotional abuse and recognized the need to depart from her marriage (abuse was not directly indicated by the participant). She indicated her therapist worked with her to reframe some of her thoughts (e.g., God as being mad at me, judgment, condemnation), and instead connecting with grace and God's desire for her personal best. The participant also addressed practical ways in which her therapist/counselor attempted to prepare her for the upcoming demands and transitions within her life. She recalled instances where her therapist/counselor asked her to think about financial planning, the emotional impact of divorce on herself and her children, ways in which she may begin to spend her time when she did not have her children, and other issues. This was essential to

the participant at that time and may serve as an example of addressing both the spiritual and the natural needs of the participant.

Faith-based counseling Participant 3 addressed her experiences of religion/spirituality within counseling. She stated her counselor was skilled in her incorporation of spiritual practice and Biblical beliefs into therapy. She specifically noted her therapist/counselor's use of parables. Although the clinician and client had different denominational beliefs/practices, there was enough commonality to encourage growth. Demographic differences could also be viewed in that the therapist/counselor was a "preacher's kid" and Participant 3 was the first lady. Participant 3 stated that although some of her counselor's advice did not exactly fit, she was able to adapt it and make it her own.

Chapter Five: Discussion

After reviewing all participant data, there are many conclusions to consider. Overall, there was an equal distribution of male and female participants within this project (three male and three female participants). It is of note that all therapists/counselors were female. This is currently representative of the broader field of psychology and may have treatment implications. Participants estimated their clinicians were licensed at the doctoral and master's levels, and all worked in traditional mental health settings. Though the researcher did not have access to training background information for the clinicians, all therapists appeared to have been classically trained (i.e., accredited programs and licensed within their respective state). It is not known what additional training the faith-based therapists/counselors received, if any. However, for the participants who identified their therapists as engaging in faith-based practice, there appeared to have been an additional element of experience that assisted in increased comfort and practice in addressing religious/spiritual needs. This included further exploration of the client's theological beliefs and practices, use of prayer, referencing of Bible scriptures, parables, reframing, and connection with abstract concepts such as God's grace.

All participants appeared to be highly motivated to seek treatment. However, there were notable differences within the groups regarding forms of engagement and use of therapeutic space. Traditional psychotherapy participants more regularly compartmentalized their faith and viewed it as secondary or sperate from their mental health treatment. There are a variety of reasons why this may have occurred. Do Christian clients in general more regularly compartmentalize their faith within traditional

psychotherapy? Was the decreased engagement regarding faith partially related to the client's presenting concern (e.g., the client did not view faith as a primary concern entering treatment)? Were there potential direct/indirect messages or therapist–client expectations that affected the use of the therapy space by the client? Perhaps the therapist/counselor failed to adequately assess the spirituality or faith practices of the client within treatment. Were there concerns about the comfort and competency of the clinician to address issues of faith within traditional psychotherapy? For all these stated reasons (and potentially other reasons not listed), the traditional psychotherapy participants minimally engaged with their faith within treatment.

Conversely, there was an additional layer of benefit for the faith-based counseling participants. There appeared to be less of an indivisibility between faith and therapy for the faith-based counseling participants. Faith is a primary component of the treatment, and this need is foundational to the Christian client seeking this form of therapy. This aligns with previous research findings that showed highly religious Christian persons may find added value in spiritually integrated forms of therapy (Worthington & Sandage, 2001).

Evaluation of Therapy

When reviewing the specific ratings of the effectiveness of therapy between the two groups, there appeared to be a high degree of consistency. Psychotherapy participants provided therapy effectiveness ratings of 8, 8, and 10, whereas faith-based participants provided ratings of 8, 8.5, and 10. When asked to define the characteristics or qualities of therapy that went into this rating, multiple responses were recorded. Across both therapy subtypes, participants appeared to regularly highlight their process of self-discovery,

recognition/engagement with personal patterns, interactions with planning, and the ability to begin to increase their sense of self-worth or self-accountability. Additionally, many participants highlighted the benefits of being challenged and needing to review specific thoughts, views, or schemas.

Additionally, multiple participants across therapy subtypes highlighted a level of initial discomfort related to entering therapy. This period of adjustment, and the ways in which it was navigated by both the therapist and the client, was likely critical to the success (or lack thereof) of the therapeutic process. In several instances, these African American clients felt judged or inadequately supported by their therapists. Two participants (psychotherapy Participant 3, faith-based counseling Participant 2) discussed their initial experiences with traditional psychotherapy and discontinuing because of value-related differences (e.g., child support, sexual masturbation). Though there may not have been sufficient time for the therapeutic relationship to develop in those instances, it underscores the importance of both value alignment and perceived cultural sensitivity when working with White therapists.

Results also showed that when making decisions about entering therapy, factors such as insurance played a primary role. Several participants across both subtypes mentioned choosing their provider based on insurance coverage or what was readily available to them. Though access to care is not the only consideration for African American clients, it likely remains central to the decision to seek mental health services or not. There were also some internal and external barriers to seeking therapy, as highlighted by faith-based counseling Participant 3. She stated several of her friends and

family inquired as to if she was “crazy,” and generally had a negative evaluation of seeking out assistance through the use of therapy.

Evaluation of the Therapist

When evaluating participants’ responses on therapist effectiveness across subgroups, there again appeared to be a high degree of consistency. Psychotherapy participants provided therapist effectiveness ratings of 9.5, 8.5, and 10, and faith-based participants provided therapist effectiveness ratings of 9.5, 8.5, and 10. Though participants largely rated their therapist/counselor in a positive manner, there were multiple examples of small rifts or misunderstandings within the therapeutic relationship. This can be specifically viewed in connection to issues of race, social justice, or politics.

Psychotherapy Participant 2 discussed potential contention with his therapist over issues related to sociopolitical differences and former President Trump. Similarly, faith-based counseling Participant 2 discussed social justice concerns and the ways in which her therapist remained ignorant or unsupportive in addressing her mental health and emotional needs within this area. In both instances, the participants were working with White female therapists. There were also multiple instances in which the therapist/counselor generally misunderstood the client’s experience or the views being expressed (psychotherapy Participant 1 and faith-based counseling Participant 2). Both participants expressed that they would commonly just move past things without clarifying the misinterpretation by the therapist/counselor.

When reviewing the therapy/counseling experiences evaluated for this study, all the participants were able to work through rifts or misunderstandings with their current therapist/counselor (although not true for past therapy experiences). Perhaps this was

related to client–therapist match, readiness to engage within therapy/counseling, or other factors. There appeared to be a strong correlation between participants' evaluations of therapy (benefits of therapy) and evaluations of the therapist. Although this was not intended to be interpreted as the same question, it appeared to have been evaluated as similar. This is largely understandable, as effective therapy likely cannot be provided by a practitioner who is viewed as ineffective by the client. In this respect, findings align with current research on therapeutic factors such as therapeutic alliance, therapist empathy, positive regard, and genuineness. Additional evaluation of the ways in which client expectations affected therapy outcomes would be needed.

Though the racial/ethnic identities of mental health clinicians likely continue to affect the experiences of African American Christian clients, it appeared all participants were able to work effectively across differences. Continued investigation into subjects such as values, therapy alliance, and working across difference is needed. African Americans are required to work across difference every day. As a result, it should come as no surprise that African Americans seemingly must do so within the therapeutic relationship as well. Given the potential benefits of therapist–client ethnic matching, we must continue to evaluate ways in which we can more effectively support African American clients.

Evaluation of the Therapist in Addressing Faith-Related Concerns

When reviewing the results related to therapist/counselor ability to effectively address faith-related concerns, there was a high degree of consistency between the subgroups. Psychotherapy participants provided ratings of 10, 8, and 9, and faith-based participants provided ratings of 9.5, 10, and 8. Though these were relatively high ratings,

one group was providing an estimation of therapist/counselor abilities (traditional psychotherapy group) whereas the other group was providing a rating based on experiences within therapy (faith-based counseling group).

None of the participants within the traditional psychotherapy group elected to process their faith within sessions. This was particularly compelling given that all traditional psychotherapy participants identified as Christian, identified their faith as being important to them, had established long-standing relationships with their therapists, and likely experienced situations in which faith was relevant to the presenting concern.

When further evaluated by the researcher, a variety of rationales were provided by the participants. Two of the traditional psychotherapist participants mentioned that they were either not there for the express purpose of addressing faith-related issues or they felt they had adequate church support outside of therapy and tended to address issues of faith with other members of their church or social support group. Psychotherapy Participant 1 stated he would spend more time analyzing why he had not brought up issues of faith and indicated he might consider doing so in the future. This was particularly salient because he identified struggles within himself regarding faith identification and support within his current faith. Psychotherapy Participant 2 indicated it was important that his therapist/counselor did not diminish his faith beliefs in any manner but stated processing his faith was not of particular importance to him. Additionally, psychotherapy Participant 3 identified that she perceived the sexual identity of her therapist (e.g., gay) affected her comfort level in addressing faith-related concerns.

Faith-based participants cited specific benefits associated with therapist feedback related to God, spiritual practice, Biblical scriptures or parables, and use of prayer. This

aligns with literature previously mentioned. Therapist faith identification was likely beneficial to faith-based participants. Though the faith-based therapists/counselors may not have held the exact same theological beliefs as the clients, there appeared to be a level of spiritual commonality that allowed for significant growth and development among participants. Though the client's spiritual orientation and use of faith is essential, the therapist/counselor's willingness to engage with these beliefs is equally important in supporting the client as they move forward.

Limitations and Future Recommendations

When reviewing the limitations of this study, it is important to acknowledge the relatively small number of participants. Though this was not intended to be a large-scale study, results cannot be more broadly applied to all African American Christian populations. Additionally, though there was diversity within the sample in the areas of gender, age, church denomination, and experience, there appeared to be limited diversity in terms of education, sexual identity, and gender non-conforming persons. Another limitation of this study is that the interviews were conducted via telephone. Though there was a benefit to using this technology insofar as the researcher could access broader geographic diversity, participants' at-home interruptions at times interfered with the depth of content. Though COVID-19 was a primary consideration for choosing telephone interviews, the researcher would recommend future research endeavors explore options for in-person interviews to facilitate an enhanced level of depth and safety in emotionality.

Chapter Six: Conclusion

As this study progressed, a high level of importance was placed on hearing the emerging voices of the participants, voices that acknowledge hurt, pain, pleasure, success, and an enduring spirit to triumph. Though there were groupings of shared attributes across some participants, as well as individual differences acknowledged, a key commonality of self-growth and discovery was shared across all. This likely denotes that regardless of therapy subtype, African American Christian clients can benefit from therapy. However, practitioners in the fields of both psychology and theology must make a continued effort to address the needs of all people.

Those in the field of psychology have an obligation to better train clinicians in the treatment and support of African American Christian clients. Though it must be recognized that not all African Americans are Christian, the African American Christian client is dually exposed in their likelihood to be mistreated based on race and faith identification. This mandates additional training on the part of providers. Moreso, the field of psychology is more than 80% White (Lin et al., 2018). What impact does this have on African Americans as they are continually mandated to work with White therapists who are undertrained in addressing diversity?

The field of psychology as well as individual clinicians must do a better job in the provision of faith-based support. This may include, but is not limited to, spiritual assessment, self-disclosure, faith-based referrals, and the integration of faith practices into therapy. This begins with becoming more curious about the client's background, current experiences, practices, and potential interests as they progress forward. This process also likely includes an identification of old maladaptive ways of thinking and

responding and encouraging further creation and connection with new more adaptive solutions or choices.

In conclusion, the Black Church must continue to play a central role in the support and advancement of mental health initiatives within the Black community. This means recognition, acknowledgement, and partnership with mental health professionals for the benefit of its congregants. For far too long, there has remained divisiveness related to mental health provision and religion/spirituality. Just as the field of psychotherapy must advance, so must the Black Church. We have seen recent initiatives by mental health agencies that have sought to better support communities of color through the provision of community-based services and cooperation with local churches. It is through this model that we may continue to see progression and advancement.

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Appendix A: Research Project Consent Form

My name is Shannon Gray, I am a fourth-year doctoral student at National Louis University. I am asking you to participate in my study, "Faith Based Counseling Approaches versus Traditional Psychotherapy: A Phenomenological Evaluation of African American Protestant Experiences", occurring from 07-2020 to 07-2021. The purpose of this study is to evaluate and assess the therapy/counseling experiences of African American Christian clients in traditional psychotherapy and faith-based counseling settings. This form outlines the purpose of the study and provides a description of your involvement and rights as a participant.

By signing below, you are providing consent to participate in my research project. I will be conducting a semi-structured interview with you, in which I will pose a series of questions to you about your therapy/counseling experiences. A second interview session would only be requested if you are unable to complete the first interview in full; or if I require further clarification regarding certain responses in the initial interview.

Your participation is voluntary and can be discontinued at any time without penalty or bias. The results of this study may be published or otherwise reported for educational purposes. Your identity as a participant will in no way be revealed (data will be reported anonymously and will bear no identifiers that could connect data to individual participants). To ensure confidentiality, the researcher will secure recordings, transcripts, and field noted in a locked cabinet in my home office.

The anticipated risk with this project is categorized as minimal. I may prompt you to recall emotionally sensitive content. While the intent of the study is to collect as much data as possible; my goal as a researcher is to remain respectful of your rights as a participant. If at any time you require a break, an emotional intervention (i.e., deep breathing or guided exercise), or are unable to continue; please notify me.

Upon request you may receive summary results from this study and copies of any publications that may occur. Please email me at sgray13@my.nl.edu to request results from this study. Upon completion of this research all data will be destroyed after 3 years.

If you have questions or require additional information regarding this study, please contact me via phone: [redacted] or email: [redacted].

If you have any concerns or questions before or during participation that have not been addressed, you may contact my project chair, Dr. Margret Warner. She may be reached at mwarner9@nl.edu. Additionally, the co-chairs of National Louis University's Institutional Research Board may be contacted: Dr. Shaunti Knauth; email: Shaunti.Knauth@nl.edu; phone: (312) 261-3526; or Dr. Kathleen Cornett; email: kcornett@nl.edu; phone: (844) 380-5001. Co-chairs are located at National Louis University, 122 South Michigan Avenue, Chicago, IL.

Thank you for your consideration.

Participant's Signature	Date	Researcher's Signature	Date
_____	_____	_____	_____

Appendix B: Semi-Structured Interview Questions

Hello, my name is Shannon Gray. I am a fourth-year doctoral student at the Illinois School of Professional Psychology at National Louis University. I am conducting a clinical research project as a requirement of my program. The aim of my study is to attempt to assess the clinical and counseling experiences of African American Christian clients. A series of questions will be posed to you. Please answer with as much detail as possible. I may follow-up with some additional questions based off your initial responses. If you experience any difficulties during the interview, please notify the examiner. The examiner will work with you to provide breaks, intervene with appropriate emotional support techniques, or amend the interview questions if necessary. If you consent, we will now begin.

1. When you sought counseling, did you see a psychotherapist or faith-based counselor?
2. Why did you chose the form of counseling you chose?
3. What was the nature of your concern that led you to receive counseling?
4. What year did you see the therapist or counselor (an approximation is fine)?
5. How many sessions did you see the counselor for (an approximation is fine)?
6. On a rating scale of 1–10, how would you rate the effectiveness of therapy/counseling?
    - Potential follow-up question: Why did you rate the effectiveness as you did?
    - Potential follow-up question: Can you tell me more about your rating?
7. After reviewing your therapy/counseling experiences, what therapeutic benefits have you identified?
    - Potential follow-up question: Can you tell me more about that?

8. When examining your therapy/counseling experiences, what challenges or ineffective attributes have you identified?

    - Potential follow-up question: Can you tell me more?

9. On a scale of 1–10, how would you rate the effectiveness of your therapist/counselor?

    - Potential follow-up question: Why did you rate the therapist/counselor's effectiveness as you did?

10. Were issues of faith addressed within your therapy?

    - Potential follow-up question: What specific areas of faith were addressed?

11. How were areas of faith addressed?

12. On a scale of 1–10, how pleased were you with the therapist/counselor's ability to address your faith related concerns?

    - Potential follow-up question: Why did you rate the effectiveness as you did?

13. Did you perceive your therapist/counselor as being comfortable in addressing areas of faith?

    - Potential follow-up question: How did you arrive at the conclusion you reached regarding this?

14. When you examine your therapy/counseling experiences, are there any specific elements which you can identify as lending to an effective outcome?

15. As you examine your therapy/counseling experiences, is there anything you believe your therapist could have done to promote a more effective outcome?

    - Potential follow-up question: Can you speak more about that?

16. Is there any additional information you would like to provide?

17. Can I contact you later if I have any follow-up questions?